STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Les Peters Academy

TrueCore Behavioral Solutions, LLC.
(Contract Provider)
3930 W Dr. Martin Luther King Jr. Blvd
Tampa, Florida 33614

Review Date(s): October 20-23, 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:

Kara Brown, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Melissa Johnson, Office of Accountability and Program Support, Regional Supervisor, Central Region (Standard 3)
Greg Mahoum-Nassar, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Amanda Nelson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Crystal Shannon, Sequel Youth Services, Director of Nursing (Standard 4)
Stephanie Shay, Office of Accountability and Program Support, Deputy Supervisor, Central Region (Standard 2)
Paul Sheffer, Office of Accountability and Program Support, Regional Monitor (Standard 1)
Ron Warrick, Office of Education, South West Region Education Coordinator (Standard 2)

Program Name: Les Peters Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): October 20-23, 2020

MQI Program Code: 1282
Contract Number: 10098
Number of Beds: 24
Lead Reviewer Code: 184

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.07 Pre-Service/Certification Requirements *	3.09 Psychiatric Services *
4.04 Parental Notification/Consent	
5.06 Logbook Entries and Shift Report Review	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	Pre-Service/Certification Requirements *	Limited
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/Guardian 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 *	Failed
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Limited
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	Limited
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision 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	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

Les Peters Academy is a twenty-four bed program, for fourteen to eighteen 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 intensive mental health treatment services. In addition, the program fosters each youth by providing Impact of Crime, Teen Relationships, Voices: A Program of Self Discovery and Empowerment for Girls, Mindfulness Movement, Social Rhythms, Dialectical Behavioral Therapy (DBT) by Media Therapy, and Matrix Model. Additional treatment services provided includes individual, family, and group therapy. Program administration is comprised of a facility administrator, assistant facility administrator, program director, director of clinical services, health services administrator, and director of case management. The way the contract is set up, Les Peters Academy and Tampa Residential Facility share one facility administrator; however, the listed assistant facility administrator acts as the facility administrator at Les Peters Academy, is referred to as the facility administrator, and will be referred to as the facility administrator in the annual compliance report. Case management services are provided by a director of case management, two case managers, and a transitional services manager. Mental health staff at the program includes a director of clinical services, two therapists, an assistant director of clinical services, a certified behavior analyst, a psychologist, and a psychiatrist. Medical services are offered sixteen hours a day, seven days a week, and are provided by the health services administrator, three registered nurses, and a designated health authority. Educational services are provided by the Hillsborough County School Board. The layout of the program includes: one main building, education portables, and maintenance sheds. The program has forty-three operating security cameras providing coverage. At the time of the annual compliance review, the program had seven vacant youth care worker positions.

Strengths and Innovative Approaches

Graduation to College

Les Peters' transition service manager (TSM) works closely with the education department on-site and has developed a partnership with Hillsborough Community College (HCC) to provide the youth an opportunity to continue their education upon completing high school or obtaining their General Educational Diploma (GED). Les Peters has held two graduation ceremonies with a total of three graduates. Two of the three girls have been enrolled in elective courses at HCC while still in the program. The TSM assists the youth applying for Free Application for Federal Student Aid (FAFSA), completing the application process, and entrance testing. The youth are enrolled online so they are able to continue their education from their home counties upon release. This year, Steadfast Mentoring sponsored one of the youth by paying for her first two courses and providing assistance with books. The youth are so proud of their accomplishments and are grateful to have the opportunity to continue their education and build on their future.

Les Peters Academy Treatment Assistant

Les Peters' transition service manager (TSM) created a Student Worker program to build the youth's life skills. The assistant will carry out administrative and technical tasks requested by the TSM and will assist and mentor and/or provide support to Les Peters Academy treatment team members. This opportunity is open to all youth after they complete their first formal treatment team meeting. Positive risk assessments (background screening) are required. The youth will need to have a personal (direct care staff) and professional (case manager, therapist, administration) reference and a three-page job application/questionnaire. Once a youth passes this process, an interview is scheduled with the TSM and youth. If the youth is selected an offer letter is provided.

Steadfast Mentoring

Steadfast Mentoring is a faith-based mentoring program which provides mentoring services to incarcerated youth throughout the state. The mentors are assigned to the youth within the first month of being at the program and keep in contact with the youth once released. Steadfast has an "every youth, every facility" initiative to ensure every youth is provided with a mentor to offer consistent friendship, encouragement, guidance, and concrete help. Mentors are a part of everyday programming. They provide assistance with and participate in activities at the program such as, family day, graduations, holiday break activities, bible study, and pancake breakfasts. Steadfast Mentoring is sponsored and coordinated by Bay Hope Church. To meet the needs of vulnerable children throughout Florida, they partner with Christian Churches across the state. One of the unique opportunities Bay Hope and Steadfast provide is Baptism. The youth participate in a six-week bible study group and Baptism group, so they understand the choice they are making. Les Peters has had eight youth baptized this year. The girls love having mentors as they provide spiritual, emotional, and physical support.

Arts for All

Les Peters' youth can begin working with an artist from Arts for All. Arts for All is a non-profit organization which serves thousands of local students each year, many of whom would not otherwise have opportunities to receive arts education. Arts education positively impacts the lives of children by helping to develop critical thinking, problem solving, resourcefulness, teamwork, and many other skills.

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 to ensure background screening is conducted for all staff, volunteers, mentors, and interns with access to youth and/or confidential youth records. The program had seven newly hired staff and one new mentor since the last annual compliance review. Each newly hired staff and the new mentor were on the program's Agency for Healthcare Administration (AHCA) Clearinghouse roster and had clear and eligible background screenings which were completed prior to their hire date. Each staff record had documentation a criminal history report was reviewed prior to hire and no exceptions were required. In addition, each staff record had documentation the Staff Verification System (SVS) module, the Department's Central Communications Center (CCC) personal involvement history report, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) were reviewed prior to hire. Four of the newly hired staff were direct care staff and eligible for a pre-employment assessment. All four staff had a passing score recorded in their employment record. The remaining individuals: a clinical staff, a case manager, a nurse, and the mentor did not require a pre-employment assessment. The program completed and sent their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU) on December 10, 2019. The Hillsborough County School Board, which provides teachers for the program, submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on December 10, 2019.

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

The program has a policy and procedures which address the five-year background rescreening process. A background rescreening is required every five years from the initial date of employment. A review of the program's staff, volunteer, and contracted staff program rosters indicated the program had three staff eligible for rescreens. All three rescreens were completed and submitted to the Agency for Healthcare Administration (AHCA) Clearinghouse at least ten business days prior to the five-year anniversary date as required.

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 maintains a policy and procedures to ensure 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 program's policy states all staff must immediately report any knowledge or suspicion regarding an incident of abuse to the Florida Abuse Hotline if the youth is under age eighteen, or to the Central Communications Center (CCC) if the youth is eighteen years of age or older. If a youth refuses to make an abuse call based on an incident of abuse, staff are still required to make a call. Staff is to verbally notify the on-duty supervisor once a call has been completed and let them know why the call was made. This is not required if an anonymous call was made regarding sexual misconduct. Following a call, staff must complete an internal incident report.

In an interview the facility administrator (FA) stated when they are notified of an incident they determine if the incident is CCC reportable by reviewing the Department's CCC reportable incidents criteria. If an incident is reportable, all necessary information is obtained and the CCC is contacted within the two-hour time frame. The FA is the primary reporting person; however, any staff or youth over the age of eighteen are also able to make a CCC report. All staff are mandated reporters and can contact to Florida Abuse Hotline at any time. If a youth requests to contact the Florida Abuse Hotline, they are provided the opportunity to do so immediately. The FA confirmed staff and youth are knowledgeable in contacting the Florida Abuse Hotline and CCC. Staff are trained on the matter in their pre-service and in-service training. The phone numbers for the Florida Abuse Hotline and CCC are posted throughout the facility and are available to both staff and youth. Five staff were interviewed and indicated they are knowledgeable in the process for allowing staff and youth to call the Florida Abuse Hotline or CCC. None of the staff have observed another staff tell a youth they could not call the Florida

Abuse Hotline. Five interviewed youth indicated they have never been stopped from reporting abuse to the Florida Abuse Hotline or the CCC.

Staff adhere to a code of conduct, which is agreed to and documented on each staff's new hire checklist. An interview with the FA indicates general standards of conduct and performance apply to all staff and contractors. The standards are categorized into three levels; minor offense, major offense, and critical offense. Failure to follow a standard of conduct may result in disciplinary action ranging from an oral warning to termination of employment depending on the frequency and nature of an offense. Five interviewed staff stated they have never observed another staff using profanity when speaking to youth or using threats, intimidation, or humiliation when interacting with youth. Three interviewed youth stated staff are respectful when talking with the youth. One youth stated some staff are sometimes respectful when talking with them, but the floor staff are not. The remaining youth indicated floor staff are disrespectful when talking with them and other youth. Three youth indicated they have not heard staff use curse words when speaking with them or other youth. One youth stated floor staff use profanity when speaking with them and other youth, and the remaining youth stated they hear staff use profanity two times a week on average. Each youth stated they have never exchanged e-mails, telephone numbers, or social media contact information with staff. Each youth indicated they feel safe in the program.

The environment is free of physical, psychological, and emotional abuse. There were two reported incidents related to abuse since the last annual compliance review and neither were substantiated. A review of the two incidents found one resulted in a call to the Florida Abuse Hotline and both resulted in a call to the CCC. Both incidents were complaints about staff. One alleged physical abuse and the other alleged physical and emotional abuse. Neither of the incidents included a potential human trafficking victim, commercial sexual exploitation or labor trafficking. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment to assist them in incorporating trauma responsive principles into the program environment. The TRACE self-assessment was completed on February 28, 2020.

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. A review of all incidents since the last annual compliance review found two incidents which involved a complaint against staff for physical and emotional abuse. One incident involved one staff and the other involved three staff. Reviewed documentation found management took appropriate and immediate action by initiating an internal investigation regarding staff on the allegation of abuse. Documentation confirmed the staff in the first incident was suspended pending the investigation and the three staff in the second incident were not required to be removed from youth contact. The reviewed reports were found to be unsubstantiated for abuse; however, the staff in the first incident was terminated based on non-abuse allegations reported during the same incident. An interview with the facility administrator (FA) confirmed there have been no staff to receive disciplinary action due to allegations of abuse towards a youth since the last annual compliance review. The FA stated an internal investigation is initiated anytime management is made aware of any allegations of abuse. The involved staff is to be placed on suspension pending investigation to

prevent further incident. The Florida Abuse Hotline or Central Communications Center (CCC) is to be notified as required. Upon completion of an investigation, disciplinary action will be issued following the program's progressive disciplinary system.

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 maintains a policy and procedures to ensure the Department's Central Communications Center (CCC) is notified within two hours of an incident occurring or within two hours of any program staff becoming aware of a reportable incident. A sample of five incidents from the last six months were reviewed and each incident was reported within the required two-hour time frame. Two of the incidents were youth behavior incidents, two were complaints against staff, and one was a medical incident. All five incidents were documented in the logbook as required. A review of incidents, grievances, and youth records found no additional incidents which should have been reported to the CCC. A total of twenty-one reportable incidents took place within the last six months. This was an increase from the last annual review period, which had eighteen reportable incidents; however, fifteen of the CCC incidents this review period were related to COVID-19 testing. The facility administrator (FA) was interviewed and reported all staff receive pre-service and in-service training on abuse and CCC reporting. The FA stated all CCC and abuse incidents are reviewed and reported in morning managements meetings.

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 regarding the use of physical intervention techniques in accordance with Florida Administrative Code. Anytime staff uses a physical intervention technique, a Protective Action Response (PAR) incident report is completed and filed in accordance with the Florida Administrative Code. A sample of five incidents involving the use of PAR in the last six months were reviewed. The PAR incident report was completed by the end of the staff's workday for all five incidents. Each report included a statement from each staff involved. Mechanical restraints were not used in any of the incidents; therefore, the Mechanical Restraint Supervision Log did not need to be completed. None of the reviewed PARs resulted in an injury to youth or required a call to the Department's Central Communications Center (CCC). No youth alleged abuse in any of the incidents. Each incident report included a review by a PAR certified staff and was reviewed by the facility administrator (FA) within seventy-two hours of the incident. A post-PAR interview was conducted with the youth within thirty minutes of the incident for four of the incidents. The remaining post-PAR interview was completed two hours and ten minutes following the incident. This was identified by the FA when reviewing the incident and the incident report indicates the FA reviewed with staff the post-PAR interview must take place within thirty minutes of the incident. None of the post-PAR interviews indicated a need for a PAR medical review. Each incident report was placed in the program's PAR binder along with

monthly summaries of all PAR incidents, which were submitted to the Department's regional office by the fifteenth of each month.

The program has a PAR plan which was approved by the Department on December 20, 2019. The program's PAR rare during the annual compliance review period was 4.06, which is above the statewide residential PAR rate of 2.23. The program has experienced a decrease in the number of PARs since the last annual compliance review. The PAR rate at the last annual compliance review was 6.92. An interview with the FA indicated PAR reports are reviewed in morning management meetings and reported for tracking in the morning meeting database. The FA stated a video review of each incident is conducted following the incident to ensure proper PAR procedures were followed, there was no use of excessive force, and PAR was a necessary level of response. The FA stated a PAR Summary Report is completed monthly, reviewed for trends, and submitted to the Department for tracking. Five staff were interviewed, and four staff stated they have used PAR. All four staff who have used PAR were able to explain the program's process and procedures when using PAR.

1.07 Pre-Service/Certification Requirements (Critical)	**Limited 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 regarding pre-service training. The program has a pre-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 staff training records were reviewed for pre-service requirements. All five staff completed a minimum of 120 hours of pre-service training within 180 days of hire. All five staff completed the essential pre-service training which must be completed prior to any contact with youth, including cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), forty hours of Protective Action Response (PAR), ethics, suicide prevention/intervention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), human trafficking, and active shooter training. All five staff completed other required trainings listed in the program's contract including trainings on topics of staff stress management, gender responsive services for adolescent delinquent youth, positive reinforcement techniques and strategies, emotional and behavioral development of children and adolescents, risk factors for delinquency and their treatment, physical development and common health issues of adolescent youth, restorative justice programming, risk factors and triggers relating to youth with history of victimization, post-traumatic stress disorder (PTSD), victimization, exploitation, domestic violence, trauma, and recovery issues, trauma responsive services, universal precautions, Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), risk factors and triggers relating to homicidal risk and homicidal prevention, immediate access to emergency medical, mental health, and substance abuse services, the program's treatment model, trauma informed care, emergency procedures, safety, and security/supervision, TrueCore program philosophy, gang awareness, emergency evacuation procedures for youth with medical alert system, cognitive/behavior and social learning, law enforcement policy and involvement, civil rights, and delinquency prevention. The program's contract requires all staff to receive Motivational Interviewing (MI) training. None of the reviewed staff received MI training and an MI training was not included on the program's pre-service training plan. All five staff received training on Mental Health Overlay Services. All five staff's completed pre-service trainings were documented in the Department's Learning Management System (SkillPro) within thirty days of completing their training.

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

The program has a policy and procedures regarding in-service training. Five staff records were reviewed for in-service training. Each staff completed a minimum of twenty-four hours of annual in-service training, with each reviewed staff completing between fifty-four and seventy-seven hours of in-service training. Each reviewed staff's completed in-service trainings included cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), an eight hour Protective Action Response (PAR) update, ethics, six hours of suicide prevention, two hours on the Department's Learning Management System (SkillPro) and four hours instructor-led or webinar, human trafficking, and active shooter training. Two of the reviewed training records were for supervisory staff. Only one staff was applicable for annual supervisory training as the remaining staff was promoted to a supervisory position in December 2019. The one applicable staff received more than the required eight hours of supervisory training. The applicable staff completed eleven hours of supervisory training and received training in management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All staff training was documented in SkillPro. The program maintains an annual in-service training calendar, which is updated as necessary. The program's in-service training plan was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020.

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 maintains a policy and procedures which include the training requirements for the grievance process. All program staff are trained on the grievance process, facility operating procedure for grievances and required documentation during their pre-service and in-service training. Five staff were interviewed, and they all indicated they were knowledgeable about the program's grievance process. The program's grievance process includes an informal phase, which is completed by utilizing Chatty Cathy forms, a formal phase, and an appeal phase. The steps and time frames are documented for all phases. An interview with the facility administrator (FA) confirmed the program's grievance process. The FA indicated youth are encouraged to resolve issues through informal communication with staff; however, a grievance may be filed at any time. A review of the program's grievances found the program maintains copies of grievances for the past twelve months. The program had sixty-seven grievances filed during the review period. A sample of seven grievances were reviewed. The nature of the grievances were discipline and grievances based on communication with staff, shelter, safety, clothing, food, and searches by staff. The informal phase was not completed for any of the seven; however, it is not required. All seven grievances were resolved prior to the appeal phase and responded to within

the proper time frames. Five interviewed youth stated grievance forms are placed throughout the program and they can ask for assistance when completing a grievance.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program's contract requires the program to provide interventions to each youth including Impact of Crime (IOC), Voices - A Program of Self-Discovery and Empowerment for Girls (Voices), Matrix Model, Dialectical Behavior Therapy (DBT) with media therapy, Mindfulness Movement, Teen Relationships, and Social Rhythms. Nine staff members facilitated groups during the annual compliance review period, one of which was a licensed clinical social worker (LCSW), two were licensed mental health counselors (LMHC), four were masters-level clinicians, and two were bachelors-level clinicians. A review of staff training records indicated each staff had the required training, education, and experience to deliver delinquency intervention services which were considered when assigning staff to deliver the interventions. An interview with the facility administrator (FA) confirmed the program is providing the contractual intervention services and staff are appropriately trained to administer groups. The FA indicated only bachelors and masters-level staff provide life skills trainings or groups. An interview with the designated mental health clinical authority (DMHCA) indicated they ensure provided programming meets all contractual requirements. All five interviewed youth stated they are participating in intervention groups.

A review of group sign-in sheets confirmed the program is completing all groups on the contract table according to the program's schedule. A review of the program's activity schedule found more than sixty percent of the youth's time is scheduled with structured, planned programming or activities, including time for groups. Five youth records were reviewed, and each youth was found to be participating in delinquency interventions which are evidence-based, promising practices, or practices with demonstrated effectiveness. Each youth was participating in a delinquency intervention addressing a priority need as identified by the Residential Assessment for Youth (RAY). Each youth's performance plan addressed an identified priority need.

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 maintains a policy and procedures which ensure interventions or instruction focusing on developing life and social skill competencies in youth are provided. Masters-level clinicians or therapists facilitate life skills groups which address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. The program's life and social skills groups include Teen Relationships, Voices - A Program of Self-Discovery and Empowerment for Girls (Voices), Dialectical Behavior Therapy (DBT) with media therapy, Social Rhythms, Mindfulness Movement, and the Matrix Model. A review of the program's activity schedule and group sign-in sheets indicate groups are held daily as scheduled. An interview with the designated mental health clinical authority (DMHCA)

revealed a monthly fidelity monitoring of each facilitator is conducted to ensure groups are being conducted as required.

In addition to the life skills curriculum, the program is incorporating other life skills for the youth. The program provides parenting classes for youth who are parents or are expecting. The program's transitional services manager works with each youth on career interests and job skills and assists them with résumés and sample job applications. Each youth is trained in cardiopulmonary resuscitation (CPR) and first aid. Youth are also trained in what to do in emergency situations and are taught how to test a smoke detector. Five youth were interviewed, and each youth stated they participate in groups. Each youth was able to describe skills they have learned in groups and explain how they have practiced these skills.

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

The program has a policy and procedures for the provision of restorative justice awareness to the youth. The program's contract identifies Impact of Crime (IOC) as the required restorative justice service provided to all youth. Interviews with the designated mental health clinical authority (DMHCA) and the facility administrator (FA) confirmed each youth in the program receives IOC. A review of the program's group schedule and group sign-in sheets revealed the program holds IOC groups twice a week for one hour as scheduled. A review of group documentation found the group addresses assisting youth in accepting responsibility and teaching youth about the impact of crime. The group exposes youth to victims' perspectives and provides youth opportunities to participate in reparation activities. A review of group documentation indicated the program had three staff who conducted IOC groups during the annual compliance review period. Each staff received IOC training.

An interview with the FA revealed the program has not been able to go on off-site outings since COVID-19 started; however, the youth have been able to participate in alternative restorative justice activities. The FA stated the youth have been exposed to guest speakers through videos, have written letters to elderly individuals in nursing homes, and have planted flowers and plants around the center to honor victims. While the review team was on-site, the youth were working on a restorative justice activity to raise money for hygiene products to make hygiene bags for the homeless. The youth made posters and advertised different food items for each day of the week in which the youth could use their daily points to purchase. During the annual compliance review, youth were observed using their daily points to purchase wings and fries during lunch. The points used for purchasing the items were then exchanged for money to buy the hygiene items. The youth came up with ideas for items and encouraged other youth to participate in the fundraiser. Five interviewed youth stated they are participating in groups.

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

The program's contract requires Voices - A Program of Self-Discovery and Empowerment for Girls (Voices) as their gender-specific programming. Each youth participates in Voices, which consists of two sessions a week for eighteen sessions. An interview with the designated mental health clinical authority (DMHCA) confirmed each youth completes Voices prior to their release. Three of five interviewed youth indicated they have participated in Voices, with two of them having already completed the group. Each youth participates in the Teen Relationships group which is a therapeutic group. Teen Relationships is held two times a week. A review of the program's activity schedule and group sign-in sheets confirm gender-specific programming is being held as required. The program designs its services based on the common characteristics of its primary target population. The program's facility administrator (FA) stated the program follows the girls matter gender responsive philosophy. The FA stated the program provides youth with personal items which allow gender expression, to include meeting the needs of youth who identify as the opposite gender.

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 which outlines how alerts are identified, documented, updated, and communicated to staff. The program has an alert board in the staff duty station, which documents all youth alerts. The program utilizes a medical alert log to document medical related alerts. A review of alerts entered in the Department's Juvenile Justice Information System (JJIS) were consistent with the program's internal alert system. An interview with the facility administrator (FA) confirmed the program's alert system. The FA stated any change in a youth's alert status is updated on the alert board, documented in the logbook, and discussed during the morning management meeting. The FA stated the shift supervisor briefs incoming staff on any new or changed alerts.

Five youth records were reviewed for all alerts on each youth. A review of alerts and logbooks confirmed each alert was entered, updated, and/or closed, as required, by the appropriate staff and documented in the logbook, if applicable for each youth. Staff in each department are responsible for managing alerts applicable to their department. An interview with nursing staff indicated only healthcare staff can update the medical alert system. A review of youth records in case management, mental health, and medical services revealed no issues with alerts. Five

staff interviews were conducted, and each reported they are informed of alerts through the alert board and during shift briefings.

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

The program maintains three records for each youth, an individual healthcare record, an individual mental health record, and an individual management record. Five youth individual management records were reviewed, and each contained the youth's name, Department of Juvenile Justice Identification (DJJID) number, date of birth, county of residence, and committing offense. Each record contained a table of contents with sections for legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All youth records are labeled "Confidential" and are maintained in a locked cabinet or closet in the case management office, clinical office, and medical office, inaccessible to the youth.

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

The program has a formal process to promote constructive input by youth including the youth advisory board, Chatty Cathy forms, daily meetings, and community circle. Youth advisory board meetings are held twice a month and a community circle is held monthly at a minimum. The process of promoting youth input was confirmed in an interview with the facility administrator (FA). A review of advisory board meeting minutes and Chatty Cathy forms confirmed youth are given opportunities to provide input. During youth advisory board meetings any issues with the program or youth, incentives, and ideas are discussed. The youth advisory board currently consists of two members and they are soliciting more members. Five youth interviews were conducted, and each stated they are given opportunities to provide input through the youth advisory board and Chatty Cathy forms.

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 community advisory board which is scheduled to meet on a quarterly basis. A review of the community advisory board binder found the last quarterly advisory board meeting was held on September 22, 2020 utilizing a video conferencing software program. A review of the list of attendees, the board roster, and letters from the program found the facility administrator (FA) has solicited involvement from a law enforcement representative, a judiciary community representative, other community partners, a business community representative, a school board or district representative, a faith community representative, and a lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community representative. Reviewed letters in the community advisory board binder confirmed the FA recruited a victim, victim advocate, and a parent/guardian whose child was previously involved in the juvenile justice

system. Reviewed documentation reflected a representative from each category was a member of the advisory board or had been invited to join the advisory board. An interview was conducted with the FA who confirmed meetings are held quarterly. The FA stated meeting minutes are shared with all board members following each meeting to inform those who may not have been present. The FA stated recruitment letters are mailed out periodically to solicit new membership and ensure each position on the board is properly represented. An interview was conducted with a board member from the business community. The interviewed board member stated she has served on the board since last October. She stated she had been volunteering at the program prior to being invited to be on the community advisory board. She stated she is a chef and would come into the program once a month to conduct a food presentation. She stated she served the youth a Thanksgiving dinner last year. The board member stated she has been unable to come in and volunteer this annual compliance review period due to COVID-19. She stated she has been attending the community advisory board meetings by video conferencing and during the meetings they discuss what they can offer the program and come up with different ideas for the program. She stated the board is all about helping the youth and the program is always willing to listen to ideas.

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

The program uses data to inform their planning process and to ensure provisions for staffing. The program conducts youth and parent/guardian surveys prior to, during, and after youth stays. Parent/guardian surveys are sent upon intake and again at discharge. Youth surveys are conducted quarterly to receive feedback regarding day to day programming. The program provided youth surveys for review but would not allow the reviewer to make copies. The program stated they have not received any parent/guardian surveys back, but they provided a sample of the surveys they send out. An interview with the facility administrator (FA) indicated they use the surveys to make improvements in practices to enhance parent/guardian involvement or ensure systems are being followed as expected. The Department's Comprehensive Accountability Report (CAR) was found to be discussed during a monthly staff meeting on April 28, 2020 and integrated into programming. The FA stated the data is explained so everyone is able to understand how programming translates into statistics and how they can make improvements or maintain positive areas. The program's Trauma Responsive and Caring Environment (TRACE) was reviewed with staff at a monthly staff meeting on July 28, 2020. The facility administrator stated The Monitoring and Quality Improvement Report was discussed with staff during a monthly staff meeting as well, as Department of Juvenile Justice updates are discussed at every staff meeting.

The program has a system of communication to keep staff informed and give them the opportunities to provide input and feedback pertaining to operation of the program. The program's system includes monthly staff meetings and staff surveys. The program holds monthly staff meetings for all staff, debriefs at the beginning and end of each shift, morning management meetings Monday through Friday, and monthly operational meetings. A review of documentation confirmed meetings are being held as scheduled. Staff surveys are conducted quarterly. The program has a plan for staff retention including steps to minimize turnover and improve staff morale. Documentation was reviewed showing the program has an employee referral program where staff get incentives for recruiting new staff. They have an above and beyond award and staff recognition awards where staff can receive shirts or a jacket. The program holds spirit weeks, staff outings, and on-campus socials for the staff. The program currently has seven youth care worker vacancies. The FA stated they are focused on filling

vacancies but are also very focused on maintaining current staff by emphasizing staff morale and engagement.

Five staff were interviewed and stated staff meetings are held monthly. One staff also stated operational meetings are held monthly. All five staff stated the meetings are informative. The interviewed staff stated topics discussed at the meetings include any issues, drills, trainings, new youth, gang behaviors, policies and procedures, progress and improvements, youth needs, scheduling, and general information. Each staff stated they are briefed on annual reports and/or youth and parent/guardian survey results. Two staff stated communication in the program is very good, two stated it is good, and one stated it is fair. One staff indicated they do not always know about situations they may be in or problems going on, but supervisors may know. Four staff stated the program has an open-door policy to provide input and feedback into the program operations. Two staff indicated there is an employee suggestion box.

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 to ensure staff are evaluated, at least annually, based on established performance standards. Each staff receives an evaluation after the first ninety days of employment and annually thereafter. A review of position descriptions confirmed job duties are clearly identified for each position. A review of five pre-service staff records confirmed three staff received a ninety-day evaluation and two staff had not yet hit their ninety-day mark. A review of five in-service staff records confirmed each staff received an annual performance evaluation. Each staff was evaluated on established performance standards matching their job descriptions. A review of the position descriptions and documentations confirm all required positions in the program's contract are being maintained and performed as outlined in the contract. The facility administrator (FA) confirmed evaluations are completed within ninety days of hire and annually. Five staff were interviewed and four stated they receive a formal evaluation of their performance based on their performance standards yearly. The remaining staff stated they are evaluated every ninety days.

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 ensuring the program provides a variety of recreation and leisure activities. The program's activity schedule and logbook were reviewed and confirmed the youth receive at least an hour of recreation each day. The program's recreation calendar designates an activity for the youth to participate in during outdoor recreation each day. The activities include volleyball, stretching, flag football, kickball, running, basketball, and dance. There is a list of indoor activities if youth are unable to go outside including Zumba, yoga, jogging, and workout circle. Youth are given a choice of leisure activities in the evenings and are encouraged to explore their interests. Activities are provided based on the developmental levels and needs of the youth in the program and promote cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Youth were observed during outdoor recreation and it appeared the program takes precautionary measures to prevent over-exertion, heat stress, and dehydration. There were shaded areas outdoors for the youth to sit and a water jug was available for the youth. The youth are able to provide input through the youth advisory board and Chatty Cathy forms. Five

interviewed youth all stated they are allowed the opportunity to exercise, play outside, read a book, or play a board game. Each youth stated physical activities are provided for at least an hour a day and they participate in activities such as volleyball, walking laps, basketball, kickball, yoga, Zumba, and running. Five interviewed staff stated youth are provided one hour of activity a day including volleyball, walking laps, kickball, running, basketball, Zumba, and yoga.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures to address notification to a youth's parent/guardian, by telephone, within twenty-four hours of admission, and by written notification within forty-eight hours. A review of five youth case management records confirmed each parent/guardian notification was completed and contained documents which validated telephone contact with the youth's parent/guardian was completed on the day of admission. Each record contained the appropriate documentation in the case management chronological notes indicating the contact occurred. All records reflected staff mailed letters to parents/guardians, the court, and the juvenile probation officer within forty-eight hours of admission to notify them the youth was admitted to the program.

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 to address the delivery of a program orientation to the youth on the day of admission. The procedures outline all required orientation topics and a description entailing how each youth is to receive the information. The program orientation covers services available, daily schedule, youth expectations and responsibilities, a written behavioral management system, availability and access to medical and mental health services, access to the Florida Abuse Hotline and/or Central Communications Center (CCC), the program's zero-tolerance policy regarding sexual misconduct, special accommodations available to youth, the right to be free from sexual misconduct, rights to be free from retaliation for reporting misconduct, the agency's sexual misconduct response policies and procedures, items considered contraband, the performance planning process, dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, assignment to living unit and room, and medical topics. A review of five youth case management records confirmed orientation took place within twenty-four hours of each youth's admission to the program. All records included youth initials on an orientation checklist which confirmed their understanding of program rules, expectations, and acknowledgment they received the orientation packet. The program did not have a youth admission during the annual compliance review period; therefore, the program's orientation was not able to be observed. Interviews with five youth were conducted and each confirmed orientation to the program began within twenty-four hours of their arrival; and the program's rules, procedures, and schedules were covered. All five interviewed youth indicated they received a program handbook on the day of their arrival.

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

The program has a policy and procedures to address written consent for 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. Only one of the five youth case management records selected for review was applicable, as the remaining four youth were under the age of eighteen. Two additional youth case management records were requested; however, the program only had one additional youth age eighteen or older at the time of the review. The two applicable records were reviewed and each contained a signed written consent form and Authorization for Use or Disclosure of Protected Health Information for youth eighteen years of age. Each form was signed by the youth and obtained before releasing any information relevant to the youth's treatment, assessments, and screenings to parents/guardians and/or to the Department of Children and Families.

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 to address the initial classification and reclassification of youth at the program to promote safety and security, in addition, to the effective delivery of treatment services. The purpose of the youth's initial classification is designed for assigning each newly admitted youth to a living unit, sleeping room, youth group, or staff advisor. When warranted, reclassification is conducted 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.

Five youth case management records were reviewed for classification factors, procedures, and reassessments for activities. In all five records, initial classification was administered on the day of admission. All initial classification assessments included physical characteristics, age, maturity level, identified special needs to include medical, mental health development, intellectual and physical disabilities, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, youth's perception of vulnerability, and youth's history of potential or verified human trafficking. All five records documented risk factors which were assessed and identified such as suicide risk, medial risk, escape risk, and security risk and all were entered into the program's internal alert system and the Department's Juvenile Justice Information System (JJIS), as required. All five records confirmed each youth was

assessed for sexual aggression or vulnerability to victimization utilizing the Victimization and Sexually Aggressive Behavior (VSAB) screening instrument, which was completed in JJIS on the day of each youth's admission. All five youth records were applicable for reassessments. The program's practice is to conduct reassessments during each youth's formal treatment team meetings. A review of five case management records revealed all reassessments were filled out, signed, and dated by the program director, therapist, and the case manager. All youth who were granted an increase in privileges, freedom of movement, and/or have participated in work projects or other activities involving tools had a completed risk reassessment to determine they were appropriate for the activities. A review of the facility administrator's (FA) interview confirmed youth room placements are based on alerts identified during the VSAB and the admission classification meeting. The FA also confirmed the program completes a reclassification on youth if they need to be reassigned to a different room.

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

The program has a policy and procedures to gather and share gang information with law enforcement. The program uses a gang affiliation questionnaire, administered to each youth on the day of admission. The questionnaire is designed to gauge each youth's level of gang involvement. Upon admission, if gang affiliation is identified or suspected, an alert is placed in the Department's Juvenile Justice Information System and within twenty-four hours, the information is sent to the juvenile probation officer, local law enforcement, and law enforcement in the youth's home county.

Five youth case management records were reviewed and none of the records were applicable for gang notification. The program did not have any other applicable youth during the annual compliance review period for review.

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 to address gang prevention and intervention strategies. The program uses a gang affiliation questionnaire, administered to each youth on the day of admission. The questionnaire is utilized to gauge each youth's level of gang involvement. Youth identified as a criminal street gang member, affiliated with any criminal street gang, or are at high-risk for gang membership, are provided intervention programming. Program policy indicates the facility administrator (FA) is personally responsible for ensuring gang prevention and intervention strategies are implemented. An interview with the FA indicated a review of each youth's history and/or alerts is conducted upon admission to identify if a youth is gang affiliated. The FA indicated any youth identified as having gang involvement or affiliation is issued a gang intervention goal on their individualized performance plan. A gang binder is maintained which contains youth's gang intervention goals, the gang affiliation questionnaires, and any notifications made to law enforcement. The main gang prevention and/or intervention curriculum used by the program is, "ARISE: Gangs 50+ Stories of Fractured Lives". The

program utilizes chapters involving gang prevention and intervention from the Impact of Crime curricula. The FA indicated youth are provided with various materials to educate them on the risks of being involved in a gang through the duration of their commitment. A review of five youth case management records confirmed none of the youth were identified as a gang member, affiliate, or suspected gang member and the program has not had any youth who have been identified as a gang member, affiliate, or suspected gang member since the last annual compliance review period. A review of the program's policy and procedures confirmed the program ensures identified youth have the opportunity, if desired, to develop a plan to disaffiliate with a criminal street gang.

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 to address an initial Residential Assessment for Youth (RAY) assessment to be completed within the first thirty days of admission and be maintained in the Department's Juvenile Justice Information System (JJIS). The policy indicates a RAY reassessment is to be conducted every ninety days after the completion of the initial RAY. A review of five youth case management records confirmed each contained an initial RAY which was completed within thirty days of admission to the program and was completed in JJIS. All records reviewed, were applicable for one or more RAY reassessments and each were completed within the ninety-day time frame, or as needed, if a change in interventions were needed prior to the ninety days. All RAY reassessments were completed in JJIS and a copy was maintained in each youth's case management record.

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is conducted with each youth within thirty days of admission and maintained in the Department's Juvenile Justice Information System (JJIS). A review of five youth case management records confirmed each contained a YNAS completed within thirty days of admission. Each YNAS was completed prior to the required time frame, a copy was maintained in each youth's case record, and entered in JJIS.

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

The program has a policy and procedures to address the development of individual performance plans based on findings from the initial assessments of each youth within thirty days of admission to the program. The treatment team conducts a needs assessment meeting to obtain information for the youth's performance plan development. Each treatment team member signs the needs assessment form indicating they participated in the assessment and development of the performance plan.

A review of five youth case management records confirmed the development of performance plans were completed within thirty days of admission. Each treatment team consisted of the intervention and treatment leader, youth, administrative representative, living unit representative, treatment staff, education staff, and any applicable Department of Children and Families (DCF) caseworkers, as required. Youth performance plans contained signatures of all treatment team members with significant responsibility in goal completion. All five youth performance plans were developed after the completion of the initial Residential Assessment for Youth (RAY). All five plans contained individualized goals, based on the prioritized needs reflecting the risk and protective factors identified during the initial RAY assessment. Additionally, all five youth performance plans addressed the youth's top three criminogenic needs. Each of the five performance plans contained specific delinquency interventions with measurable outcomes to decrease criminogenic risk factors and promote strengths, skills, and support to reduce the likelihood of recidivism, action steps for the youth and program staff to complete, target court ordered sanctions, transition activities targeted for the youth's last sixty days in the program, and target dates for completion. None of the five youth case management records contained a recreation plan due to the elimination of the recreational therapist position from recent Department budget cuts; however, prior to the Department budget cuts the individual performance plans included each youth's recreation plan. Copies of the completed plans were provided to each youth's parent/guardian, youth, juvenile probation officer, the committing court, and DCF caseworkers, if applicable, within ten working days of the plan being completed. Interviews with five youth were completed, and each confirmed the program's treatment process and identified the specifics of their performance plan goals. Each youth indicated they assisted in the development of their performance plan and received 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 ensuring each youth's performance plan is revised, as necessary, by the intervention and treatment team. A review of five youth case management records indicated each youth's plan had been revised based on newly acquired information and/or the Residential Assessment for Youth (RAY) results. All records verified each youth's performance plan was updated when they demonstrated progress or lack of progress towards completing a goal. The program's practice confirms the treatment team meets formally at least every thirty days to discuss each youth's performance plan and necessary revisions are made, if needed. Two youth records were applicable for being in transition. Both applicable records documented revisions were made to each youth's performance plan to facilitate transition activities during their last sixty days in 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 policy and procedures to ensure the treatment team prepares a performance summary within ninety days following the completion and signing of each youth's performance plan. A review of five youth case management records indicated each youth had a performance summary completed at least every ninety days following the completion and signing of their initial performance plan. Each summary included the youth's status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment to the program, and any significant positive and negative events. One reviewed record was applicable for having a performance summary completed prior to the youth's release, discharge, or transfer from the program. The applicable record had a completed performance summary which included all the above applicable information, and justification for release. Documentation revealed all five youth could read and add comments prior to signing their performance summary. Documentation confirmed each youth was provided a copy of their performance summary and their original summaries were filed in their case management record. All summaries were signed and dated by the treatment team leader, staff member preparing them, program director or designee, and youth. A review of transmittal documentation in all five records validated all summaries were sent to the committing court, youth's juvenile probation officer (JPO), youth, parent/guardian, and the Department of Children and Families (DCF) caseworker, when applicable, within ten working days. Two of the five youth were involved with the DCF. Five youth interviews confirmed four youth received a copy of their performance summary sent to the court while one interviewed youth indicated this question was not applicable to them.

A review of three closed youth case management records indicated the original release summary, along with justification for release was sent to the assigned JPO with the Pre-Release Notification (PRN). All three summaries and PRNs were sent at least forty-five days prior to the planned release date. A signed copy was retained in all three records. The court did not object to the release for any of the three youth. Each record contained documentation showing the program provided written notification to each youth's parent/guardian notifying them of their youth's release. Each record contained documentation supporting the Residential Assessment for Youth (RAY) was completed for each youth following approval of their release. Each youth record confirmed the program provided the JPO with the performance summary, transition plan, and any psychological/psychiatric reports, if applicable, while the youth was in the program. None of the youth were applicable for the Sexually Violent Predator Program (SVPP). None of the youth were applicable for victim notification.

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

The program has a policy and procedures indicating the program will encourage and facilitate involvement of each youth's parent/guardian in the case management process, including the assessment process, development and participation in the performance plan, progress reviews, formal treatment team meetings, and transition planning. If unable to attend, the parent/guardian can participate by phone or give verbal/written input prior to the meeting. One treatment team meeting was observed during the annual compliance review and the youth's parent/guardian participated in the treatment team by phone and provided positive feedback to the youth. An interview with the facility administrator (FA), indicated each parent/guardian is involved in the above listed areas and the program uses letters, phone calls, and treatment team meetings to facilitate parent/guardian involvement. The FA also indicated each youth is allowed a weekly phone call with their parent/guardian. Reviewed documentation confirmed a telephone call is made to the parent/guardian upon admission to gather information on the youth's background and family. An admission letter is sent to the parent/guardian, along with a survey. The youth goals are discussed with the parent/guardian and the parent/guardian can provide input to assist with the development of the youth's performance plan. A review of five youth case management records revealed the parents/guardians were invited to all formal treatment team meetings and were able to provide feedback. A survey is given to the parent/guardian for their input on transition planning. Interviews with five youth confirmed parental/guardian involvement in their case management services.

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 addressing how each youth's treatment team includes all pertinent parties. The treatment team consists of the treatment team leader, youth, administrative representative, living unit representative, educational staff, Department of Children and Families (DCF) caseworker, when applicable, juvenile probation officer (JPO), parent/guardian, gang prevention specialist, when applicable, transition services manager, and human trafficking service provider, when applicable, in addition to nursing. Every staff assigned to the treatment team participates in each youth's formal treatment team meetings and provides

input on the youth's goals and progress. A formal treatment team meeting for each youth is held at least every thirty days. A review of five youth case management records confirmed each youth's juvenile probation officer (JPO), parent/guardian, as applicable, and other pertinent parties were invited and encouraged to participate in the youth's treatment team meeting. Each youth case management record documented the treatment team leader, youth, parent/guardian, representatives from program administration and living unit, treatment staff, educational staff, JPO, and medical representative participated in the treatment team meetings. One formal treatment team meeting was observed during the annual compliance review and all required individuals attended and actively participated. Observations confirmed the youth's parent/guardian was contacted by telephone and participated in the treatment team.

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

The program has a policy and procedures to ensure each youth's performance plan references or incorporates their treatment or care plans. A review of five youth case management records confirmed each youth had additional plans addressing academics, medical, mental health, and substance abuse which were incorporated in their performance plans. Two of the reviewed youth were involved in the Department and Children and Families (DCF). The DCF case plan for each youth was incorporated into the youth's performance plan.

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

The program has a policy and procedures indicating informal treatment team meetings are held with each youth and their case manager at least biweekly and formal treatment team meetings occur at least once every thirty days. A review of five youth case management records revealed each youth received a formal treatment team review at least every thirty days. Reviewed documentation in all records included signatures for the treatment team leader, youth, representatives from program administration and living unit, treatment staff, educational staff, and medical representative. The juvenile probation officer (JPO) and parent/guardian's participation, when applicable, was documented through telephone participation. One formal treatment team meeting was observed during the annual review and all required staff were present and participated, and all required information was discussed.

Five youth case management records were reviewed for documentation of informal treatment team meetings. All records contained documentation confirming informal reviews were conducted, as required. All informal reviews were documented in the youth's case management record, and included the youth's name, date of the review, comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical intervention, and treatment progress. All five interviewed youth reported staff review their performance, to include progress on performance plan goals, positive and negative behavior,

and treatment progress. All five youth stated they were given an opportunity during treatment team meetings to demonstrate skills they have learned in the program.

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

The program 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. The program provides Safe Staff for food handler training which leads to certification and cardiopulmonary resuscitation (CPR) certification. 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. The three closed records had documentation stating the youth were unable to acquire Florida Identifications or social security cards due to COVID-19. The career courses are age appropriate and aligned with the educational goals and abilities of the population served. An interview with the lead teacher revealed the program offers education services and assessments utilizing My Career Shines. The facility administrator (FA) was interviewed and indicated each youth is issued the Daniel Memorial Assessment to identify their individual vocational needs. The FA confirmed each youth is provided with the opportunity to complete job applications and receive cardiopulmonary resuscitation(CPR), first aid certification, and a Safe Serve Food Handling Certification, if appropriate.

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 program integrates education into the daily schedule in such a way to ensure the integrity of the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and incorporated the required 240 days of instruction with six days used for teacher planning. This schedule provided six fifty-minute class periods fulfilling the weekly requirement of twenty-five hours of instructional time. Youth are enrolled in academic courses through the Hillsborough County School District and receive credit for course completions as appropriate. An interview with the lead educator verified the youth are attending school according to the daily schedule. In a review of the logbook, and confirmation with the lead educator, due to the COVID-19 pandemic, students were previously communicating with teachers through a video conferencing software program and given educational material in packets when on the units during the school schedule. Three interviewed youth indicated there are no interruptions during school. The remaining two indicated there are interruptions. One youth stated they are occasionally late if they need another staff to stay in ratio. The remaining youth did not explain their answer.

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 maintains a policy and procedures providing for an educational transition plan to be developed upon admission. Three closed youth case management records were reviewed. All three youth records included an individual education transition plan, developed upon entry, and included the youth's post-release goals. The records documented specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services, post release. Also included in each record was an Electronic Educational Exit Plan (EEEP) which identified the next educational placement information and input from the post release school district representative. All records contained the youth's current educational records to be used for the post release placement. Five youth were interviewed. Three youth were applicable for an educational transition plan and each indicated they were involved in the development of their educational transition plan. Four of the interviewed youth feel they are very well prepared by the program for their education. The remaining youth stated they are not well prepared and they are trying to get their General Education Diploma (GED), but the program will not let them because they are not going to class enough.

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 to address treatment team planning for each youth's successful transition to the community upon release from the program. Three closed youth case management records were reviewed, and documentation verified the program held a transition conference for each youth at least sixty days prior to their anticipated release date. Documentation in all three records confirmed the program invited each youth's parent/guardian, juvenile probation officer (JPO), educational staff, and other pertinent parties to the transition conference. All required parties participated either in person or by phone. All three records contained documentation verifying the attendees signed and dated the transition plan; a copy of the plan was sent by mail to the parents/guardians; and JPOs who participated by phone, with a request they sign the plan and return it to the program. Documentation verified the transition conference included a review of transition activities and identification of additional transition activities, including target dates for goal completion and persons responsible for completion. A review of three records confirmed each youth participated in a Community Re-Entry Team

(CRT) meeting with their case manager prior to their release from the program. Evidence in all three case records indicated an invitation to participate in the CRT meeting was sent out prior to the meeting.

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

The program has a policy and procedures to ensure an exit portfolio is assembled for each youth to assist them when they are released back into the community. A review of three closed youth case management records confirmed an exit portfolio was discussed and initiated for each youth at their transition conference. Each portfolio was completed by the program, verified at the exit conference, and given to the youth upon release. Each record contained a copy of the youth's exit portfolio, including a State of Florida identification card, copy of the youth's transition plan, calendar with all upcoming community appointments, education or vocational certificates, education records, school transcripts, résumé, and sample job applications. Reviewed documentation confirmed a copy of the exit portfolio was sent to each youth's juvenile probation officer and was documented in each youth's case management record.

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

The program has a policy and procedures to ensure an exit conference is conducted for each youth, 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 youth case management records were reviewed, and documentation indicated each youth had an exit conference which was held after the program notified the juvenile probation officer (JPO) of release and at least fourteen days prior to the youth's release date. All conferences were documented in the case management record and included a summary and review of pending transition goals, the date of the conference, and signatures of participants. Participants included the treatment team leader, education representative, youth, and treatment staff. Documentation of parent/guardian and JPO participation was noted as participating by telephone. In each of the three records reviewed the date of admission and the date of termination documented in the case management records correlate with the Department's Juvenile Justice Information System (JJIS). In each of the three records, the status of transition activities was established at the transition conference and the finalized plans of release for each youth was reviewed. The program conducts exit conferences separate from transition and Community Re-Entry Team meetings.

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 addressing the process of safety planning for each youth in the program. The program maintains a safety plan for each youth in the duty station of the program which is a centralized location for all staff. Each youth's safety plan includes warning signs, youth baseline behavior, crisis recognition, jointly developed coping strategies,

intervention strategies preferred by the youth, and a debriefing process. A review of five youth case management records confirmed each safety plan was completed on the day of admission, and is jointly prepared by the youth, parent/guardian, and the program's clinical staff. All five safety plans were updated a minimum of every thirty days or following any significant behavioral or mental health event identified by the youth's intervention and treatment team. Interviews with five youth confirmed each youth contributed to the development of their safety plans. Five interviewed staff all indicated the youth safety plans are in the duty station and all staff review the safety plans on a consistent basis. Three of the five interviewed staff confirmed the process for reviewing the safety plans while the other two staff were not sure of the process.

Standard 3: Mental Health and Substance Abuse Services

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

The program provides intensive mental health services to female youth ages twelve through nineteen. The program has a designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services in the program. The DMHCA is a licensed mental health counselor under Chapter 491. The license is clear and active with an expiration date of March 31, 2021. Documentation supports the DMHCA is on-site weekly for approximately forty hours. An interview with the DMHCA confirmed he is on-site eight hours a day Monday through Friday, with additional hours as needed. The DMHCA indicated he is on call twenty-four hours a day, seven days a week. The program's assistant clinical director serves as the back-up DMHCA. The assistant clinical director is a licensed clinical social worker under Chapter 491. The license is clear and active with an expiration date of March 31, 2021. During the informal interview, the DMHCA verified his role in the coordination and implementation of mental health and substance abuse services at the facility.

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

The program had three licensed staff providing services to the youth during the annual compliance review period. The designated mental health clinician authority (DMHCA) and the assistant clinical director are currently licensed. Both staff are licensed under Chapter 491 and meet the staffing qualifications. The program had a third licensed staff providing services to the youth during the annual compliance review period. This staff is a licensed clinical social worker with a clear and active license which expires on March 31, 2021. The program has a current Chapter 397 license which expires on April 7, 2021. The program contracts with a licensed psychiatrist, licensed school psychologist, and a licensed certified behavioral analyst. The licensed psychiatrist has a clear and active license with the State of Florida which expires January 31, 2022. The licensed psychologist has a clear and active license with the State of Florida which expires January 31, 2021.

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

The program had four non-licensed clinical staff, one of which is a clinical intern, providing services to the youth during the annual compliance review period. All four clinical staff are qualified to provide the services based on their education, training, and experience. All non-licensed clinical staff have a master's-level degree from an accredited university or college in the field of counseling or social work. The clinical staffing is in accordance with the current contract and Florida Administrative Code. Weekly supervision is provided by the designated mental health clinician authority (DMHCA) to all non-licensed clinical staff providing services. Weekly supervision is typically conducted in a group session for at least one hour a week on-site, face-to-face. Individual cases were discussed for the purpose of overseeing and directing the mental health services provided at the program. Documentation of direct supervision was recorded on the Department's Direct Supervision Log. A review of weekly supervision documentation for the last six months supported all non-licensed clinical staff providing services received weekly supervision by the DMHCA. Two of the non-licensed clinical staff completed Assessments of Suicide Risk (ASR) and documentation supported both staff received the twenty-hours of training and the administration of five ASRs conducted in the physical presence of a licensed mental health professional. The training was documented on the Department's form. A licensed mental health professional reviewed each completed ASR, Follow-Up ASR, crisis assessment, and follow-up crisis assessment conducted by the non-licensed clinical staff within the required time frame. A staff schedule is maintained to ensure clinical staff are on-site every day.

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

The program has a policy and procedures addressing the comprehensive screening process to identify the mental health and substance abuse needs of the youth and ensure referrals are made when potential risks are identified. The procedures address the program's standardized screening process which includes the review of commitment packet information, reports and previous records, and information in the Department's Juvenile Justice Information System (JJIS). The procedures address staff training in the administration of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). The procedure addressed the standardized process for referral of youth identified as in need of further mental health and substance abuse evaluation.

An interview with the facility administrator (FA) verified all youth are screened utilizing the MAYSI-2 tool. All five reviewed youth had a MAYSI-2 completed by a clinical staff during the admission process. The screening was completed in the mental health office to maintain confidentiality. Documentation supported available information was reviewed to include the youth's commitment packet and previous comprehensive evaluations. The clinical staff who completed the MAYSI-2 completed the required training, as evidenced in their training record.

The MAYSI-2 screening was completed in full in JJIS. Three of the five youth's MAYSI-2 screenings indicated a further assessment was required and the appropriate referral was made. Based on information gathered during the review of records, all five youth were referred to the psychiatrist for an initial psychiatric evaluation and an Assessment of Suicide Risk (ASR). Four of the five referrals were completed by the DMHCA or another licensed clinical staff. The DMHCA was consulted on referrals when completed by a non-licensed staff. Documentation supported the facility administrator was notified of all referrals. All five youth received an ASR during the admission process based on the information gathered during the review of records. All youth were placed on standard supervision as a result of the ASR. Documentation supported the facility administrator was notified of the results of all ASRs.

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

The program has a policy and procedures addressing the comprehensive evaluation process. All five youth had a new comprehensive mental health and substance abuse evaluation completed within the first thirty calendar days of admission. Three of the five comprehensive evaluations were completed by non-licensed clinical staff. These evaluations were reviewed and signed by a licensed staff within ten days of completion. Two evaluations were completed by a licensed staff. The comprehensive evaluations addressed all required information. Detailed information addressed the youth's identifying information and reason for the evaluation. Relevant background information was documented along with the behavioral observations and a mental health exam. The comprehensive evaluation addressed the patterns of alcohol and other drug abuse along with the impact of the substance usage on major life areas. Risk factors of continued alcohol and drug abuse was documented. The interview procedures administered, and the discussion of findings were documented. The diagnostic impression including the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis was included on the evaluation. Recommendations were individualized based on the information captured within the evaluation. All five youth signed a consent for substance abuse services.

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

The program has a policy and procedures addressing mental health and substance abuse treatment planning. Documentation in the youth's case management record supported each youth was assigned to a treatment team upon arrival to the program. The youth's multidisciplinary treatment team included the youth, program administration, a residential living unit representative, medical staff, education staff, the youth's therapist, and case manager. All five youth had an individualized treatment plan completed after the comprehensive evaluation was completed. Services included individual, family, and group counseling. Three youth were determined in need of substance abuse treatment. Two of the three youth had a goal

addressing substance abuse on their individualized treatment plans. Services were provided by a licensed qualified professional or a non-licensed clinical staff working under the direct supervision of the licensed staff. Three of the five youth had a properly executed Authority for Evaluation and Treatment (AET). Two youth were under the care of the Department of Children and Families (DCF) and had the proper AET. Two youth were the age of eighteen and had the proper consent forms completed once they turned eighteen years of age. All five youth signed a Substance Abuse Consent and Release form upon admission. Weekly progress notes were completed using the Department's form. Progress notes supported group therapy was limited to ten or fewer youth for mental health treatment and fifteen or fewer for substance abuse treatment. All five youth were receiving the treatment services as prescribed on their individualized treatment plan. These services included individual, group, and family counseling. Group notes supported psychosocial skills training was provided to all five youth. All five interviewed youth indicated they are receiving individual and family counseling. Four of the five youth indicated they receive individual counseling on a weekly basis; one youth indicated they receive individual counseling on a bi-weekly basis. Four of the five youth indicated they receive family counseling on a monthly basis; one youth indicated they receive family counseling on a bi-weekly basis. An informal interview with the designated mental health clinical authority (DMHCA) confirmed each youth receives services in line with their treatment needs. All five interviewed staff indicated they do not facilitate any mental health or substance abuse groups. Staff were asked about the process to follow when a youth expresses suicidal thoughts. All five staff indicated they would notify the clinical staff and place the youth on constant sight and sound observation.

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

The program has a policy and procedures addressing treatment and discharge planning. All five youth had an initial treatment plan completed upon admission. The initial treatment plan was documented on the Department's form. Three of the initial treatment plans were completed by a non-licensed clinical staff and reviewed and signed by a licensed clinical staff. On two of the plans the designated mental health clinician authority (DMHCA) signed the plan and served as two members of the treatment team, signing as the therapist and the program director. All five initial treatment plans required the youth complete an initial psychiatric evaluation. All five youth had an individualized treatment plan completed within thirty days of the youth's admission. The treatment plans were developed on the Department's form and signed by the clinical staff completing the plan. Four of the five individual treatment plans were completed by a licensed staff. The one treatment plan completed by the non-licensed staff was reviewed and signed by the licensed clinical staff. The individualized treatment plan was signed by all treatment team members who participated in the development of the plan. Three of the five youth were taking medication under the supervision of the psychiatrist. All three individualized treatment plans included psychiatric services including the frequency of monitoring by the psychiatrist. Two

youth were not under the care of the psychiatrist but had a medication management goal included on their individualized treatment plans. All five treatment plans contained the same prescribed services for individual, group, and family counseling. The treatment plans for the three youth receiving psychotropic medication addressed the frequency of monitoring by the psychiatrist. Weekly progress notes and treatment team reviews support services were provided as prescribed. Services were individualized to meet the youth's needs. One youth had progress notes indicating individual counseling would be split into two, thirty-minute sessions to accommodate the youth's needs. Treatment team reviews were completed on a monthly basis. All treatment team members signed the monthly treatment team reviews with two exceptions out of twenty-two reviews. There were two months were the DMHCA served as two members of the treatment team, signing as the therapist and the program director. Three closed records were reviewed for discharge plans. All three youth had received mental health services while in the program and the discharge plan was completed on the Department's Treatment Discharge Summary form. None of the youth were at risk of suicide and on precautionary observation at the time of discharge. All three discharge summaries addressed the services needed for the youth's maintenance once they returned to the community. Documentation supported the discharge summary was discussed with the youth, the parent/guardian, and the youth's juvenile probation officer (JPO) during the exit conference. Documentation supported a copy of the Mental Health/Substance Abuse Treatment Discharge Summary was provided to the youth, JPO and, parent/guardian at the time of discharge.

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

The program provides specialized treatment services to youth in need of intensive mental health services. Interviews with the facility administrator (FA) and the designated mental health clinician authority confirm the program provides intensive mental health services. A review of five youth mental health records confirmed the youth received the contractually required services. All five youth received a comprehensive evaluation and individualized treatment plan. All five youth received group therapy seven days a week and family therapy as prescribed by the individualized treatment plans. Weekly progress notes supported daily therapeutic activities were provided by the clinical staff. Crisis interventions were provided to the youth through the use of supportive counseling sessions and the use of the crisis assessment. Weekly sign-in sheets supported the psychiatrist was on-site weekly to provide services. The program has a designated mental health clinician authority (DMHCA) who is on-site weekly for approximately forty hours. A staff schedule is maintained to ensure clinical staff are on-site every day. The program has three non-licensed clinical staff providing services to the youth to ensure the counselor to youth ratio does not exceed one to twelve. A registered nurse is on-site daily to provide medication administration to the youth.

3.09 Psychiatric Services (Critical)	Failed 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 contracts with a psychiatrist licensed under Chapter 464. The license is clear and active with an expiration date of January 31, 2022. The program has a policy and procedures addressing psychiatric services. The policy was reviewed and signed by the psychiatrist on June 17, 2020. A second psychiatrist is contracted to provide back-up psychiatric services when the primary psychiatrist is unavailable. The back-up psychiatrist holds a clear and active license with an expiration date of January 31. 2021. Upon admission, all youth were referred to receive an initial psychiatric evaluation. The initial psychiatric evaluation addressed the youth's history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations and, prescribed medications, if applicable. The initial psychiatric evaluation was documented on the Clinical Psychotropic Progress Note (CPPN). The CPPN was labeled as the initial diagnostic psychiatric interview and contained all three pages of the CPPN. Three youth entered the program taking psychotropic medication. The psychiatrist continued the youth on the medication as a result of the initial psychiatric evaluation. Documentation supported the psychiatrist saw the three youth at least every thirty days if not more frequently. The CPPN was completed in full including all required information during each visit. The identifying data, diagnosis, target symptoms of the medication, and side effects were consistently documented. When new medications were prescribed, the third page of the CPPN documented the telephone contact with the parent/guardian or the attempted contact with the parent/guardian. The psychiatrist signed all completed CPPNs. There were no youth applicable for the monitoring for Tardive Dyskinesia.

The provider's contract with the Department, amendment eighteen, requires the psychiatrist to be on-site forty hours a week, split between the two programs. The contract between the program and the psychiatrist requires the psychiatrist be on-site at the provider's programs a total of twenty-four hours, which does not meet the contracted requirements with the Department.

A review of the weekly sign-in sheets supports the psychiatrist is on-site weekly approximately four hours each visit. There was one week, July 17, 2020, where someone other than the psychiatrist signed the weekly sign-in sheet and the sign-in sheet reflected the staff was on-site from 3:21 p.m. to 3:22 p.m. An interview with the psychiatrist revealed he is on-site once a week and weekly medication management meetings are held. An informal interview with the psychiatrist indicated he has begun to visit the program twice a week. The psychiatrist discussed his plans of providing groups to the youth on the weekends.

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

The program has a written plan detailing suicide prevention procedures. The plan addresses the identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, the referral process, communication with staff and the youth's parent/guardian, notification, documentation, and immediate staff response. The plan indicates the staff must complete six hours of annual training, but it does not address mock drills. The plan was signed by the psychiatrist on April 30, 2019 but the plan was not signed by the designated mental health clinician authority (DMHCA). Once this was identified, during the week of the annual compliance review, the plan was reviewed, signed, and dated by the DMHCA.

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 written plan addressing suicide prevention services. All five youth received an Assessment of Suicide Risk (ASR) upon admission based on information gathered during the admission process. All five youth were placed on standard supervision as a result of the ASR. During the annual compliance review period there were three youth who were placed on precautionary observation. Documentation supported the youth were referred to the clinical staff based on staff observations of the youth. Staff immediately began documenting constant supervision of the youth until the youth was assessed by the clinical staff. All three youth were placed on constant supervision as a result of the ASR. Safe housing areas were documented for the youth placed on constant supervision and the use of precautionary observation was authorized after consultation with the designated mental health clinician authority (DMHCA) and the facility administrator (FA). A Follow-Up ASR was completed prior to moving the youth to close supervision. The ASR and Follow-Up ASR were completed on the Department's forms by non-licensed clinical staff. There was documentation on all ASRs and Follow-Up ASRs to support the DMCHA was consulted at the time the assessment was completed. The DMHCA signed the ASRs as required. Documentation supports a conference was held with the program director and licensed professional prior to reducing the youth's level of supervision. There was documentation to support the parent/guardian was notified of the youth's potential suicide risk. All alerts were completed in the Department's Juvenile Justice Information System (JJIS) as required. The documentation supported the youth received the services in accordance with the program's suicide plan. Youth placed on precautionary observation was inconsistently documented in the logbook. One of these youth was on a heightened level of supervision for nineteen consecutive shifts. For four of these shifts the logbook reflected the youth was on close supervision when she was actually on suicide precautions in the "Communication Board/Alert

Status Review" section. The logbook had unclear documentation for an additional five shifts while this youth was on close supervision. The reviewed documentation seemed to indicate the youth was actually on security alert, and not on close supervision. The documentation for the second youth did not reflect when the youth was actually placed on suicide precautions, and there was nothing to reflect her still being on suicide precautions in the "Communication Board/Alert Status Review" section for a shift after another youth was put on the same placement a day later. The program indicated even though the documentation in the logbook was inconsistent, the information was passed on to the various shifts through a review of youth alerts during the shift briefing process. One youth was out of program placement due to being placed in a detention center. When the youth returned to the program, an ASR was completed. The program does not use secure observation. There have not been any serious suicide attempts or serious self-inflicted injuries during the review period. The program has two suicide kits containing a knife-for-life, wire cutters, and needle nose pliers. One suicide kit is maintained in the front administration office and the second kit is maintained in the staff office located in the hallway with the youth rooms. All five interviewed staff knew the two locations of the suicide kits.

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 youth placed on suicide precautions are maintained on one-to-one or constant supervision. One of five reviewed records was applicable for suicide precautions, so an additional two records were requested. Observation logs for three youth were reviewed. The suicide precaution observation logs were maintained for the duration the youth was on suicide precaution. The youth's behavior and level of supervision was documented in real time and either documented at ten-minute intervals or thirty-minute intervals depending on what type of supervision staff were providing for the youth. The Suicide Precaution Observation Logs were reviewed and signed by each shift supervisor and a mental health clinical staff. The safe housing requirements for each youth were documented. There was one youth currently in the program who had been placed on precautionary observation. One youth who had been placed on precautionary observation was interviewed and indicated staff were with her at all times while she was on precautionary observation. The youth indicated she was not left alone for any period of time while she was on precautionary observation.

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's suicide prevention plan addresses suicide prevention training. A review of five in-service training records found each staff received at least six hours of suicide prevention training during the previous calendar year. This indicator was rated as limited compliance on the previous annual compliance review, which was conducted from March 10 - 13, 2020. This was assigned a major deficiency due to the mock suicide drills not being conducted on each shift during each quarter, and by staff not having attended mock suicide drills semi-annually. The program completed an Outcome Based Corrective Action Plan (OBCAP) to address this concern. This deficiency was closed on June 4, 2020 after a successful verification visit was conducted. Due to this previous concern, there was only one quarter available for review, which

was from July through September of 2020. The review of drill documentation found the program completed one drill each of these months with each of them being held on a different shift. The program is currently operating with three different shifts. Each of the drills included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, persons involved/function of each, type of medical care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. The review found each drill had a sign-in sheet attached with the names and signatures of all staff who participated in the drill. The mock suicide drill training documentation supported eight of the twelve reviewed staff participated in drills. Since this was the only quarter available for review, the team was unable to determine if each of the staff will participate in a drill semi-annually; however, it appears the program has a system in place since they worked through their OBCAP. The review of medical drills confirmed cardiopulmonary resuscitation (CPR) was covered in their drills at least once each quarter to allow staff to practice these skills. Reviewed documentation confirmed the program reviewed drills during the monthly all-staff meetings for those staff who missed the last drill conducted.

The five interviewed staff were asked how often medical emergency and suicide drills were conducted on their shift. Two staff indicated drills are conducted monthly. One staff indicated drills are conducted weekly. One staff indicated drills are conducted two to three times a month. One staff reported drills are conducted weekly. An interview with the facility administrator (FA) indicated mock mental health and suicide prevention drills are held across all shifts, ensuring each staff participates in a minimum of one drill a quarter. The FA stated drills are reviewed during their general staff meeting each month.

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

The program has a written plan addressing mental health crisis intervention services. The Crisis Intervention Plan addresses the notification and alert system, means of referral, including youth and self-referral, communication, supervision, documentation, and review of the incident. The plan was signed by the designated mental health clinician authority (DMHCA) on July 2, 2020.

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

The program has a written plan addressing Crisis Assessments. Three of the five reviewed youth records contained a completed Crisis Assessment. None of the youth were an alleged victim in a Prison Rape Elimination Act (PREA) event. Two of the three youth required a Crisis Assessment be completed on more than one occasion. A total of five crisis incidents were reviewed. All Crisis Assessments were completed at the time the youth appeared to be in crisis based on youth self-reporting or staff observations. The Crisis Assessment addressed the reason for the assessment, mental status examination and interview, and the initial clinical impressions to include the determination of danger to self and/or others. The assessments included the supervision recommendations and treatment recommendations. Documentation supported the youth's parent/guardian was notified when required. Four of the five Crisis Assessments were completed by a non-licensed clinical staff. The assessments were reviewed and signed by the designated mental health clinician authority (DMHCA). Mental health alerts were entered and closed in the Department's Juvenile Justice Information System (JJIS) as required. Constant supervision was documented on the Mental Health Alert Observation Log. Clinical staff completed a new crisis assessment prior to reducing the level of supervision. Discrepancies were found in the logbook for the one youth who had two different instances of a crisis assessment being completed. In each of these instances, the youth was placed on close supervision after the completion of a Crisis Assessment. Documentation in the logbook for the first instance reflects three shifts in which the youth's placement was not reflected where the program documents the Communication Board/Alert Status Review section, and another shift where information regarding the youth was placed in the security alert section, and not in close supervision. The review of logbook documentation for the other instance of crisis had one shift in which the youth's placement was not reflected where the program documents the Communication Board/Alert Status Review section. The program indicated even though the documentation in the logbook was inconsistent, the information was passed on to the various shifts through a review of youth alerts during the shift briefing process.

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 plan. The plan addresses the immediate staff response, notifications, communication, supervision, review of the incident, and training. The plan addresses the authorization to transport for emergency

mental health or substance abuse services addressing Baker and Marchman Acts. The plan was not signed by the designated mental health clinician authority (DMHCA). Once this was identified, during the week of the annual compliance review, the plan was reviewed, signed, and dated by the DMHCA.

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

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

Standard 4: Health Services

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

The program maintains a policy and procedures ensuring a designated health authority (DHA) shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida licensed physician to serve as the DHA. The agreement was signed on March 4, 2014, with an automatic annual renewal. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statutes, and is a medical doctor with a license expiration date of January 31, 2021. The DHA maintains a certificate of insurance with an expiration date of November 17, 2020. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site weekly for approximately two hours. Reviewed physician logs for the past six months validated the DHA was on-site weekly. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, providing medication evaluations, and on-going monitoring of medications and chronic medical conditions. Supporting documentation validated the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans as needed. The DHA has not had any scheduled absences but in the event the DHA takes vacation, the program has an agreement on file for a back-up physician. An interview with the DHA supported their role includes performing Comprehensive Physical Assessments (CPAs), sick call, periodic evaluations, and reviewing healthcare policies and procedures and nursing protocols. Nursing license verifications were conducted, and all practicing nurses have a clear and active license with the State of Florida.

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

The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supports the DHA signed all healthcare policies and procedures on June 19, 2020. The facility administrator (FA) documented a review on October 16, 2020, and the psychiatrist documented a review on June 17, 2020. The program maintains a nursing protocol manual developed and approved by the DHA. The signature page was reviewed and found all nursing staff reviewed Facility Operating Procedures (FOPs) and treatment protocols on June 15, 2020. Reviewed training records for nursing staff supported training on the treatment protocols and healthcare policies and procedures in June 2020. Treatment protocols and standing orders were created and approved by the DHA on June 15, 2020. The program maintains a training requirement whereby newly employed healthcare personnel shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures. Reviewed training curricula and plan supported a new registered nurse would receive the required pre-service and orientation training to include on-the-job training.

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 ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department. A review of five youth Individual Healthcare Records (IHCRs) found one youth is eighteen years of age and signed a Release of Information form when she turned eighteen. Three youth were applicable for a signed AET, as the remaining two were in the custody of the Department of Children and Families (DCF) upon admission into the program. All three healthcare applicable records contained a copy of the signed AET, and the word "copy" was clearly stamped on each. Of the two youth in the custody of DCF upon admission, one youth had a signed court order to treat on file, and one youth turned eighteen and had a release of information on file. Each reviewed AET and/or Release of Information form was filed in each youth's IHCR in the appropriate section. An interview with nursing staff indicated the registered nurses (RNs) review all admissions in the Department's Juvenile Justice Information System (JJIS) and validate each AET. If needed, the assigned juvenile probation officer (JPO) would be contacted through the case manager to obtain a new AET. Upon intake or when the youth turns eighteen years of age, two releases of information are completed to include the youth stating to who, if anyone, information should be released to and listing an emergency contact for release of information to any off-site medical provider.

4.04 Parental Notification/Consent	Limited 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 maintains a policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. Procedures ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five youth Individual Healthcare Records (IHCR) were reviewed. One youth is eighteen years of age but was under eighteen and under the care of the Department of Children and Families (DCF) upon admission, requiring the DCF Medical Report form and a court order to be completed before any discontinuation or change in psychotropic medication. The DCF Medical Report form provided upon admission does not list dosage ranges. One of the youth's psychotropic medication was discontinued on May 6, 2020 and one was increased on May 20, 2020 without court orders. The remaining four reviewed IHCRs supported the parents/guardians were notified when a significant change to existing medication occurred and when a change in a youth's chronic condition and/or medication for youth identified with a chronic condition occurred. Four reviewed youth received over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parent/guardian notifications were sent for each youth. One reviewed youth received off-site emergency care and documentation supported the parent/guardian was notified. The program's practice indicated parent(s)/guardian(s) are notified within twenty-four hours of an event with a written notification. Verbal consent is obtained as soon as possible after an order is written. All verbal consents are witnessed by another nurse or program staff. Verbal consent is obtained for any OTC medication which has not been previously approved. A parent/guardian notification is completed for new prescriptions, significant dosage changes, or for discontinuing a medication. There were no youth requiring immunizations; however, policy and procedures outline the AET

provides an opportunity for parent/guardian consent to be obtained for missing vaccinations. When signing the AET, a parent/guardian shall be provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. When a parent/guardian does not consent to the vaccinations, the Parent Notification of Health-Related Care: Vaccination/Immunizations form is sent with the required VIS to obtain consent. There were no reviewed IHCRs where a parent/guardian did not consent due to religious reasons. Program practice is for the nursing staff to pull each youth's immunization record from the Florida Shots website within the first week of admission and have the designated health authority (DHA) document a review of the record. Attempts are made to verbally contact a parent/guardian prior to a youth leaving for the emergency room (ER). The parent/guardian is contacted upon the youth's return and given the results of the ER visit. Written notification is completed after returning from the ER. Nursing interviews indicated parent/guardian notifications are written and sent the same day as an event to include off-site appointments, new intakes, being seen on-site by the DHA, and/or any other pertinent medical events. Each reviewed youth IHCR supported each youth was prescribed a psychotropic medication and the required parent/guardian consents were obtained. Each reviewed healthcare record documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. Each parent/guardian received a written follow-up with a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with an acknowledgement they received the CPPN. Copies of all correspondence were maintained in each youth's healthcare record.

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 maintains a policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensuring a healthcare admission rescreening is completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth Individual Healthcare Records (IHCR) validated each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. Chronological progress notes included consent and results of pregnancy screenings for all sexually active youth. All admission screenings were completed by a registered nurse (RN). An interview with the health services administrator indicated a nursing assessment is conducted immediately following the initial search, normally within ten to fifteen minutes of the youth's arrival. The RN notifies the designated health authority (DHA) by telephone or verbally, if on-site, with the youth's history and any identified chronic conditions. Each notification is documented on a DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's IHCR in the practitioner's chronological note section. Referrals are documented in the physician's log. One of the five reviewed youth had a change in custody since being admitted to the program. A new FEPHS rescreening was completed upon the youth returning 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 maintains a policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission. A review of five youth Individual Healthcare Records (IHCR) validated each youth received a healthcare orientation on the day of admission by a registered nurse (RN), as documented on the Department's Health Education form. Each youth received a health education packet of all required health care topics. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the 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 ensuring a referral to the program's designated health authority (DHA) is made when a youth is admitted to the program with a known or suspected chronic condition which does not require emergency treatment on admission. The program's practice is for the DHA to be notified of all admissions. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. In addition, the nurse documents the DHA notification on the Nursing Chronological/Notification Progress form and the form is filed in the nursing chronological notes section of the Individual Healthcare Record (IHCR). The nursing staff update the Chronic Conditions Log after the notification is complete. A review of five youth IHCRs validated the DHA was notified of each admission by telephone and the Notification of Admission form was filed in the practitioner's section of the IHCR. Three of the reviewed youth were admitted to the program with known or suspected chronic conditions. Each admitted youth was referred to the DHA. None of the youth required emergency response upon admission. The three youth identified as having chronic conditions were seen for their conditions as required.

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 maintains a policy and procedures ensuring the Department's Health-Related History (HRH) form is completed for each youth prior to their Comprehensive Physical Assessment (CPA) being completed. A review of five youth Individual Healthcare Records (IHCR) found a new HRH was completed for each youth within seven days of the youth's admission and prior to their CPA being completed. Documentation supported each youth's HRH form was completed on the day of admission. The nursing staff provided their electronic signature on each HRH form. The designated health authority (DHA) documented a review of the HRH form on each youth's completed CPA. An interview with nursing staff validated the HRH is completed by the nurse during the initial assessment, whenever any new significant medical event or change occurs, and then annually. Three of the youth records indicated changes had occurred, and the HRH form was updated for each.

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 maintains a policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program maintains a policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth Individual Healthcare Records (IHCRs) validated the program utilizes the Department's Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O", an "X a comment of "deferred by clinician due to no symptoms at this time." Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. A review of five youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier one tuberculosis (TB) screening. All tier one TB screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff review the Department's Juvenile Justice Information System (JJIS) to ensure there is a documented TST and to ensure the TST is current and documented as required. A medical tracker is maintained to monitor TST/PPD due dates. There were no current youth with symptoms suggestive of active TB. Program procedures outline if a screening indicates a youth has symptoms suggestive of active TB, the youth is not to be placed in the general population until medically assessed by the DHA. The program does not have an airborne infections isolation room, so the youth is taken outside in the open air until the DHA is notified and the youth is transferred to a hospital for further evaluation.

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 maintains a policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide if testing for STIs is needed based on the screening tool and medical evaluation. A review of five youth healthcare records showed each youth was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation. Testing was ordered and was performed for each youth on the day of admission. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews validated the practice. The program maintains a policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment. A review of five youth Individual Healthcare Records (IHCR) validated each youth was offered the opportunity to receive counseling and testing for HIV. The program

utilizes Metro Health Wellness for their HIV risk assessment, testing, and counseling. The program provided a copy of Metro Wellness' 500/501 certification. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. Five reviewed youth revealed one youth consented for testing. The reviewed youth IHCR validated when the youth received pre-counseling, testing, and post-counseling, their Health Education Record form was updated. The program stated the results were placed in a sealed envelope marked "confidential" and the youth's name and test date were documented on the outside of the envelope; however, the results were given to the youth upon discharge. Five interviewed youth indicated they can request HIV testing.

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 maintains a policy and procedures ensuring all youth shall be able to make Sick Call Requests and have their complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which require some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's sick call process upon admission. Sick call hours are posted outside of the medical office. The program holds sick call three times a day, seven days a week. Sick calls are conducted daily from 7:00 a.m. - 9:00 a.m., 1:00 p.m. - 3:00 p.m., and 5:00 p.m. - 7:00 p.m. and are conducted by a registered nurse (RN). A review of five youth Individual Healthcare Records (IHCR) validated each youth completed a Sick Call Request form at least once during their stay. A RN documented the treatment and/or services provided to each youth during the sick call event on a Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period; however, program procedures outlined the healthcare staff will automatically refer the youth to the DHA or dentist for an evaluation and treatment if this occurs. Reviewed IHCRs indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the program's Electronic Medical Record as well as the IHCR. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the staff mentor for review. The staff mentor is required to review the sick call complaint promptly but no longer than two hours after the request was submitted. The staff mentor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff mentors received medical technician training delivered by a RN. An interview with the RN indicated refresher training is provided annually. The program maintains a sick call box located outside of medical mounted to the wall. The box is monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. Five interviewed staff indicated nursing staff conduct sick call.

Five youth were interviewed and two indicated they see a nurse immediately when submitted a Sick Call Request. The remaining three youth stated they see a nurse within one day. The reviewer was unable to observe a sick call during the annual compliance review, as no sick calls were conducted while on-site.

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 maintains a policy and procedures ensuring there is a plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. The program maintains a policy and procedure ensuring the program based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains a current agreement and scope of services with Mobile X to provide on-site radiology services. A review of five youth Individual Healthcare Records (IHCRs) found each youth required episodic and/or first aid care during their stay in the program. One youth had five separate incidents of care, two youth had one, one youth had six, and one youth had two separate incidents of care provided. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff maintained an Episodic / First Aid / Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews validated this practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Care Log. The program maintains an AED located in the day room hallway mounted to the wall. All staff, volunteers, and interns are authorized to provide assistance to victims of sudden cardiac arrest, if they have been trained in the use of the AED, as documented in their respective training record. The program maintains seven first aid kits located in the front office, classroom one and two, kitchen, back duty station, van number one, and van number three. The program maintains two suicide response kits located in the front reception and back duty station, each containing a knife-for-life, wire cutters, and needle nose pliers. The first aid kits, AED, and suicide response kits are checked monthly by nursing staff to ensure they are adequately supplied and in working order. Nursing staff ensure the AED is functioning adequately and inspects the batteries and pads to ensure they are in working order. The AED procedures are verbally given from the AED, which was demonstrated by the nursing staff. Program policy and procedures indicate all batteries should be installed prior to the “install before date.” Following installation, the battery will expire in five years. The AED batteries have a shelf life of five years. Reviewed AED batteries expire on November 20, 2021 and were last changed on November 20, 2016. The AED pads were last changed on May 29, 2019 and expire on July 31, 2021. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current certifications in CPR and AED. The program conducts announced and unannounced mock emergency medical drills monthly on each shift. Reviewed drills supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR / AED demonstration at least quarterly, with the exception of November and December 2019, when drills were

conducted on two shifts only. Observations during the tour of the program found postings throughout the program informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in the conference room and the medical clinic inaccessible to youth. Reviewed training records supported staff mentors have been trained in the administration of the Epinephrine Auto Injector. Five staff were interviewed and four indicated they could personally call 9-1-1 in the event of an emergency. The remaining staff indicated they would call a code white and have another staff call 9-1-1. Five interviewed youth indicated they can see a dentist or doctor if needed.

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 maintains a policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth Individual Healthcare Records (IHCRs) found each youth required off-site care and/or emergency care. Each youth off-site care event was documented in their IHCR. One of the five youth was eighteen years of age or older. Four reviewed youth IHCRs indicated the youth were under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the IHCR. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care form and discharge paperwork, as evidenced by signature and date. One youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List form, and Sick Call/Referral Log form. The nursing staff place all off-site care findings, instructions, and information in the DHA folder for review and signature.

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 maintains a policy and procedures ensuring youth who have been identified with a chronic illness receive regularly scheduled evaluations and any necessary follow up treatment. The purpose of the periodic evaluations is to ensure youth who require ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth healthcare records indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form and each classified with a medical grade between two and five. There was one youth currently undergoing treatment for a physical health condition which included a body mass index greater than thirty. The program maintains a youth roster of youth requiring periodic evaluations which identifies the youth's name, date of admission, whether youth was admitted with prescribed medication, their chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated

chronic conditions are monitored at least every sixty days and some conditions require monitoring more often. An interview with nursing staff indicated youth identified with a chronic condition are placed on the medical tracker to ensure the DHA follows up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth, usually weekly when on-site, and any time there are identified concerns. The DHA indicated formal quarterly meetings are conducted with the facility administrator (FA), nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. An interview with the FA indicated formal meetings are held with healthcare staff monthly and informal meetings are held as needed throughout the month. The psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. Reviewed documentation supported a treatment plan is created when a youth is diagnosed with a chronic condition. Approximately every sixty days the DHA conducts a periodic examination of the youth, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. Reviewed documentation supported the Department's Problem List was updated as required.

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

The program maintains a policy and procedures ensuring medical staff verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. The youth's signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the youth's present medication and administer the medication as ordered. An interview with nursing staff indicated only a registered nurse (RN) completes the admission and any applicable medications are verified with the medical records and the youth's parent/guardian. A review of five youth Individual Healthcare Records (IHCRs) indicated all youth were admitted into the program on prescribed medication. Reviewed nursing admission notes for each youth documented the youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication for each youth. Program practice is to notify the DHA for all youth admissions. The DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation supported all medications had a current, valid order, and were given pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Each reviewed youth IHCR indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. Each time the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered according to instructions. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. Five reviewed youth IHCRs found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications approved through AET. The medication was administered in accordance with the approved protocols and physician's order. Reviewed documentation supported the program utilizes a pre-printed MAR to document administration of medication for each youth. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All five youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Observations found the medications are procured

through a pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two registered nurses. All five reviewed MARs supported the youth received their medication as prescribed. The MAR clearly indicated medication start and stop dates, with the exception of one youth whose MAR was missing the dose, route, and stop date for four months. Five interviewed staff and five interviewed youth all indicated nursing staff provide medication to youth. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center (CCC) reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. One youth refused medication during the annual compliance review period and it was clearly documented on the MAR. Observation of medication administration by nursing staff validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. Medication pass was observed, and the Six Rights of Medication Administration was maintained for each youth. The program maintains a policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program had one controlled medication on-site which was maintained securely in a locked box within the securely locked medication cart located in the medical clinic. The program maintains one refrigerator in the medical clinic for the storage of medication. There were no applicable medications requiring refrigeration during the annual compliance review week.

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 maintains a policy and procedures stating all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter medications (OTCs) were placed in the top drawer of the medication cart. Overstock OTCs were in a locked cabinet in the back medical cabinet. Controlled medication is securely stored in a double locked compartment in the medication cart. The program's practice is to store the medications in a locked box located in the locked medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There were no medications requiring refrigeration during the annual compliance review week. The program securely stored sharps and syringes separate from medications. The program maintains a policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirm all OTC medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual inventory daily and verified weekly, usually on Saturdays and for fidelity purposes. Perpetual inventories with running balances are maintained on controlled substances with a shift-to-shift inventory conducted by two registered nurses (RNs). Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program maintains procedures for the disposal of narcotics and other controlled substances. Program

practice is for the consultant pharmacist and RN staff to dispose of medication by placing the medication in an Rx Destroyer. All non-controlled medications are sent back to the pharmacy for credit. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts.

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

The program maintains a policy and procedures ensuring there is an approved plan for exposure control and infection control to ensure staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Center for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on June 17, 2020 and by the designated health authority (DHA) on June 19, 2020. The plan includes common, infectious diseases of childhood, handwashing, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by bloodborne pathogens. The plan outlines outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, foodborne illnesses, bioterrorism agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to personal protective equipment. The program maintains a biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through a contracted provider. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The plan includes risk assessment and methods of compliance. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals during the annual compliance review period. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. All five medical records reviewed confirm youth are educated on infection/exposure control. The Department's Central Communications Center (CCC) was notified of two separate instances in which staff tested positive for COVID-19. An interview with the FA indicated the program's exposure control and infection control plan is located in the FA's

office and in the medical nursing office. The FA stated the plan is reviewed with staff bi-annually.

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 maintains a policy and procedures ensuring there is an approved plan for prenatal care/education to ensure all youth are provided gender-sensitive, trauma informed care, and gynecological/obstetrical services. Five youth medical records were reviewed, and none required pre-natal care. There were no pregnant youth in the program during the annual compliance review. Health Education Records were reviewed in all five medical charts to confirm each youth has been educated on prenatal care/education. All five youth received pregnancy testing on day of admission to rule out or confirm pregnancy. Five youth were interviewed and each youth stated they have not received prenatal, obstetrical, or gynecological services while in the program.

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.	

The program utilizes licensed nurses to include on-site nursing coverage provided by registered nurses (RNs). The program does not utilize licensed practical nurses (LPN's). A review of all three full-time RN's credentials verify all three RN's have clear and active unrestricted licenses. A review of documentation confirms all three RNs have current cardiopulmonary resuscitation (CPR) certifications. The program provides three full-time RN's to ensure on-site coverage for sixteen hours, seven days a week.

Standard 5: Safety and Security

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

The program has a policy and procedures regarding youth supervision. Staff-to-youth ratios at the program are one to six during awake hours and one to eight during sleeping hours. Observations, informal interviews, logbook entries, and video reviews confirmed staff to youth ratios were in compliance. Staff were able to immediately inform the annual compliance review team member how many youth they were supervising.

During the annual compliance review, youth were observed reading educational materials, attending scheduled classes with teachers, and participating in meals, breaks, and line movements. Positive interactions were observed between youth and staff. The program has a full schedule of activities which was posted. Observations throughout the annual compliance review week found the schedule was followed. At no time during the annual compliance review were youth observed wandering freely about the program. Five staff were interviewed and each one of them confirmed their understanding of the procedures when there is a discrepancy with the count. All interviewed staff indicated movement is stopped and the count is reconducted until the count is reconciled. Observations, informal interviews, logbook entries, and video reviews confirmed counts were conducted at scheduled and unscheduled times.

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

The program has a policy and procedures regarding the behavior management system (BMS) which the program calls the positive performance system (PPS). The BMS is clearly written and is in the youth handbook to allow easy access for youth. The program utilizes the BMS to foster accountability for behavior and compliance with the program's rules and expectations. The program's BMS is designed to positively reinforce pro-social behaviors and reduce anti-social behaviors. Each youth earn points, which are documented on a Level System Evaluation form. The BMS was observed posted on the living unit and is clearly explained in the program handbook. The program's BMS details the rules and the positive and negative consequences for actions. The program's BMS policy address' a ratio of four-to-one positive to negative consequences.

Five pre-service and five in-service training records contained BMS training. The orientation checklist documents the BMS is reviewed with the youth. Five youth case management records were reviewed, and each contained a completed orientation checklist. The BMS promotes youth

rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, and provides youth with pro-social, acceptable alternative behaviors. The youth have an opportunity to explain their behavior. The BMS is connected to the youth's individual performance and treatment plan goals. The BMS includes a token economy in which youth earn points for each activity of the day and convert the points earned into purchases at the boutiques. Five youth and five staff were interviewed, and they all stated youth are offered a variety of incentives and rewards used as positive reinforcement including boutique points, nightly incentives such as movie night, painting, snacks, bingo, weekly incentives, and monthly incentives. Each youth stated consequences can include a deduction of points, incentive freeze, or result in a special treatment team meeting. Five staff were interviewed, and all were able to explain the program's BMS including the point system, level system, incentives, and consequences. All five staff confirmed they cannot take things away from youth as a consequence. The facility administrator interview confirmed the BMS is a level/point system with daily and weekly incentives.

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

The program has a policy and procedures to ensure staff are provided feedback regarding their implementation of the behavior management system (BMS). Position descriptions confirmed staff who implement the program's BMS have the required qualifications. The program's BMS includes a process for staff to explain to the youth the reason for any sanction imposed and for the youth to explain their behavior. The program does not utilize room restriction or extend the youth's length of stay as a sanction. An interview with the facility administrator (FA) indicated the program utilizes a positive performance system (PPS) as the program's BMS. Five staff were interviewed, and each indicated staff inform the youth of consequences by talking with them or by holding a special treatment team meeting. Each staff indicated youth are able to explain their behaviors. Four interviewed staff indicate supervisors provide them with feedback regarding implementation of the BMS by talking with them, providing coaching, and encouraging them to use prompts. The remaining staff indicated they were unsure how supervisors provided them with feedback regarding the implementation of the BMS. Five youth were interviewed, and each was able to explain the consequences used in the program, the rewards used in the program, and level system, including the difference between each level and how to move from level to level. All five youth stated staff use rewards the same. Three of the interviewed youth feel the program's BMS is good and two feel it is fair. Each youth indicated youth are never allowed to punish other youth.

Five pre-service and five in-service staff training records were reviewed, and all documented training in the BMS. Documentation confirmed education staff were jointly trained on the utilization of the BMS during school hours, which is required by the Department's Rule. An

interview with an education staff member confirmed education staff have been trained in the program's BMS.

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

The program has a policy and procedures addressing ten-minute checks. Documentation indicates the program has fifty-two cameras. Forty-three cameras were operational at the time of the annual compliance review. The video coverage storage goes back thirty days. The program's practice is to conduct checks every six minutes. A review of eight different shifts, each for one hour, was conducted to monitor ten-minute checks. All reviewed checks were completed within the ten-minute window and most were completed six minutes apart. Video logs confirmed the checks were completed and documented at the correct intervals. A review of ten-minute check logs for the last six months, two dates each month, for a one-hour period on the dorm was conducted. The review found checks were conducted at least every ten minutes, taking place every six minutes. All reviewed logs included the time, youth count, and staff initials for each check. Each of the five interviewed staff indicated checks are completed at six-minute intervals. The facility administrator stated the program's practice is to conduct checks every six minutes.

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

The program has a policy and procedures addressing census, counts, and tracking. Documentation confirmed youth are always accounted for through a system of physically counting youth at various times throughout the day 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 logbooks.

The logbooks were reviewed, which included a randomly selected date for each month for April, May, June, July, August, September, and early October 2020. All three shifts were reviewed for each date and no discrepancies were found. Informal and formal counts were observed during the annual compliance review and found they were each conducted as required. Five staff interviews confirmed staff know the procedures for reconciling the count if there is a discrepancy. They indicated all movement is stopped and a recount is conducted. Staff indicated counts are conducted at the beginning of each shift, after outside activities, and during major disruptions.

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

The program has a policy and procedures to address logbooks. Logbooks entries from a sample of one day each, on each shift, totaling seven days, from April 2020 to October 2020 were reviewed. The logbooks include a shift report section, which were all signed and dated by incoming staff to confirm they had reviewed the previous two shifts. All the logbooks were bound. All entries were in ink. There was no evidence of eraser marks. None of the pages were removed or obliterated except for one logbook, which had multiple pages separated from the binding. Each logbook covers a one-month period. The logbook pages documented perimeter checks, weather alerts, Central Communications Center (CCC) reports, shift summary notes, keys, radios, Prison Rape Elimination Act (PREA) checks, fire safety, scheduled and unscheduled counts, and any calls made to the Florida Abuse Hotline and CCC. Reviewed entries included the date and time of the event, the name of staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry, with some exceptions. Eight out of seventeen COOP entries did not have documentation on the time, type of drill, and/or description of the event. They also did not include the name and signature of the staff making the entry. Five CCC incidents were reviewed and each was entered into the logbook.

A youth placed on precautionary observation was inconsistently documented in the logbook. One youth was on a heightened level of supervision for nineteen consecutive shifts. The logbook reflected the youth was on close supervision, in four of these shifts, when she was actually on suicide precautions in the “Communication Board/Alert Status Review” section. The logbook had unclear documentation for an additional five shifts while this youth was on close supervision. The reviewed documentation indicated the youth was actually on security alert, and not on close supervision. The documentation for the second youth did not reflect when the youth was actually placed on suicide precautions, and there was nothing to reflect her still being on suicide precautions in the “Communication Board/Alert Status Review” section for a shift after another youth was put on the same placement a day later. The program indicated even though the documentation in the logbook was inconsistent, the information was passed on to the various shifts through a review of youth alerts during the shift briefing process.

Discrepancies were found in the logbook for the one youth who had two different instances of crisis assessments completed. In each of these instances, the youth was placed on close supervision after the completion of a Crisis Assessment. Documentation in the logbook for the first instance reflects three shifts in which her placement was not reflected where they document the “Communication Board/Alert Status Review” section, and another shift where information

regarding the youth was placed in the security alert section, and not in close supervision. The review of logbook documentation for the other instance of crisis had one shift in which her placement was not reflected where they document in the “Communication Board/Alert Status Review” section. The program indicated even though the documentation in the logbook was inconsistent, the information was passed on to the various shifts through a review of youth alerts during the shift briefing process.

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

The program has a policy and procedures addressing key control. Documentation confirmed the program has a system to govern the control and use of keys. The program’s policy and procedures address distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are kept in a secure area in the master control area, which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. The master control operator reported restricted keys, temporary keys, and visitor keys are all kept separate from each other. There were no reports of broken or damaged keys. There were no incidents of lost keys, which was verified by a review of internal incident reports and Central Communications Center (CCC) reports. The maintenance 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 review week found personal keys were secured and staff were aware of program keys in their possession and followed the key control procedures. A sampling of three staff’s keys was completed to compare their key rings to the key inventory logs with no issues identified.

An interview with the assistant facility administrator validated they are familiar with the process of the usage of all restricted keys. The program’s method of daily tracking of keys is each staff turns in their personal keys to receive program keys. In addition, a key control log is used to log each program key assigned and notates in the log when it is returned. Five staff were interviewed regarding their understanding of the program’s key control process, how keys are assigned, the program’s process for missing, lost or damaged keys, and restricted keys and each of the staff were able to articulate the processes.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a policy and procedures addressing control of contraband. Documentation confirmed 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 includes any staff who is found in possession of contraband in the program will be subject to disciplinary action up to and including dismissal. 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 equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. An informal interview was conducted with the facility administrator (FA) during the annual compliance review. If contraband is discovered, the FA and assistant facility administrator (AFA) are notified, the item is logged into the contraband log, and the Central Communications Center (CCC) is contacted. If the item is legal, it will be disposed of. If the item is illegal, it will be turned over to local law enforcement for disposal or it can be retained by police as evidence to add charges to the youth who was found in possession. In addition, staff were asked to explain the contraband procedures. The staff indicated the contraband notice is posted on the front door and states law enforcement will be contacted for anyone bringing in contraband. All searches are documented in search binders. Documentation confirmed incoming and outcoming mail is searched by the case managers in front of the youth. The room search binders from April 2020 to October 2020 were reviewed and found searches were documented appropriately. The logbooks from April to October were also reviewed. Documentation confirmed youth are searched for contraband after every movement. Observations during the annual compliance review period also indicated youth are searched after every movement.

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

The program has a policy and procedures regarding searches and full body searches. During the annual compliance review, the annual compliance review team was unable to observe any transports or admissions as there were none scheduled during the week of the review. The annual compliance review team observed classroom transitions and transitions to and from recreation, meals, classrooms, the living unit, and group treatment meetings and all youth were searched as required by the Protective Action Response (PAR) training manual; and the required staff-to-youth ratio was observed. The searches were observed to be a normal practice for the youth and were conducted by a staff member of the same gender. The youth were treated with dignity and respect when being searched. Five staff and five youth were interviewed, and all confirmed youth are searched every time there is a 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 a policy and procedures on vehicles and maintenance. The program has one van currently operational. The van had an annual inspection completed on March 2, 2020 and all maintenance records were documented. There were no transports during the annual compliance review. Informal interviews with two staff verified seatbelts are always worn during transports. The vehicle contained a fire extinguisher, first aid kit, seat belt cutter, window punch, and the appropriate number of seat belts. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt. The door to the youth passenger area could not be opened from the inside. A random check of eight personal vehicles found all vehicles were kept locked when not in use. The program van was checked two times while on-site and the van was 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 has a policy and procedures addressing the transportation of youth. The policy requires a cell phone or radio to be issued to the transporter. The ratio of one staff to five youth must be in place for all transports. Two staff are required for transports with five or less youth. One of the staff on each transport must be the same gender as the youth. During the annual compliance review, the annual compliance review team was unable to observe any transports; however, informal interviews with two staff who provide transportation validated the process. The policy states drivers must have a valid driver's license, staff shall not leave youth unsupervised in the vehicle, and youth are not permitted to drive vehicles. A background check is completed on all new staff to include driver's license checks through the Good Hire report.

Driver's licenses are checked monthly by the program's human resources staff through the Florida Department of Motor Vehicles website for all program staff who operate a program vehicle. The program maintains a monthly approved driver list to ensure no one without a valid license transports youth. Four out of five staff interviews stated two staff members are always present on a transport trip. They also confirmed a cell phone is provided during transports as well as first aid kits. Two out of five staff interviews indicated there is a fire extinguisher in the transport vehicle and one out of five staff interviews indicated there is a window punch and seatbelt cutter in the vehicle. Four out of five staff interviews stated they are able to call the program if an emergency occurs. The remaining staff interview stated they have never been on a transport. All five staff interviews stated no staff can transport youth in their personal vehicles. Each staff indicated the vehicle is searched for contraband before and after each use. Five youth were interviewed, and each indicated they have never seen anyone place contraband in a transport vehicle. Each youth indicated they feel staff drive the transport vehicle safely.

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

The program has a policy and procedures which address who is responsible for conducting weekly security audits and safety inspections, the corrective action process, and the internal system for verifying deficiencies are corrected, which meets the Department's Rule. The program utilizes a Facility Security Audit and Safety Inspection form. A review of this form between the periods of April 3, 2020 to October 19, 2020 validated one was completed each week. The form documents a description of what is being looked at, comments, corrective action needed, and the date the repairs were completed, or due to be completed. All forms were reviewed and signed by the director of operations. The forms cover radios, cameras, keys, metal detectors, mechanical restraints, transportation, youth rooms and living areas, education, kitchen, grounds, exterior structure, perimeter, chemicals and storage, tool and sensitive item control, and other security operations. Facility safety and security audits are completed weekly to ensure follow-up on any issues. An interview with the facility administrator (FA) validated they are involved in the program's process to identify, track, and address any deficiencies captured during the weekly security audits and safety inspections. The FA indicated the physical plant manager conducts weekly safety inspections to identify safety and security risks, and the shift supervisors' complete daily perimeters checks to ensure all areas are safe and secure.

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

The program's policy and procedures address the issuance, inventory, and control of equipment and tools. Through observations, it was validated all tools, both class A and B, are secured in the locked maintenance shed and each class A tool is hanging and marked on a shadow board. All tools, both class A and B, are inventoried daily, following all work activities, and prior to being issued for work. Program youth do not have access to class A tools. All inventories were reviewed for the last six months and documented compliance with their procedures. The program has a policy and procedures to address missing or lost tools; however, no tools were missing or lost since the last annual compliance review. The policy indicates, if a tool becomes damaged or dysfunctional, the program follows their procedures to replace the tool. Ten staff records, five pre-service and five in-service, and five youth records were reviewed, and each

documented staff and youth were trained on the intended and safe use of tools. Five staff were interviewed, and all indicated youth are permitted to use 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's policy and procedures indicate staff-to-youth supervision during the use of tools is one staff to five youth. It further states the program has a process for issuance of tools, assessment of youth, tool distribution, and the search criteria during work projects. A review of five youth records validated all youth received an assessment to determine the youth's risk to self and others prior to the use of tools. Through an interview with the facility administrator (FA), it confirmed the program's process for youth handling and confirmed their knowledge of youth tool handling. Five youth were interviewed and asked what tools they are permitted to use, and they all indicated they can 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 the process for outside contractors. The program's form, Written Notification and Guidelines for Outside Contractors, is used to document when contractors arrive on-site with tools, when they leave with the same tools, and any follow up if tools are missing. The policy documents tool restrictions and indicates youth are not permitted in the work areas. A review of nine vendor invoices and Written Notification and Guidelines for Outside Contractors forms for each invoice validated the program followed their procedures each time an outside contractor was on-site. Each Written Notification and Guidelines for Outside Contractors form was signed by the contractor upon entry into the facility and signed by the contractor again when they exited, as well as by the physical plant manager. Each form documented a review by a program administrator within twenty-four hours. The program's procedures indicate prior written approval from the facility administrator is required for the approval/permission for a contractor to enter the facility with a personal cell phone or electronic devise capable of capturing pictures and/or audio/video recordings.

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.	

A review of the program's Continuity of Operations Plan (COOP) indicated drills are conducted in accordance with the COOP and Facility Operating Procedures. Drills are conducted monthly on each shift. The program has conducted fire, smoke, COOP, bomb threat, and escape drills during the review period. The program is operating on three shifts. The drill documentation included the type of drill, date and time of the drill, participants, a brief scenario, and findings/recommendations. Fire evacuation routes and egress plans were posted throughout the program. In October 2020, an inspection was completed, by a fire and security company, of all program fire extinguishers and each were tested and passed inspection. The facility administrator was interviewed and indicated fire and COOP drills are completed monthly and on

each shift. Five staff were interviewed and indicated they participated in the following drills within the last twelve months: weather, major disturbance, bomb threat, hostage situation, terrorist situation, chemical spills, flooding, escape, fire, medical, and mental health. Five youth were interviewed, and all indicated they have been instructed on what to do in case of a fire. Four youth indicated drills are conducted at least once a month. The remaining youth stated drills are conducted weekly.

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 maintains a Continuity of Operations Plan (COOP), which was reviewed and updated on February 27, 2020. The program's COOP is posted in the facility administrator's (FA) office and staff duty station. The plan, which was sent to and approved by the Department's residential regional director, addresses alternative housing. The COOP is combined with the program's disaster plan. The required COOP equipment is distributed by a contracted provider if needed, as well as by an alternative program, Tampa Residential Facility. The COOP contains all the required elements, in addition to updated and approved annexes. The program maintains a youth emergency shadow record for each active youth in a binder which documents all the required elements for each youth. The binder is maintained by case management. When the FA was asked where the COOP is posted, they indicated it was kept in their office and readily available to staff. Signs are posted throughout the facility notifying staff where the COOP is located.

The program does not have provisions of stored food supplies on-site for the continuous operation and services during emergency or disaster situations; however, there is a food supply stored at Tampa Residential Facility which is to be delivered to the program in the case of an emergency. This information is included in the COOP for Les Peters Academy, which was submitted to the Department of Juvenile Justice, reviewed, approved, signed, and dated with no issues or concerns noted. In addition, the program noted it has been the practice of TrueCore Behavioral Solutions to maintain an agreement with a food service provider to provide supplies in the event of an emergency. The food service provider maintains an adequate supply of food and water, continuously rotates the stock so items are not expired, and will deliver them in the event of an emergency.

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.	

A review of the program's policy and procedures validated the program follows their policy regarding storage and inventory of flammable, poisonous, and toxic items and materials. All flammable, poisonous, and toxic items are maintained in a locked storage building and in a

locked closet, in a locked cabinet, in the administration area of the program, which is always secure and inaccessible to youth. A review of the inventory of such items and the actual items on-site validated the inventory matched. A selection of four chemicals in the chemical shed were counted and compared to the inventory list. On the door of the storage building cabinet the program maintains a list of authorized staff, along with their positions and titles, who have access and can handle such items. Each of the reviewed items had a Safety Data Sheet.

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.*	

A review of the program's policy and procedures indicated the program maintains strict control of all flammable, poisonous, and toxic items and further indicates youth do not handle or dispose of any such items. All poisonous and toxic items are maintained in a locked storage building and in a locked closet, in a locked cabinet, in the administration area of the program, which is always secure and inaccessible to youth. The program does not maintain flammable items on-site. On several occasions during the annual compliance review, youth were observed cleaning in the cafeteria, and were never observed handling any flammable, poisonous, and/or toxic items. The program conducts preventative maintenance and documents their findings on the program's preventive maintenance checklist. The facility administrator ensures these items are scheduled and repaired, to meet the Department's Rule. Five youth were interviewed and all indicated they do not handle any type of cleaning products or 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 in place for the control of hazardous materials. The policy states the physical plant manager is responsible for disposal of hazardous materials. The procedures indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed of, according to Safety Data Sheet (SDS) requirements, and the disposal is to be documented on the applicable disposal form. A review of the physical plant manager's training plan shows they were trained in flammable, poisonous, toxic item control. Items are stored in a room inaccessible to youth. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA) standards. During the annual compliance review, there were no materials disposed of and the program has not had any

materials to dispose of during the annual compliance review period. The program does not keep any hazardous materials at the facility. An interview with facility administrator confirmed the program would follow OSHA guidelines for all disposal of waste, log any waste disposal, and would bring waste to the proper waste disposal provider agency.

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, the 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 maintains a policy and procedures addressing visitation and communication for youth and their families. The information is provided to each youth and their parent/guardian at orientation and is in the youth handbook. The policy states the program will make alternative arrangements for visitation during non-traditional hours, if necessary. The program's visitation schedule is posted throughout the facility on the program's facility schedule. The program conducts visitation every Saturday and Sunday.

The visitation log was reviewed and revealed no visitation occurred from March 13, 2020 to June 26, 2020 due to COVID-19 preventive measures. The program resumed from June 26, 2020 to June 30, 2020. A review of the visitation logs revealed only six visits took place during the time visitation had resumed. Of the six visits, all were with an approved person and documented on the visitation log. Visitation was again suspended from July 1, 2020 to present due to resumption of COVID-19 preventive measures.

A review of five youth records validated each youth had an approved phone, mail, and visitation list. All phone calls and incoming and outgoing mail are documented on each youth's list. A review of each of these forms for each youth validated all were able to communicate with their families by phone, mail, and visitation. An informal interview was conducted with the lead case manager about the practice of handling incoming and outgoing mail. The lead case manager validated the program is following policy and procedures concerning incoming mail and the whole process is monitored by case management staff. Five youth were interviewed, and all indicated they have been given the opportunity to communicate with family members by phone and/or mail.

5.23 Search and Inspection of Controlled Observation Room	**Non-Applicable**
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.