STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

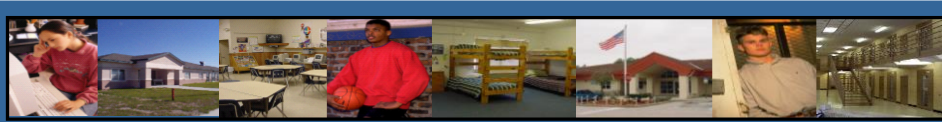
PROGRAM REPORT FOR

Les Peters Academy

TrueCore Behavioral Solutions, LLC

(Contract Provider)
3930 West Martin Luther King Blvd.
Tampa, Florida 33614

Review Date(s): January 29-February 1, 2019



PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Felicia Goldstein, Office of Program Accountability, Lead Reviewer (Standard1)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 4)
Jamila Bacchus, Office of Program Accountability, Regional Monitor (Standard 4)
Brenda Comadore, Office of Program Accountability, Regional Monitor (Standard 2)
Johnnie Downing, Executive Director, Sequel Youth Services Inc, (Standard 5)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 3)
Rowena Rose, Office of Education, Education Coordinator (Standard 2)
Canitha Taylor, Office of Program Accountability, Deputy Supervisor (Standard 1)
Sherri Wilson, Office of Program Accountability, Technical Assistance Specialist, (SPEP)

Program Name: Les Peters Academy
Provider Name: TrueCore Behavioral Health Solutions LLC.
Location: Hillsborough County / Circuit 13
Review Date(s): January 31, 2019-February 1, 2019

MQI Program Code: 1282
Contract Number: 10098
Number of Beds: 24
Lead Reviewer Code: 146

Methodology

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.

Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
2 # Case Managers
1 # Clinical Staff
0 # Food Service Personnel
1 # Healthcare Staff
1 # Maintenance Personnel
2 # Program Supervisors
5 # Staff
5 # Youth
2 # Other (listed by title): **Lead Educator, Psychiatrist**

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☐ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☒ Egress Plans
☒ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☐ Fire Inspection Report
☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☒ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs
☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
6 # Health Records
5 # MH/SA Records
15 # Personnel Records
10 # Training Records/CORE
3 # Youth Records (Closed)
6 # Youth Records (Open)
_____ # Other: _____

Observations During Review

☐ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration
☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☒ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth
☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☒ Transition/Exit Conferences
☐ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for 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	Non-Applicable
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Limited
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	Failed
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Satisfactory
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Failed
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Les Peters Academy is a twenty-four bed program, for males ages fourteen to eighteen, located in Tampa, Florida. The program is operated by TrueCore Behavioral Health Solutions Incorporated, through a contract with the Department. The program provides mental health overlay services (MHOS) to each admitted youth. In addition, the program fosters each youth by providing the following curriculums: Don't Let Emotions Run Your Life, Thinking for a Change, Owning Up, The Passport Program, Strategies for Anger Management, Living in Balance, and Toward No Drug. Additional treatment services provided includes family, individual, group, and recreational therapy. The program's administration team is comprised of the following positions: facility administrator, assistant facility administrator, program director, recreation therapist, director of clinical services, health services administrator, and a director of case management. Since the facility administrator is based out of another location, the assistant facility administrator and program director oversee the day-to-day operations. The director of case management, located at another program, oversees the case management services at this program provided by two case managers, and one transitional services manager. Mental health staff at the program includes one licensed director of clinical services (who serves as the designated mental health clinician authority), one licensed assistant director of clinical services, two master's-level therapists, and a certified behavior analyst. The certified behavior analyst position is shared with another program with the provider. The program contracts with two licensed medical doctors to provide psychiatric services to youth; one of which serves as the primary psychiatrist and one as a back-up when needed. Medical services are offered 7:00 a.m. to 11:00 p.m. and are provided by three registered nurses (RN) and one RN who serves as the health services administrator. Educational services are provided by the Hillsborough County School Board. At the time of the annual compliance review, the program had six vacant positions including three youth care workers, one case manager, one master's-level therapist, and one recreation therapist. The layout of the program includes: one main building which includes all staff offices, youth living units, dayroom, a kitchen, and the medical clinic. Additionally, the program layout includes three portables: two for education and one for vocational programming. Two sheds are on the property; one is used as a weight room and the other is used as the maintenance office and tool storage. The program has twenty-six security cameras to provide coverage throughout the facility; however, only eighteen were functional at the time of the annual compliance review. All main areas inside and outside of the program where youth reside and congregate have a functioning camera. New camera installations are on the list of repairs currently underway. A target date for completion is unknown by the program since they are waiting on approval from the Department. The program is going to change from a male program to a female program within the next quarter. The program's last youth will be released from the program in early April 2019.

Strengths and Innovative Approaches

- Every Tuesday, a mentor from the community comes to the program during lunch time and teaches a small group of youth how to play the guitar. The setting is informal, and youth are encouraged to participate as they feel comfortable. The mentor walks through how to play the correct cords and how to play by ear. The youth also have access to the guitars throughout the week to practice. This mentor was on-site during the week of the annual compliance review.

- A different daily incentive activity is offered to youth who have a positive day. A different staff member hosts/facilitates the daily incentives. This provides youth an opportunity to interact with different staff members, thus reinforcing the social communication. Staff hosting the incentive activity range from nurses, administration, therapist, and case managers. Daily incentives are based on a daily point total and provide an immediate positive reinforcement for youth who have a positive day. These incentives happen at the same time and location nightly.

- The program has teamed with Jesus for Juveniles (JFJ) ministries to provide a mentorship program called Steadfast Mentors. Mentors have been providing the youth with reading material, hygiene products (when youth do not have access to them), and tickets for special outings like professional football games. Youth benefit from the mentoring program as JFJ also assists in the family reunification process. Mentors have traveled to the youth's home county or city and brought the youth's family to a visitation or a family day event.

- The youth participates in Dress for Success training where they learn how to tie a tie and learn about the appropriate attire to wear on job interviews. Clothing items are provided to those in need, for job interviews, and/or returning to school upon release from the program. Dress for Success clothing items are donated from staff and community-based agencies.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures for the background screening of all employees, volunteers, mentors, contracted providers, and interns prior to employment. A new screening is completed on every person hired with no exception. The program has thirty-two staff and twenty-eight volunteers. Five staff and four volunteers have been hired since the program's last annual compliance review. The program has not initiated any new provider contracts or subcontracts. A review of nine personnel records indicated all new staff, volunteers, and interns had a final background screening completed prior to their date of hire. None of the staff or volunteers had a criminal history which required the review of a person involvement history report and Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results. Each of the applicable records for direct care staff contained a pre-employment assessment with a passing score. Volunteers do not have access to confidential records. All staff and volunteers were reflected on the program's Clearinghouse employment roster. None of the staff or volunteers required an exemption by the Department. The program submitted their Annual Affidavit of Compliance with Level 2 Screening to the Department's Background Screening Unit (BSU) on December 5, 2018 and the Hillsborough County School Board submitted one on December 7, 2018, meeting the annual requirement.

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

The program has a policy and procedures for the background screening of all employees, volunteers, contracted providers, and interns every five years from the initial date of employment. During the annual compliance review period, five staff and one contracted physician were applicable. Each of the screenings were completed and submitted several months prior to their five-year anniversary dates. The program had no volunteers or interns applicable to this indicator. A review of the program's employee/volunteer roster and Clearinghouse was completed to validate information.

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.

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are 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.*
- *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.*

The program has a policy and procedures which promote an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The program has a zero-tolerance policy regarding abuse. Upon hire, all staff receive a new employee handbook and sign a TrueCore Ethics form. New staff also sign the Acknowledgement of Receipt and Understanding of Employee Handbook form which they received and understand all the items included in the employee handbook to include the code of ethics and abuse reporting procedures. A review of five electronic personnel records, for staff hired since the program's last annual compliance review, revealed each contained a copy of the signed acknowledgement and ethics forms. Upon admission and during the orientation process, all youth are informed of their right to report abuse to the Florida Abuse Hotline or the Central Communications Center (CCC) if they are over eighteen years of age. A review of five youth case management records revealed each contained an orientation checklist signed by the youth, acknowledging their receipt of this information on the day of admission. A review of five pre-service staff training records indicated all were trained on the abuse reporting requirements prior to contact with youth. The program's procedures indicate all staff are to immediately report any knowledge or suspicion regarding an incident of abuse or harassment which has occurred in the program. The procedures further state a youth's refusal to make a call themselves does not relieve the staff from being mandated to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred.

A tour of the program verified the Florida Abuse Hotline and the CCC phone numbers were posted throughout the program to include the living unit and dayroom area. If a youth requests to call the Florida Abuse Hotline or the CCC, an available staff will take the youth to the program director's office (or any open office with a phone) where there is access to a telephone and privacy, to facilitate the call. If the youth requests telephone access during a scheduled structured activity, the program will provide access as soon as the activity concludes. Since the last annual compliance review, the program had one incident reported the CCC, for allegations made by a youth to the Florida Abuse Hotline. The incident was reviewed and closed with no substantiated findings. A review of internal incident reports for the last six months revealed no incidents of abuse which should have been reported. The assistant facility administrator (AFA)

indicates their policy is to immediately remove any staff alleged of abuse from contact with youth until an investigation is completed.

Five youth were interviewed and all of them stated they feel safe at this program. All youth stated they have never been stopped from reporting abuse. When asked if staff are respectful when talking to youth, all five indicated yes, with two of the five youth indicating one staff is not. The lead reviewer discussed the youth's concerns with the AFA and by the conclusion of the annual compliance review, the AFA completed a coaching session with this staff based on information he received during his own internal review. When asked if staff use profanity two youth said never, one youth said occasionally, and two youth said often. One youth stated staff use profanity in conversation and two youth stated one staff uses profanity towards youth. Five staff were interviewed and asked to describe the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All staff indicated they would allow the youth to call and stated they would notify the program director. All staff mentioned they can make a call anytime and stated they have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. Four staff stated they have never observed other staff using profanity when speaking with youth, using threats, intimidation, or humiliation. One staff indicated they have heard staff use profanity in conversation and not directed at the youth. The annual compliance review team observed all program staff modeling prosocial behaviors for youth and reinforcing proper social skills. The team did not observe or hear of any allegations of abuse during the week of the annual compliance review.

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 had one incident reported to the Central Communications Center regarding a call made by the youth to the Florida Abuse Hotline. Department of Children and Families came to the program and determined the incident was unsubstantiated and no further actions would be required.

1.05 Incident Reporting (CCC) (Critical)	**Satisfactory Compliance**
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program has a policy and procedures to address the process of incident reporting. Thirteen incidents were reported to the Central Communications Center (CCC) since the last annual compliance review. All incidents were reported within two hours of the incident or within two hours of becoming aware of the incident with one exception. One CCC report shows one youth did not report to medical for his scheduled administration of medication at noon. At 12:55 p.m., the nurse called staff to again request for the youth to come to the clinic for his medication. It was at this time the nurse became aware the youth was off-site and would not return in time to receive their medication. The missed medication dosage was called in at 4:46 p.m. when the regional nurse was in receipt of this information. Six reports are closed and seven are still pending investigation results. During the week of the annual compliance review, no incidents were discovered or reported to the CCC. A review of the last six months of internal incident

reports and grievances validated there was no indication of any reportable incidents not reported to the CCC. The program has had zero grievances since the last annual compliance review. A review of the master logbook revealed all incidents reported to the CCC were documented in the appropriate sections with one exception. One CCC report was not documented in the logbook. The assistant facility administrator confirmed the program's observed practice and their compliance with the Department's reporting procedures.

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

The program's Protective Action Response (PAR) Plan was updated and approved by the Office of Staff Development and Training, and the Central Region Operations Director on May 23, 2018. The program maintains each PAR report and required attachments in a centralized PAR binder. The reports are separated by month and each section has a copy of the PAR monthly summary. The program has had four PAR incidents since the last annual compliance review. A review of all the reports showed all required elements and attachments were present. Each of the reports were completed prior to the end of the staff member's workday and included all required staff statements. All reports were reviewed by a PAR certified staff/instructor and the supervisor on-duty. All techniques applied were approved by the Department in the program's PAR Plan. All reports indicated a post-PAR interview was conducted with the youth within thirty minutes. One of the reports indicated the youth was injured and required a PAR medical review. The PAR medical review was completed by a nurse, within thirty minutes of the incident and minor first aid was provided. All reports were reviewed and approved by the assistant facility administrator (AFA) or designee within seventy-two hours. Further review of documentation from the last six months verified the program submitted a monthly summary of all PAR incidents to the Department, as required. The program's PAR rate during the annual compliance review period is .47 which is below the statewide average of 1.55. Last year, the program's PAR rate for the year was 2.40, which was above the statewide average of 1.55. The AFA's interview validates the program's practice and states all incidents are reviewed within twenty-four hours (excluding weekends) at the morning management meeting.

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

The program maintains a written pre-service training plan which outlines all of the training required, specified by Florida Administrative Code 63H, within 180 days of hiring. The program's plan indicates all staff must complete a minimum of 120 hours of pre-service training in the required topics. The program's pre-service training plan was submitted, in writing, to the Department, and approved by the Office of Staff Development and Training on December 28, 2017 and again on January 10, 2019. The training plan includes course names, descriptions, objectives, and hours for any instructor-led training. The training plan also indicates all new staff must participate in forty hours of on-the-job training (OJT) which will take place over five days. The assistant facility administrator (AFA) revealed youth care workers, shift supervisors, and the program director are counted in staff-to-youth ratio. Five staff training records and the

Department's Learning Management System (SkillPro) were reviewed for completion of pre-service training. Three of the five staff are still within their 180 day pre-service training period and two staff are beyond their 180 day training period. One of these two staff is a registered nurse (RN) and one is an assistance clinical director (ACD). Both staff beyond their first 180 days of employment received training in all required topics except for Protective Action Response (PAR), as well as 120 hours of required training. The RN has not completed PAR training. Training was documented in SkillPro for all applicable staff. SkillPro updates are still occurring for staff within their first 180 days of employment. All staff received essential skills training prior to being in the presence of youth. A review of documentation verified instructors were qualified to deliver the training provided. All job-specific OJT training has been delivered and documented for both the RN and the ACD.

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

The program maintains a written in-service training plan and calendar which lists all training required for staff beyond the first year of employment. The training plan was submitted, in writing, to the Department and approved by the Office of Staff Development and Training on December 28, 2017 and again on January 10, 2019. The plan includes course names, descriptions, objectives, and training hours for any instructor-led trainings. The assistant facility administrator revealed youth care workers, shift supervisors, and the program director are counted in the staff-to-youth ratio. A review of five staff training and the Department's Learning Management System (SkillPro) records were reviewed for training completed in the 2018 calendar year. Each reviewed training record documented the staff completed more than the required twenty-four hours of annual in-service training; however, not all required trainings, such as cardiopulmonary resuscitation (CPR) and first aid, were completed. Although still certified into 2019, two staff did not receive an update in CPR, first aid, and automated external defibrillator. Three staff did not receive training in the site-specific exposure control plan and/or emergency response to include participation in mock drills.

Each staff completed training in professionalism and ethics, in addition to six hours of suicide prevention. Two of the five staff were supervisors and both records documented more than the required eight hours of required supervisory training. Supervisory training included the topics of management, leadership, personal accountability, employee relations, and communication skills. A review of documentation verified all instructors were qualified to deliver the training provided. Not all training was documented in SkillPro.

CPR/FA certification was reviewed for eight nurses. All nurses are currently certified; however, documentation for one of the four full-time nurses did not show an update was provided in 2018.

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

The program has a policy and procedures in place to describe the grievance process for youth. The process has three phases to their grievance process (informal, formal, and appeal). The program encourages all youth to resolve the issue(s) informally. In the informal phase, youth can discuss his issues with the staff or supervisor on-duty or discuss it with the community in daily meetings. The youth can submit a Let's Talk form to administration, asking for specific staff to speak with and the form prompts the youth to suggest a possible resolution prior to meeting with staff. The program's procedures indicate informal complaints are handled as expeditiously as possible, but no later than twenty-four hours. In the formal phase, the youth can submit a written grievance to the supervisor or place in a grievance drop box. Completed grievances can be dropped off at the supervisor's office and placed in the drop box. Grievances are reviewed daily. The program director/grievance officer will investigate the grievance and render a decision, in writing, to the youth within seventy-two hours of receiving the grievance. Should the decision be in support of the grievance, actions to rectify the situation are made immediately and the youth's signature is obtained to document their agreement. If the decision made does not support the grievance or the youth does not agree, the grievance is immediately forwarded to the assistant facility administrator (AFA). The youth can appeal findings with the AFA and the decision made will be final. During a tour of the program, blank Let's Talk and grievance forms were found in the dayroom area and available to youth. The program has had zero grievances and seventy-nine Let's Talk forms submitted since the last annual compliance review. Six Let's Talk forms were reviewed; all forms were answered within the forty-eight hour required timeframe and the youth agreed to the resolution. Further review showed the program has been able to resolve the youth's complaint at the informal phase. All grievance forms are to be logged and maintained in a binder for one year. A review of five staff pre-service training records were reviewed and only one staff's record did not document training in the grievance procedures. In an interview, the AFA validated the program's grievance process. Five staff were interviewed, and all five confirmed the program's process. Five youth were interviewed and four were aware forms are available to them and could share the system's phases and timeframes. One of the five youth stated they have never filed a grievance.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

The program has a policy and procedures regarding delinquency interventions provided to the youth and how staff will be trained on the interventions. The program provides the youth with the contractually required delinquency interventions entitled: Thinking for a Change (T4C), T4C Aftercare, and Life Skills Training (LST). T4C and LST are documented in the Department's Sourcebook of Delinquency intervention. The program currently has two staff who have facilitated T4C groups over the last six months. One of the staff works full-time at another

program run by TrueCore. Both staff have the required educational background and each have been trained/certified to facilitate the curriculum. A review of five case management records revealed all youth participated in or have completed a delinquency intervention addressing an identified priority need. A review of sign-in sheets confirmed this finding. The program's schedule reflected the youth are provided sixty percent structured programming or activities during awake hours. T4C groups are currently facilitated three times a week. An interview with the assistant facility administrator (AFA) revealed during the intake and classification process, it is determined which intervention group would benefit the youth based on their history and identified needs. He also added staff must meet the qualification of the specific job they are applying for prior to being considered.

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

The program provides youth with interventions and instruction focused on developing life and social skills. The program is contractually required to utilize and facilitate the Life Skills (LST) delinquency intervention group for life skills. The program provides this curricula in a group setting and groups are conducted two days a week for up to sixty minutes. The program currently has one staff qualified and trained to deliver the curriculum. A review of five youth records and sign-in sheets confirmed the youth are receiving the services, as outlined in their individualized performance plan (IPP). Five youth interviews revealed three mentioned LST as a group they have participated in and all five could describe at least one new behavior and/or skill they have been taught in these groups. The youth also indicated they use role play methods in groups to help practice these skills the most.

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 utilizes Impact of Crime (IOC) and Thinking for a Change (T4C) as their main curriculums for restorative justice awareness. Restorative justice awareness is designed to teach the youth the impact of their crimes on victims, their families, and the community. T4C provides activities which increase the youth's accountability for their criminal actions. Sign-in sheets show one staff member from another program, also run by TrueCore, has been facilitating both IOC and T4C groups. Additionally, the program's case manager has also been trained to facilitate T4C groups. Both staff members have the proper educational background and training in the curriculum they facilitated. A review of staff training, and personnel records confirmed this. The program also provides community service work hours as part of the youth's case plan. The program has utilized guest speakers who have provided motivational information and information from the perspective of a victim. The assistant facility administrator was interviewed, and he stated youth are exposed to restorative justice through delinquency groups, which are provided at least twice a week. Four of the five interviewed youth validated the restorative justice groups they participate in are T4C and/or IOC. The youth also indicated they use role play methods in groups to help practice these skills.

1.13 Gender-Specific Programming	Satisfactory Compliance
The program provides delinquency intervention and gender-specific treatment services.	

The program utilizes Owning-Up and Young Men's Work as the gender-specific programming provided to youth. Both curriculums address the needs of the targeted gender population. The program's activity schedule reflects time for gender-specific programming. Group notes and observations made during the week of the annual compliance review validate groups occur at their scheduled time. Both groups are facilitated by a trained therapist and youth participate in only one curriculum at a time. If a youth is in the Owning-Up group then they are not in the Young Men's Work group, and visa versa. Youth are split up into both groups. When they are done with the cycle of one curriculum they will move to the next one. In his interview, the assistant facility administrator verified this process.

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 to address the maintenance of an internal alert system. The program maintains a continually updated, internal alert system which is easily accessible to program staff and keeps them alerted about youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks. This system alerts program staff when there is a need for specific follow-up or precautionary measures or more vigilant or increased levels of observation or supervision, and by assisting staff when making treatment or safety and security decisions. Upon admission, alerts are determined through a classification meeting. Alerts in the Department's Juvenile Justice Information System (JJIS) are reviewed prior to the classification of any new youth on the day of admission. Alerts are also updated in the JJIS, as needed. The program has an internal alert roster, maintained electronically, and reviewed daily by the management team during the morning management meetings. In his interview, the assistant facility administrator (AFA) indicated the case manager is responsible for updating the alert list/board and ensuring the alert roster information matches the alerts in JJIS. The alert list is maintained on the alert board in the AFA's office. This office stays unlocked and accessible to staff, when needed. Alerts are also listed in the program's logbook which is reviewed with all staff on each shift. Supervisors provide alert information to staff during shift briefings. A review of five internal and JJIS alerts revealed all alerts were properly entered into JJIS and the internal alert system by the appropriate staff. All applicable alerts were downgraded by the appropriate staff in a timely manner. A review of logbooks for the last six months supported the staff's consistent documentation of youth on alert status from shift-to-shift. Five interviewed staff stated alert information is shared in shift briefings and can be found on the alert board.

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

The program maintains an individual youth case management record and an Individual Healthcare Record (IHCR) for all youth in the program. The program also maintains an active mental health and substance abuse record, separate from the IHCR, during a youth's on-going program stay. Prior to discharge, the mental health and substance abuse record is merged into the IHCR. Records for five youth were reviewed. All records were marked "confidential" and secured in locked cabinets within a locked office room. All case management records contained all of the required file tabs.

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. In his interview, the assistant facility administrator (AFA) described the youth advisory board (YAB) as the program's formal process for gathering input from youth regarding issues within the program and making recommendations for resolution to improve conditions and enhance the quality of life for staff and youth in the program. The YAB meets monthly and is comprised of a president, vice president, and secretary. The YAB allows for youth to come together and provide input into issues/concerns within the program, as well as make suggestions for program improvement. The AFA and/or program director meet with the board to hear their issues, concerns, and ideas. A review of agendas for the last six months revealed a YAB meeting has occurred five of the last six months. There was not a meeting held in November 2018. Each agenda shows standing topics discussed including program issues, youth concerns, issues in need of follow-up, daily incentive activities, follow-up from previous meeting, open issues and announcements. At 2:00 p.m. each day, the program conducts a daily meeting with all staff and youth to give staff an opportunity to deliver important program information to youth and solicit their feedback and questions. On a quarterly basis, a selected group of youth are asked to answer survey questions about the program through the provider's Survey Monkey website. Results are tabulated at the corporate-level and sent back to the program to inform administration of any follow-up necessary. Five youth were interviewed and all of them mentioned the YAB process, daily meeting, or the submission of a Let's Talk form as ways for them to give ideas or input.

1.17 Advisory Board	Failed Compliance
The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.	

The program has a community advisory board roster which was last revised November 2014. The roster indicates the board has full representation from required agencies and community members. The board met at least once every quarter with one exception. There was no meeting in the last quarter of the 2018 calendar year (October-December). There is documentation showing the program sent invites to all members listed on the roster; however, the only parties in attendance were program staff. There was no documentation to show a non-program member of the board attended a meeting in the last year. The program provided documentation

to show one attempt was made, during the week of the annual compliance review, to solicit a new member. The new assistant facility administrator (AFA) came into this position in December 2018. The AFA indicated he cannot explain any deficiencies prior to his arrival but did provide one attempt to solicit a new board member during the week the review. No board members were contacted due to the lack of attendance seen from board members since the program's last annual compliance review.

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

The program has a policy and procedures regarding program planning. The program conducts a daily management meeting (Monday through Friday), during which issues regarding the youth, staff, and programmatic issues, such as pending background screenings, trending data, work orders, and general announcements are discussed. The program conducts monthly All Staff meetings and daily meetings with the youth. During All Staff meetings, programmatic issues are discussed, as well as employment trends, Protective Action Response trends, review program policies and procedures, and program drill reviews. The program maintains a binder with All Staff meeting agendas, minutes, and sign-in sheets, which confirm the staff meetings are held monthly. A review of meeting documentation revealed the program missed one All Staff meeting in the last six months. There was no documentation to show a meeting occurred in November 2018. Documentation also supports discussion of previous auditing and state reports are reviewed with staff.

The program utilizes several methods to obtain input from staff, youth, and parents/guardians to use in the program planning process. Program administration conducts quarterly youth and staff surveys through the online Survey Monkey system. Ten percent of youth and staff are selected each quarter to complete a survey. These survey methods provide a wide range of information which contribute to the program's planning process. Results are tracked by the program's corporate office and discussed at morning management meetings. Discussions include any follow-up necessary to address negative results or results needing follow-up. On the day of a youth's admission, a letter is sent to the parent/guardian with an admission survey attached. The parent/guardian is offered the option of sending back the handwritten survey or using a link, to complete their survey online. A letter with a survey link goes out to the parent/guardian forty-five days prior to a youth's release and post-release, which again asks for their survey input on Survey Monkey.

Additionally, the program is required to enter data daily into the company's Performance Outcome Report (POR). The PORs includes, but is not limited to, vacancies, workers compensation claims, staff injuries, youth injuries, off-site medical visits, number of youth on medication, number of youth on mental health observation status, daily behavior management outcomes on each youth, and Protective Action Response incidents.

The current assistant facility administrator (AFA) came into the position after the previous AFA left on December 10, 2018. The current AFA indicates the program and company focus on staff retention and he is trying to establish a strong staff morale. With the program converting their population to girls within the next couple of months, several new staff have been hired and several veteran staff have decided not to stay. The AFA is focused on recruitment of qualified candidates to find the best staff to provide care for the youth.

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 system for ensuring all staff are evaluated, at least annually, based on established performance standards. The program has a job description for each staff position, which clearly identified their job functions, and performance standards. The staff's implementation of the program's behavior management system was also added into each description. For the applicable staff, descriptions included job functions as it related to delivery of delinquency intervention services. Staff are evaluated annually on performance standards. The program provided the only three applicable staff personnel records to review. Each staff had a performance evaluation completed in the 2018 calendar year. The program's contract was reviewed, and all positions required are still within the program's organizational chart. With the switch from a male to female population, several staff decided not to stay on-board and work with the program's new structure. The program makes daily attempts to interview and fill these positions. The assistant facility administrator indicated employee performance reviews/evaluations are conducted annually in September/October. The immediate supervisor will evaluate the individual's performance for guidance to help the individual maintain or improve in their job performance.

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 notify a youth's parents/guardian, by telephone, within twenty-four hours admission and by written notification within forty-eight hours. Five case management records were reviewed and each of them demonstrated the program contacted or attempted telephone contact within twelve hours of admission and written notification within twenty-four hours. One of the five youth was under the supervision of the Department of Children and Families (DCF); however, parental rights have not been terminated. For this youth, notification was provided to both the parent/guardian and DCF. The program notified each youth's parent/guardian, juvenile probation officer, post-residential counselor, if applicable, and committing court, in writing, within twenty-four hours of the youth's admission.

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

The program has a policy and procedures to address youth orientation. The procedures outline all required orientation topics and describes how each youth receives the information. Five case management records were reviewed, and all records contained a copy of the orientation checklist form signed by the youth and case manager on the day of admission. The list indicates thirty-eight topics discussed with the youth, all of which are required by Florida Administrative Code. Additionally, each youth is provided a handbook which details every aspect of the program to include all topics listed on the orientation checklist. Each youth signs an acknowledgment form upon receipt of the handbook. All five youth interviews confirmed orientation is held within twenty-four hours of intake. An admission could not be observed during this compliance review. The program's procedures do not include or require documentation of youth orientation in the program's logbook. Documentation of this process is found in each youth's record. The program will soon be transitioning into a program for females, so admission of male youth stopped in November 2018.

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 ensure they obtain written consent for all youth eighteen years of age or older, unless the youth is incapacitated, and a legal court appointed guardian is assigned. In such instances, the consent of guardian would be obtained. Of the five reviewed case management records reviewed, two records were applicable. An additional record was provided by the program for review. All three youth signed an authorization for use

or disclosure of protected health information form consenting to the release of case management, medical, and mental health information to the parent/guardian.

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 that 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 classification process and reassessment for activities. The initial classification process is used for assigning each newly admitted youth to a sleeping room. On the day of a youth's admission, the program's treatment team members come together for a classification meeting. In this meeting all members review all the required classification factors and assign the youth to a room. A review of five youth case management records revealed all records contained an admission classification form which included required factors. The program conducts an initial risk assessment upon admission and reassessments for activities monthly during each youth's treatment team. Each reviewed record contained documentation to support the reassessment was conducted during each treatment team meeting. All five youth have had an increase in privileges or freedom of movement and have participated in work projects or other activities involving tools. Four of the youth have participated in an off-campus activity. A reassessment was completed prior to each of these events or activities for all youth. A review of the assistant facility administrator's (AFA) interview confirmed a youth's sleeping room placement is determined based on all required factors at the classification meeting. The program has an internal alert system, which is continually updated and easily accessible to staff. An alert list is updated by the case manager, as needed, and clipped to a board in the AFA's office. All alerts are documented on this board however; risks pertaining to safety, security, and mental health risks are documented shift-to-shift in the program's logbook. Medical alerts are not documented in the logbook to protect the youth's information.

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. A gang affiliation questionnaire is administered to each youth on the day of admission, as part of the classification process. This questionnaire assesses each youth's level of gang involvement. Information gained through this questionnaire will be used in the classification process and shared with staff to include the education department. If gang affiliation is identified or suspected upon or after admission, an alert is placed in the Department's Juvenile Justice Information System (JJIS) and then, within twenty-four hours, the information is sent to the juvenile probation officer (JPO), local law enforcement, and law enforcement in the youth's home county. Five youth case management records were reviewed, and two were applicable. The program did not have any additional records applicable. One

youth was identified upon admission; therefore, an alert was entered in to JJIS and notifications went out to all parties within twenty-four hours. The second youth was identified as having gang affiliation prior to his admission to this program; therefore, a JJIS alert was not required. Notification for this youth's affiliation was sent out to all required parties within twenty-four hours of admission.

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 administers a gang affiliation questionnaire to every youth upon admission. The program provides intervention strategies when youth are identified as a criminal street gang member, are affiliated with any criminal street gang, or are at high risk for gang membership. Program policy indicates the facility administrator is responsible for ensuring gang prevention and intervention strategies are implemented in the program. The program utilizes the Thinking for a Change curriculum as a gang prevention strategy. Each youth at the program completes the curriculum prior to their release. The program had two youth case management records applicable for this indicator. Each youth has a goal on their individual performance plan which indicates they will refrain from any gang activity while in the program. Additionally, the program uses ARISE: Gangs 50+ Stories of Fractured Lives as the curriculum for gang prevention and/or intervention activities. There was documentation showing the program provided intervention groups for applicable youth. A review of group sign-in sheets show each identified youth participated in gang prevention and intervention strategy groups for the past six months. Both youth were documented in the Department's Juvenile Justice Information System (JJIS) as having gang involvement.

2.07 R-PACT Assessment 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 which indicate each youth will receive Residential Positive Achievement Change Tool (R-PACT) assessment within thirty days of admission and every ninety days thereafter. Five youth case management records were reviewed, and each had an initial R-PACT completed within thirty days of admission. Each of the youth were applicable for an R-PACT Reassessment and which were completed ninety days after completion of the initial R-PACT. All five records contained required R-PACT documentation.

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 YNAS.	

Five youth case management records were reviewed. Each record contained a copy of a Youth Needs Assessment Summary (YNAS) completed in the Department's Juvenile Justice Information System within thirty days of admission. The treatment team meets to complete each youth's YNAS to prioritize the performance plan goals the youth should complete prior to release.

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 requiring the intervention and multidisciplinary treatment team to develop each youth's individualized performance plan (IPP) within thirty days of admission. Five youth case management records were reviewed, and each IPP was developed by the treatment team within thirty days of admission and included individualized and measurable goals for the youth to achieve prior to release from the program. Transition goals to be completed prior to release were included and placed in a pending status until the youth reached transition status; at which time the goals would be activated. All goals are based upon the prioritized needs reflecting the risk and protective factors identified in the Youth Needs Assessment Summary. Each of the IPPs contained target dates for completion of each goal, the youth's responsibility to accomplish the goal, and the program's responsibilities to help the youth achieve the goal. All plans included goals which targeted the youth's top three criminogenic risk factors identified by the Residential Positive Achievement Change Tool (R-PACT). Within ten days of completion, a copy of each youth's IPP was mailed to the committing court, the youth's juvenile probation officer, Department of Children's and Families (DCF) counselor (if applicable), and parent/guardian. Each plan was mailed to the parent/guardian and DCF counselor, if applicable, with a request to sign and send back the signature page. Two of the five youth were over the age of eighteen. None of the plans have been sent back signed by the parent/guardian and/or DCF counselor in the three applicable records. Five interviewed youth confirmed they participated in the development of their IPP. Each verified they received a copy of their plan and were aware of the goals they were working on.

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 to address revisions to a youth's individualized performance plan (IPP) when determined necessary by the intervention and treatment team. Revisions are to occur when new criminogenic needs are identified during the Residential Positive Achievement Change Tool (R-PACT) Reassessment, when the youth demonstrates progress or lack of progress toward completing a goal, or when new information is acquired or revealed. Five youth case management records were reviewed and all of the youth were eligible for IPP updates due to progress/lack of progress, completion of goals, and/or changes in goal target completion dates. One of the plans was updated based on R-PACT Reassessment results. One of the five records was eligible for a revision and was completed based on the requirements under facilitating transition activities. All plans were updated in the Department's Juvenile Justice Information System when goals were completed, added, or continued.

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

The program has a policy and procedures related to the completion of performance summaries and transmittals. Nine performance summaries were reviewed in five active and three closed case management records. Each record contained a Performance Plan Summary completed at ninety-day intervals and prior to release with minor exceptions. Two summaries were completed late and beyond the ninety day requirement. One was completed two days late and one was completed sixteen days late.

All summaries included youth status on performance plan goals, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers and staff, adjustment to the program, and significant positive and negative events. All records contained evidence of youth reading and adding comments prior to signing and each youth was given a copy of the summary with the exception of one youth who refused to sign his summary. Performance summaries were signed and dated by the treatment team leader and program director or designee in all five records and by the youth in four of the five records. All five records evidenced a copy of the summary was sent within ten days to the committing court, juvenile probation officer (JPO), and the parent/guardian.

Three closed case management records were reviewed for the completion of release summaries. All three records included a copy of the release summary and the Pre-Release Notification (PRN); the original release summary and PRN were sent to the youth's juvenile probation officer. There was justification for the youth's release documented in each record. In each record, the release summary and PRN were mailed at least sixty days prior to the youth's

scheduled release date. The committing court approved the release of all three youth. Upon receipt of court approval, the program provided each youth's parent/guardian with a written notification of pending release. The program completed the Exit Residential Positive Achievement Change Tool assessment prior to release. The original and/or copy of summaries were filed in each record, as applicable. Five youth were interviewed and each of them reported receiving a copy of their summary.

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

The program has a policy and procedures to address parent/guardian involvement in case management services. Upon admission, each parent/guardian is sent a welcome letter which includes the date and time of the youth's entry meeting where the Youth Needs Assessment Summary and youth's Individualized Performance Plan (IPP) will be completed. Five youth case management records were reviewed. Three of the five records were applicable. One of the three applicable youth is being supervised by the Department of Children and Families; however, parental rights have not been terminated. Two of the five youth were over the age of eighteen. Documentation in all records confirmed the program encouraged the parents/guardians to be involved by sending written notifications of activities, and through telephone communication. All records contained documentation to support each applicable youth's parent/guardian was invited to participate in each performance plan and performance plan review meeting. All five records document the parent/guardian's participation in the development of the IPP. Documentation in the applicable records indicated parents/guardians participated in most of treatment team meetings and if they did not attend by phone, an attempt to call was made by the treatment team. During the annual compliance review, three treatment team meetings were observed. The youth's parent/guardian was called in each of the meetings and two were available to participate. A message was left by the case manager for the parent/guardian who was not available. Three closed youth case management records had transition and exit plans which documented the parent/guardian participated by phone.

In an interview, the assistant facility administrator indicated the program reaches out to parents/guardians at admission and notifies them of the needs assessment meeting information which is used to determine goals for the youth to complete while in the program. During weekly phone calls to parents/guardians, the case manager encourages their participation in upcoming treatment team/performance plan review meetings. Five youth were interviewed, and each youth indicated their parent/guardian was involved with 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 to include the description of treatment team members. The procedures indicate the treatment team consists of the youth, the case manager, the therapist, the youth's parent/guardian, juvenile probation officer (JPO), representative of administration, a living unit representative, and the transitional case manager, when applicable. Staff from the education and medical departments are not required to attend; however, their input is documented and provided to the treatment team ahead of the meeting. Five youth case

management records were reviewed, and all contained evidence the following treatment team members attended monthly performance review meetings: youth, representative of administration, a living unit representative, the case manager, the therapist, JPO, parent/guardian, Department of Children's and Families counselor (if applicable), and a program nurse. An educational representative and licensed nurse always submitted their input in writing prior to each meeting if they were not in attendance.

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 policy and procedures to address the incorporation of other plans into the youth's performance plan. Five youth case management records were reviewed, and all contained an individualized performance plan (IPP). All five IPPs incorporated the youth's academic and treatment plans. One of the five youth was under the supervision of the Department of Children's and Families; however, there was no evidence of an existing case plan which needed to be incorporated into the IPP. None of the youth were involved with the Agency for Persons with Disabilities.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

The program has a policy and procedures requiring formal and informal treatment team/performance plan reviews to take place every thirty days to review each youth's performance, progress on performance plan goals, and treatment team member's participation. Five youth case management records were reviewed, and each had documentation of a formal treatment team meeting every thirty days and an informal treatment team meeting occurring bi-weekly. Two of the five youth are over the age of eighteen and one of the five youth is under supervision with the Department of Children and Families (DCF); however, parental rights have not been terminated. Treatment team forms documented the youth's demographic information, the date of the meeting, the attendees, and the youth's overall treatment and behavior. Three formal treatment team meetings were observed during the annual compliance review. All required treatment team members were in attendance. The case manager/treatment team leader attempted contact with each youth's parent/guardian and juvenile probation officer (JPO), to allow for their participation. Only one parent/guardian was unavailable for participation. The case manager meets with the youth during informal reviews and uses input from treatment members, as needed. In the five youth records reviewed a total of thirty-seven treatment team forms were reviewed. A review of documentation reveals formal review forms includes comments from treatment team members, a brief synopsis of the youth's progress in the program, revisions to performance plans, progress on treatment and case management goals and behaviors (positive and negative). Behaviors resulting in physical interventions were

mentioned in the one applicable record. Additionally, all reviews included results from Residential Positive Achievement Change Tool (R-PACT) Reassessments and opportunities for the youth to make comments. Informal reviews were completed on each youth bi-weekly and included the youth and the case manager. All five youth interviews confirmed the youth are provided an opportunity to demonstrate learned skills during treatment team meetings.

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

The program provides Type 2 education programming, which consists of teaching a broad scope of career choices based on personal accountability skills, employability skills, interests inventory, and learning occupation clusters. Learning clusters include communication, interpersonal, and decision-making skills. The youth are scheduled to visit a Career Source Center representative to develop career goals, discuss post-secondary college applications, learn how to write resumes and complete job applications. Four youth closed records with employability goals were reviewed. Each record contained a sample employment application, resume, calendar of appointments, state-issued identification cards, and certifications completed while in the program. There was documentation to support each youth had either been provided with information regarding the Career Source Center or had an appointment at a Career Source Center upon release. There was documentation to support each youth's parent/guardian and juvenile probation officer were aware of the youth's vocational plans at the youth's exit and transition meetings. The lead educator was interviewed regarding the career education services offered at the program. The lead educator indicated all youth take an entry and exit vocational assessment. Up until the recent retirement of the vocational teacher, high school students had the opportunity to participate in autobody and/or carpentry vocational classes. All youth are placed in coursework to obtain their My Florida Ready to Work Certificate and a Florida Soft Skills certificate. The assistant facility administrator interview validated this process and indicated the vocational programming and career education for their new female program is currently under discussion with the local school district.

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.	

Educational services are provided by the Hillsborough County Public School District. The lead educator indicated, in an interview, the education department provides 300 minutes of educational services to youth each day. Each day, youth attend school in three blocks. Each block consists of two classes which last fifty minutes each. Instruction for 250 days, distributed over twelve months is provided to all youth. High school students are in enrolled in auto body and/or carpentry vocational classes and up to when the vocational teacher retired at the end of December 2018, youth were able to participate in the hands-on portion of the curriculum once they had passed a security risk assessment. Youth receive credits for the educational and vocational training experience. A review of the program's daily schedule and movement was reviewed in a sample of logbooks from July 2018 to January 24, 2019. Each logbook entry reviewed had specific times and dates for educational services and youth movement which indicated minimal interferences during education instruction. Five youth were interviewed, and all indicated minimal interruptions in the school schedule.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

The education and transitional specialists work cooperatively to ensure the youth complete an education transition plan prior to release, including provisions for continuation of education and/or employment. The program has a policy and procedures in place to address the youth's education transition plan. Staff and youth complete an education transition plan at the time of admission and is finalized prior to release which includes provisions for continuation of education and/or employment. Four closed youth case management records were reviewed, and all records had a completed education transition plan, which included the youth's post-residential educational goals. All four plans addressed services and interventions based on the youth's assessed educational needs, post-release educational plans, the youth's recommended educational placement, and any monitoring responsibilities for reintegration and coordination of support services.

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

The program has a policy and procedures in place ensuring the intervention and treatment team planning for the youth's transition back to their community upon release. Three closed youth records were reviewed. Each of the three records confirmed transition conferences were held at least sixty days prior to youths' targeted release date and included all required parties. All records contained evidence of the transition conference addressing the performance plan and identifying the additional activities and services, as needed. Target completion dates and person responsible for their completion were identified. Transition plans were dated and had signatures which served as an acknowledgement of the activities and accountability. Each of the records documented the youth attended their Community Re-Entry Team (CRT) 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.	

Three closed youth records were reviewed. Each youth had an exit portfolio which contained copies of the following documents or proof of application: a copy of the youth's transition plan, calendar with all follow-up appointment information in the community, vocational certificates, educational records, school transcripts, a resume, and a completed sample job application. Two of the three records contained a copy of the youth's social security card, birth certificate, and state issued identification. The parent/guardian of the third youth indicated her refusal to provide the information to the program. All attempts to obtain the paperwork and her refusal were documented in the youth's closed record. All three records confirmed education staff forwarded a copy of the portfolio to the receiving school district and a copy was also given to the youth upon release. Review of the program's contract did not reflect any additional requirements.

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

Three closed youth records were reviewed. Each of the records confirmed an exit conference was conducted after the program notified the juvenile probation officer (JPO) of the release and documentation of the exit conference including dates, signatures (name if participated by telephone) and a summary of pending transition goals. All three records contained documentation the following participated in the exit conference: treatment team leader, parent/guardian, education representative, JPO, and the youth. The exit conference was held separately from the transition and community re-entry team meeting.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a designated mental health clinician authority (DMHCA), who is a licensed mental health clinician (LMHC). A review of the Department of Health Medical Quality Assurance License search website revealed the DMHCA's license is clear and active in the state of Florida and expires on March 31, 2019.

An interview with the DMHCA indicated they are on-site weekly and work Monday through Friday, 8:30 a.m. to 4:30 p.m. The DMHCA also indicated they work weekends and they are on-call twenty-four hours a day, seven days a week. During the interview the DMHCA indicated their role at the program is to oversee treatment services provided to the youth at the program. The DMHCA ensures clinical programming complies with all requirements outlined within the specialty service guidelines for mental health overlay services (MHOS). Furthermore, the DMHCA indicated they ensure the youth in the program receive therapeutic services which are in-line with their individualized treatment needs, and coordinate with the treatment team to further ensure each youth receives psychiatric services, therapeutic services and any other treatment service using the multi-disciplinary treatment team approach.

The DMHCA further indicated they oversee the quality and fidelity of the mental health and substance abuse services provided at the program. The DMHCA ensures the timely and accurate completion of comprehensive mental health and substance abuse evaluations, which are then used to determine the youth's individualized treatment needs. The evaluations are reviewed and signed, as well, as discussed in weekly supervision with clinician staff to ensure continued improvement. The DMHCA also provides weekly supervision to the non-licensed staff at the program. During the weekly supervision, the DMHCA reviews other clinical documentation such as treatment plans reviews, assessments of suicide risk and weekly progress notes with non-licensed clinicians. A review of the DMHCA's position description confirms they are responsible for oversight of the program's mental health and substance abuse services. The job description further confirmed the DMHCA's responsibilities gathered from the DMHCA's interview.

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 utilizes the services of two licensed clinicians. The program's designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC with a current and active license in the State of Florida expiring March 31, 2019. The program's second licensed clinician is a provisional licensed mental health counselor (PLMHC), who acts as the program's assistant clinical director. The PLMHC is provisionally licensed in the State of Florida until September 17, 2020. The clinician moved to Florida from New Jersey where they were a LMHC. Due to the State of Florida's stringent criteria for LMHCs the clinician is required to take and pass the Florida licensure test and gain specific educational requirements prior to the expiration of their provisional licensure. The program's PLMHC acts as the back-up to the DMHCA and provides clinical oversight in their absence.

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

The program has two full-time non-licensed therapists working under the supervision of the designated mental health clinician authority (DMHCA). The program is licensed under Chapter 397, F.S. to provide outpatient services, and the license expires April 7, 2019.

At the time of the annual compliance review, the program staff only had one non-licensed staff working at the program; however, during the six-month review period, the program had a total of three non-licensed staff working at the program. A review of the three clinician's staff records revealed they all had master's degree from an accredited university or college in an appropriate field of study. A review of all three non-licensed clinicians training records confirmed they received twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five Assessments of Suicide Risk, which were conducted on-site, in the physical presence of a licensed mental health professional.

All non-licensed clinicians worked under the direct supervision of the DMHCA. The non-licensed clinicians provided both mental health and substance abuse services to the youth at the program. The DMHCA provided weekly direct supervision to all non-licensed clinicians. An interview with the DMHCA indicated direct supervision normally occurs on Wednesday afternoons for an hour. A review of the program's direct supervision binder revealed all non-licensed clinicians received an hour of direct supervision from the DMHCA every week they provided services to the youth, with one exception. There was one week in October 2018 where a non-licensed clinician facilitated a group but did not receive direct supervision. During the debriefing process, the DMHCA indicated the clinician provided a group over the weekend and then fell ill. The clinician was out with a doctor's excuse for the remainder of the week and could not receive clinical supervision for the week they provided the group. Upon further review of the

weekly clinical supervision binder, there was a copy of the clinician's doctor's note excusing them from work the rest of the week attached to the weekly supervision documentation for the specific week missed.

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 in place outlining the program's process for mental health and substance abuse admission screenings for all youth who enter the program. The policy indicates each youth is to receive a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Assessment of Suicide Risk (ASR), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and the Substance Abuse Subtle Screening Inventory – Second Version (SASSI-2) assessment upon admission.

A review of five youth mental health/substance abuse records revealed upon each youth's admission, the clinical team completed a MAYSI-2, ASR, SASSI-2, and the VSAB. All MAYSI-2s, VSABs, and ASRs were completed in the Department's Juvenile Justice Information System (JJIS) database. All MAYSI-2s were completed by the designated mental health clinician authority (DMHCA), who has been trained to complete the assessment. There was also documentation in each youth's record to show the clinician completed a review of all available information to include the youth's commitment packet, reports, and records for existing documentation of mental health and substance abuse problems. Three of the five youth's MASYI-2s indicated further assessment was required, and a referral was made for further evaluation. Two of five youth's MASYI-2s indicated the staff believed the youth had mental health or substance abuse problems and required further assessment based on observations and information reviewed. All five reviewed records contained a completed VSAB and none of the youth were found to be vulnerable to victimization or sexually aggressive. All five records also contained a completed ASR and all ASRs recommended the youth be continued on standard supervision, as the youth were not at risk for suicide. All records contained a completed SASSI-2 assessment.

During an interview with the assistant facility administrator (AFA), they indicated upon each youth's admission, the youth are assessed by the clinical team using the MAYSI-2, VSAB, and the ASR. The AFA also indicated a mental health referral form is completed, when necessary, and each youth is referred to a therapist for a comprehensive evaluation and a psychiatric evaluation. The AFA stated the findings from all assessments are used to determine each youth's course of treatment.

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 in place indicating all youth who enter the program shall receive a new mental health and substance abuse assessment within thirty days of admission. The program is licensed through the Department of Children and Families (DCF) in

accordance with Chapter 397, Florida Statute, to provide outpatient substance abuse treatment to the youth in the program, and the license expires April 7, 2019.

A review of five youth mental health and substance abuse records revealed each youth had a new mental health and substance abuse evaluation completed within thirty days of admission. All evaluations were completed by a non-licensed clinician and were approved by the designated mental health clinician authority (DMHCA) within ten calendar days of completion. All five reviewed evaluations contained each youth's demographic information, reason for the evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis, recommendations, patterns of alcohol and drug abuse, impact of alcohol and drugs on major life areas, risk factors of continued alcohol and drug use, and clinical impressions. All reviewed records contained a signed consent for substance abuse services and release of substance abuse information.

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 in place outlining the program's mental health and substance abuse services. A review of five youth mental health and substance abuse records revealed all youth were assigned to a multidisciplinary treatment team on the day of admission. The program combines each youth's mental health and substance abuse treatment team meetings with each youth's case management treatment team meeting. All treatment teams consist of all required parties outlined in Florida Administrative Code 63N-1. During the annual compliance review, three youth's multi-disciplinary treatment team meetings were observed by a peer reviewer. All required members of the treatment team were present at all three meetings except for one youth's parent/guardian; however, the treatment team leader attempted to reach the parent/guardian to no avail. Discussed at the meeting was the youths' treatment goals, behavioral issues and the youths' progress. Each member of the treatment team was given an opportunity to discuss the youth's progress and the youth was also given an opportunity to talk with the team and demonstrate skills they have learned in the program.

A review of the five records confirmed each youth had a signed consent to receive substance abuse services and release substance abuse information. Three of the five reviewed records had a properly executed Authority for Evaluations and Treatment (AET). Two youth were eighteen years of age and had signed an authorization for use or disclosure of protected health information form indicating the person who was able to receive information about their mental health, case management, and educational services.

All reviewed records confirmed each youth was receiving mental health and substance abuse services from the program staff, and the program has a current Chapter 397 license, which expires April 7, 2019. A review of the five youth's individual progress notes and group sign-in sheets reflected mental health groups had no more than ten youth in a group and substance

abuse groups did not have more than fifteen youth in a group. Observations of a mental health group also confirmed the group had the appropriate amount of youth participating. A review of each facilitator's training record reflected they received proper training in mental health and substance abuse services, as well as training to facilitate each curriculum they taught.
All five youth records contained documentation each youth participated in daily groups for substance abuse or mental health issues, bi-weekly individualized sessions, monthly family sessions, and supportive sessions, when necessary. Each of the five youth received an initial psychiatric evaluation and four of the youth were placed on psychotropic medications and receiving monthly medication monitoring. A review of clinical progress notes confirmed each of the youth received mental health and substance abuse services as outlined in their individualized mental health and substance abuse plans.

During an interview with the designated mental health clinician authority (DMHCA), they indicated the program provides mental health and substance abuse treatment services through the provision of mental health overlay services. The DMHCA indicated all mental health and substance abuse treatment services provided at the program are provided by or under the supervision of the assistant clinical director and themselves. The DMHCA further indicated, at a minimum, mental health treatment includes individual therapy sessions on a bi-weekly basis, family therapy monthly, treatment groups seven days a week, and supportive counseling sessions, as necessary. The DMHCA also indicated mental health groups are facilitated five days a week and substance abuse groups and prevention groups are facilitated twice a week. The DMHCA indicated all mental health services are provided by a master's-level therapist or a licensed professional. The DMHCA also confirmed they are responsible for oversight of all clinical services and provides weekly direct supervision to the master's level clinicians.
Five interviewed staff indicated they did not facilitate group treatment and one of the interviewed staff indicated mental health staff conduct groups. Five youth were interviewed about group participation and they all stated they were participating in groups. The youth all stated they were participating in groups such as Thinking for a Change, Life Skills Training, Don't Let Your Emotions Run Your Life, Drug Abuse, Living in Balance, Passport, Impact of Crime, Florida Ready to Work and Healthy Relationships.

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 in place outlining which program staff form each youth's multidisciplinary treatment team. The policy indicates the treatment team is to be comprised of the youth, parent/guardian, juvenile probation officer (JPO), representative from the programs administration, representative from the residential living unit, other's directly responsible for providing or overseeing provisions of intervention and treatment services to the youth , and education staff, which can provide written input if unavailable to attend the meeting.

A review of five youth mental health and substance abuse (MHSA) records revealed each youth had an initial MHSA treatment plan completed the day of their admission. All initial MHSA treatment plans were developed on a program form which contained all elements of the Department MHSA form 015, entitled Initial Mental Health/Substance Abuse Treatment Plan. All five reviewed initial treatment plans indicated the youth would be assessed by the psychiatrist for psychiatric needs and those needs along with each youth's medication and frequency of monitoring by the psychiatrist was documented in the plans. All five initial treatment plans were completed by a non-licensed clinician and were signed by a licensed professional within ten days of completion.

Each of the records contained an individualized treatment plan completed within thirty days of admission. All individualized treatment plans were developed on a program form which included all elements of the Department form MHSA 016 entitled, Individualized Mental Health/Substance Abuse Treatment Plan. All individualized treatment plans were completed by a non-licensed clinician and were reviewed and signed by a licensed professional within ten days of completion. All individualized treatment plans were developed with input from all required treatment team members and the plans were signed by all treatment team members. Four of the five individualized treatment plans were applicable for psychiatric services and medication monitoring and the information was found in all applicable plans. All five individualized treatment plans documented the prescribed services outlined for each youth's individualized treatment, such as group treatment, individual sessions, family sessions and psychiatric services.

All five records required individualized treatment plan reviews, which were completed on a program form with all elements of the Department MHSA form 017 entitled, Individualized Mental Health/Substance Abuse Treatment Plan Review. The five reviewed records contained treatment plan reviews completed every thirty days for a total of twenty-five individualized treatment plan reviews. All twenty-five individualized treatment plan reviews contained documentation all required treatment team members participated in each treatment team review meeting.

Three closed youth records were reviewed to verify the program's mental health and substance abuse discharge process. All three records contained a completed mental health substance abuse discharge summary, which was completed on the Department MHSA form 011, entitled Mental Health/Substance Abuse Treatment Discharge Summary. None of the three closed records revealed the youth was at risk of suicide when being discharged from the program. All three MHSA discharge plans contained information needed for each youth to maintain the improvements they made in behavioral, emotional and socials skills while participating in the program's treatment services. There was documentation in all three records the mental health and substance abuse discharge plan was discussed with the youth, parent/guardian and the JPO during the exit conference. All three closed records contained documentation to support the MHSA discharge plan was provided to the youth, parent/guardian and the JPO upon the youth's 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."	

A review of five youth mental health and substance abuse records and group sign-in sheets confirmed each youth has completed or is currently participating in the mental health and substance abuse groups provided by the program.

The program has a certified behavioral analyst (CBA) assigned to the program and they provide services to the youth at the program who need behavioral modification, as necessary. The CBA has not been on-site at the program since the middle of September 2018, which is when the program last had a youth in need of behavioral modification services. A review of the program's two therapists' caseload lists indicated neither of their caseloads exceeded sixteen youth. One therapist's caseload list indicated they had four youth assigned to them, and the other therapist had eight youth assigned to their caseload.

The program has another licensed clinician who is a licensed mental health clinician (LMHC) who volunteers at the program and provides the youth an incentive program focused on music. The clinician provided youth who have earned the incentive to learn how to create music, mix music, and record music. According to the Department of Health Medical Quality Assurance License search website the clinicians license is clear and active in the State of Florida and expires on March 31, 2019.

An interview with the assistant facility administrator (AFA) confirms the program is designated to provide mental health overlay services (MHOS) and the above stated Standardized Program Evaluation Protocol (SPEP) groups, mental health and substance abuse groups, along with monthly individualized treatment sessions, and monthly family sessions.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program has a contract with a licensed psychiatrist who is board certified in psychiatry, as well as child and adolescent psychiatry to provide services to the youth at the program. A review of the Department of Health Medical Quality Assurance License website revealed the psychiatrist's license is clear and active in the State of Florida and expires on January 31, 2020. A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatrist services to the youth at the program, as well as be on-call for emergencies and consultation twenty-four hours a day, seven days a week. An interview with the psychiatrist confirmed they are on-site weekly and available by telephone twenty-four hours a day, seven days a week. A review of the sign-in sheets for the six months prior to the annual review revealed the psychiatrist was on-site every week, except for one week. During a brief interview with the designated mental health clinician authority, it was confirmed the psychiatrist was on vacation this particular week. The psychiatrist does have an agreement with another psychiatrist to provide back-up services for vacation; however, the back-up did not provide services the week the psychiatrist was not on-site. A review of the Department of Health

Medical Quality Assurance License website revealed the back-up psychiatrist's license is clear and active in the state of Florida and expires on January 31, 2021.

A review of five youth mental health and substance abuse records revealed all youth received an initial diagnostic psychiatric interview with fourteen days of their admission. All initial psychiatric interviews documented the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), documented diagnosis, and treatment recommendations. One of the initial psychiatric interviews resulted in the youth being continued on their prescribed psychiatric medications. The record documented the need of the medication related to the youth's diagnosis, target symptoms, treatment goals, potential side effects, and risks and benefits of taking the medication documented in the psychiatric interview. The one initial evaluation also contained the frequency of the medication monitoring. All initial diagnostic psychiatric evaluations were completed on the Department form entitled Clinical Psychotropic Progress Note (CPPN) and it clearly identified the evaluations as the initial diagnostic psychiatric interview. All records contained a fully completed page three of the CPPN.

During subsequent psychiatric evaluations, the youth who was continued on their prescribed medication during their initial psychiatric evaluation had their medication discontinued, with the consent of the youth and parent/guardian. The remaining four records, the youth were prescribed psychiatric medications during subsequent psychiatric evaluations. All evaluations had page three of the CPPN filled out completely. Two of the youth were over the age of eighteen and did not require parental consent for the medication. The two other youth's parents/guardians agreed to the prescribed psychiatric medications which was documented on the third page of the CPPN or in a nursing progress note. The parent/guardian consent was witnessed by two staff members.

The five applicable records required twenty-three medication management reviews every thirty days with the psychiatrist, with one exception. One record had the January 2019 medication meeting held thirty-five days after the December 2018 medication meeting. During the debriefing process, the program advised the reason for the discrepancy was the youth was not in the program when the youth's medication management meeting was to take place prior to the thirty-day time frame, and the program held the meeting on the youth's first day back in the program.

An interview with the psychiatrist revealed they evaluate every new youth within a week of arrival and diagnose and treat psychiatric disorders with medications and other modalities. The psychiatrist also indicated they work with the case management, medical and mental health teams to implement the full range of treatment recommendations. The psychiatrist confirmed they are on-site weekly and they are normally on-site Wednesday afternoons. The psychiatrist indicated they meet weekly with the mental health team, and assistant facility administrator to discuss the youth in the program on psychiatric medications. The psychiatrist indicated the nursing staff handle all medication refusals and have the youth review and sign a medication refusal form. The nursing staff in turn notifies the psychiatrist of all psychiatric medication refusals. The psychiatrist stated if a youth refuses their medication three times in a row, the nursing staff contacts them. The youth is then placed on the next medication management team meeting roster and the psychiatrist will meet with the youth to discuss any issues.

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

The program has a policy and procedures in place addressing the program's suicide prevention plan. The suicide prevention plan was recently reviewed and approved by the designated mental health clinician authority, psychiatrist, and the facility administrator on January 23, 2019. The assistant facility administrator reviewed and approved the plan on December 21, 2018. The program's suicide prevention plan includes the following elements: identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response and a review process. The program's plan follows Florida Administrative Code, 63N-1. An interview with the program assistant facility administrator (AFA) indicated all staff receive a full day of training in suicide precautions and prevention, which exceeds the six hours of required training. The program's training also includes mock suicide drills conducted quarterly on each shift.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations shall be placed on Suicide Precautions and receive an Assessment of Suicide Risk.*	

The program has a suicide prevention plan which outlines the program's process for providing suicide prevention services to the youth at the program. The program's plan indicates the facility administrator will conduct a review for every serious suicide attempt or serious self-inflicted injury incident. The program's policy also indicated each youth will be screened for suicide risk upon admission using an Assessment of Suicide Risk (ASR). A review of the program's completed ASR forms and Follow-up ASR forms indicated the program is using the Department's Mental Health and Substance Abuse (MHSA) forms. The program has two suicide response kits and observations confirmed both contained a knife-for-life, wire cutters, needle nose pliers, gloves, and a cardiopulmonary resuscitation mask. One response kit is in the administrative office and the second kit is in the dormitory supervisor duty station. Five staff were interviewed and asked where the program's suicide response kits are located. Three staff indicated there is a kit in sub-control; two staff indicated one is in master control; two staff indicated there is one in medical; one staff indicated there is one in the supervisor's office, and four staff indicated there is one in the youth dormitory area. All of these areas are relatively in the same location. The same five staff were asked what they would do in the event a youth expressed suicidal ideations and all staff indicated they would notify mental health, search the youth and their room, and document supervision of the youth. Additionally, four staff indicated they would place the youth on sight and sound supervision status.

A review of five youth mental health and substance abuse records revealed all youth received an ASR upon their admission to the program. All five admission ASRs were completed by the designated mental health clinician authority (DMHCA) who is a licensed professional. All five ASRs indicated the youth was not at risk for suicide and they were all placed on standard supervision after the DMHCA confirmed with the assistant facility administrator (AFA). All admission ASRs were completed correctly, signed by the AFA and by the DMHCA, as the person completing the form and as the licensed professional. All admission ASRs indicated the youth's parent/guardian and juvenile probation officer (JPO) were notified the program completed an ASR on each youth and the youth were found not to be at risk of suicide. One of the five reviewed youth records indicated the youth had an incident where the youth was determined, through staff observations, to be at risk of suicide. The record revealed the youth was immediately placed on precautionary observations (PO) and a PO log was started to document the youth's behaviors. The youth was also referred to a mental health therapist for the completion of an ASR. The ASR was completed within two hours of the youth exhibiting signs of suicidal ideations. The ASR was completed by a non-licensed therapist and the youth was recommended to be maintained on constant supervision. The ASR recommendations were approved by the DMHCA and the AFA, and their approval was documented on the ASR. The program completed PO logs for the entire time the youth was on PO and there were no lapses in observations. A Follow-up ASR was completed by the DMHCA and the youth's supervision level was decreased to close supervision after the DMHCA conferred with the AFA and they agreed to the step down. A review of the close supervision logs indicated they were done correctly with no lapses in observations. The youth was maintained on close supervision until the DMHCA conducted a mental status examination and concluded the youth was no longer a risk to themselves. There was documentation on the mental status examination form the DMHCA conferred with the AFA prior to placing the youth on standard supervision. The ASR and Follow-up ASR completed on the youth indicated the youth's parent/guardian and JPO were notified of the youth's risk of suicide and elevated suicide supervision status. There was documentation in the youth's record they participated in all regular program activities and they were never restricted to a specific area of the program such as their room or an individual cell. A review of the Department's Juvenile Justice Information System (JJIS) alert database indicated a suicide alert was entered into the system for the youth when they were placed on PO and the alert was closed when they were placed back on standard supervision. There was also documentation found in the program's logbook indicating when the youth was placed on PO, when the youth was placed on close supervision and then when the youth was placed on standard supervision.

The program did not have any other youth applicable for suicide prevention services and only one youth was able to be reviewed for elevated supervision.

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

A review of five youth individualized mental health and substance abuse records revealed one youth was applicable for suicide services based on staff observations of their behavior. The program was not able to provide any additional youth records for review of suicide services and precautionary observation (PO) logs because there were no other youth in the program who required suicide services. A review of the one record revealed the youth had two PO logs and

two close supervision logs completed for the duration of the youth's stay on suicide precautions. While the youth was on elevated status, they were maintained on the appropriate level of supervision and the logs contained staff observations of the youth in real time and there were no lapses. All PO logs documented supervision of the youth in thirty-minute intervals and the close supervision logs documented supervision of the youth in five-minute intervals. None of the logs contained warning signs documented by the staff. All PO logs were reviewed and signed by the shift supervisor and licensed professional. All close supervision logs were reviewed and signed by the shift supervisor. All PO logs had designated safe housing areas noted on the form indicating where in the program the youth could be while on PO status.

An interview was conducted with the youth who was placed on PO and they indicated the staff always stayed with them while they were on PO, and the staff never left them alone. The youth also stated at night they slept on their mattress in the hallway, so staff could always maintain visual observation of them.

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

The program has a policy and procedures in place outlining staff training in suicide prevention and intervention. The policy indicates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, along with participation in mock suicide and emergency drills. A review of five in-service training records and five pre-services training records revealed all ten staff received the required six hours of suicide training.

A review of the program's mock suicide drills confirmed the program conducted drills, at a minimum of, quarterly on each shift. The mock suicide drills conducted since the last annual compliance review were reviewed to ensure all staff who have direct contact with youth participated in at least one quarterly drill semi-annually. There were twenty-one staff who were hired since the last annual compliance review which should have participated in the two drills semi-annually. A review of the sign-in sheets for the drills revealed twenty of the twenty-one staff participated in two mock drills semi-annually. The twenty-first staff member participated in one mock suicide drill during the semi-annual period. There were five additional staff who were hired in the last quarter of the annual compliance review period and documentation supported those staff participated in at least one mock suicide drill. All drills documented all required elements.

During an interview with the designated mental health clinician authority (DMHCA), they indicated all mock suicide drills are reviewed with staff at the program's monthly all staff meetings.

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's mental health crisis intervention plan was recently reviewed and approved by the facility administrator, assistant facility administrator (AFA), and the designated mental health clinician authority on January 23, 2019. The prior AFA resigned their position on December 10, 2018 and they last reviewed and approved the plan on July 18, 2017. The program's mental health crisis intervention plan addresses notification and alert system, means of referral, to include youth self-referral, communication, supervision, documentation, and review of the crisis, which follows Florida Administrative Code, 63N-1.

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

The program has a policy and procedures in place for the completion of a crisis assessment if a youth is in psychological distress. A review of five mental health and substance abuse records revealed none of the youth were applicable for the completion of a crisis assessment. The program provided one additional youth record which was applicable for the completion of a crisis assessment. The program used the Department's Mental Health and Substance Abuse (MHSA) form 023, entitled, Crisis Assessment when they completed the assessment. The crisis assessment contained the reason for the assessment, a mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up. After the completion of the crisis assessment, the youth was maintained on standard supervision. The crisis assessment was completed by a non-licensed clinician and was reviewed by the designated mental health clinician authority (DMHCA) within fifteen minutes of completion. Due to the youth determined not to be in crisis, there was no need to notify the youth's parent/guardian and juvenile probation officer (JPO); nor was it necessary for a mental health alert to be entered into the Department's Juvenile Justice Information System (JJIS) alert database.

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

The program has an emergency mental health and substance abuse service plan, which outlines the care for youth in imminent danger to themselves or others due to mental health or substance abuse emergencies. The program's emergency mental health and substance abuse service plan was recently reviewed and approved by the designated mental health clinician authority (DMHCA) and the facility administrator on January 23, 2019. The current assistant facility administrator signed and reviewed the plan on December 21, 2018. An interview with the DMHCA indicated youth over the age of eighteen with mental health emergencies will be transported to the crisis stabilization unit at St. Joseph's hospital and youth under the age of eighteen will be transported to Gracepoint stabilization unit. They also indicated any youth with a substance abuse emergency would be transported to St. Joseph's Hospital for treatment. The program's plan contains the following elements: procedures for immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and substance abuse evaluation and treatment, documentation, training requirements, and a review process, which meets all elements of Florida Administrative Code, 63N-1. A review of five pre-service training records indicated all staff received training on the program's emergency mental health and substance abuse services. A review of five in-service training records indicated two of the staff received training on the program's emergency mental health and substance abuse services. The three remaining in-services staff participated in two mock emergency mental health drills which would count as training in emergency mental health and substance abuse services.

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 the annual compliance review period; therefore, the 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 contracts with a licensed medical doctor to serve as the designated health authority (DHA). The DHA's license is clear and active in the State of Florida and expires on January 31, 2021. The program does not have an advanced registered nurse practitioner (ARNP). It was verified, through weekly sign-in sheets, the DHA is on-site weekly, every Monday, for two hours. Sign-in sheets were reviewed and verified for July 30, 2018 – January 14, 2019. The DHA designates another medical doctor for clinical duties, in the event the DHA is not available. An interview with the DHA validated he is on-site once a week to complete initial physical exams, medication management, sick calls, and referrals. The DHA is available twenty-four hours a day, seven days a week for emergency care and consultation, which is noted in the program's contract. The program has four full-time registered nurses (RN), one of whom serves as the Health Services Administrator. The program indicates they utilize three RNs and one licensed practical nurse for services, as needed (pro re nata). A copy of all licensed clinical staff was reviewed and verified to be clear and active in the State of Florida. Expiration dates of licenses range from April 30, 2019 to July 30, 2020.

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.	

A review of the treatment protocols and facility operating procedures (FOPs) validated the facility administrator (FA) and designated health authority (DHA) reviewed and signed them on July 9, 2018. The assistant facility administrator (AFA), who has day-to-day oversight of this program, signed the FOPs on December 21, 2018 after he transferred to the program. The FOPs validated they outline the program's health care services. The nursing staff reviewed, signed, and dated the FOPs, treatment protocols, and procedures, as validated by the sign-in sheets. When new policies or changes to policies are made during the year, they are reviewed at this time. Newly hired clinical staff participate in on-the-job training and orientation with a comprehensive training plan. This practice was validated for all four clinical staff. All FOPs are reviewed and signed annually by the FA and DHA. The DHA creates and approves all treatment protocols and standing orders. All psychiatric related services and psychiatric medication management is performed by the program's contracted psychiatrist. A review of all psychiatric FOPs validated they were reviewed by the psychiatrist on July 11, 2018, the FA on July 9, 2018 and the AFA on December 21, 2018.

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.	

A review of five youth medical records validated each maintained a valid Authority for Evaluation and Treatment (AET) and all were copies, with the word "copy" stamped on each. All parental notifications were filed in the youth's medical record, behind the AET. One of the five youth was in the care of the Department of Children and Families (DCF); however, the parental rights had

not been terminated. Two of the five youth are over the age of eighteen and their medical record contained a Release of Information – Authorization form for Youth 18 Years of Age and Older, in addition to the AET, both giving consent to provide "any and all information" to their parent/guardian.

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

A review of five youth medical records validated each maintained parental notifications. Three youth had notifications for medication changes, one for medication changes and off-site non-routine dental care, and one for notifications for medication changes and changes in chronic conditions. One youth was nineteen; however, he signed a form to release all medical documentation/information to his parent/guardian. The medical records for the youth under eighteen years of age, documented their parent/guardian was called and each of the calls were witnessed and documented. Regardless of telephone notifications, written notifications were sent to the parents/guardians for every notification for each youth. One of the five youth was in the care of the Department of Children and Families (DCF); however, parental rights had not been terminated.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

A review of five youth medical records validated three youth were prescribed a new psychotropic medication and this information was documented on the Clinical Psychotropic Progress Note (CPPN), page 3, and for one youth, this information was mailed to the parent/guardian notifying them of the new prescription. In addition, this parent/guardian was contacted by phone with a staff witnessing the call. Attempted contact with the remaining youth's parent/guardian was also witnessed by another staff. The attempted contact was not documented on the CPPN; however, when the parent/guardian called back and gave consent, it was documented in the nursing chronological notes. The third youth is nineteen years of age; therefore, the parent/guardian was not called, but was sent written notification and page 3 of the CPPN, due to the youth signing a release for the parent to be sent all medical information. This same youth who is nineteen years of age, discontinued his medication and written notification was sent to the parent/guardian, not verbal notification, as it was not required. Two youth medical records validated neither were prescribed a new psychotropic medication, discontinued, and/or any significant changes to psychotropic medications.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

The program has a policy and procedures regarding immunizations which states an immunization history of each youth admitted to the program shall be obtained. A review of five youth medical records validated each youth's vaccinations were documented on the Florida Department of Health Form DH 680, Florida Certification of Immunization. All of the youth's

vaccination records were verified within thirty days of admission; all were verified on their date of admission and obtained by Florida Shots through the education department. All youth immunizations were up-to-date. None of the youth, nor parents/guardians requested a religious exemption of immunizations or refused consent for immunizations for any reason.

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

A review of five youth medical records validated each youth record contained a completed Facility Entry Physical Health Screening (FEPHS) form and each was completed on the day of admission and completed by the program's registered nurse (RN). There were no youth medical records reviewed which documented the FEPHS form was completed by direct care staff.

4.08 Medical Alerts	**Satisfactory Compliance**
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

A review of five youth medical records validated each youth was identified with a chronic illness upon admission and four were classified with a medical grade between three to five. The program has an internal alert system which medical staff update, as required. All youth were entered on the internal alert system for each identified condition. The internal alerts matched each youth's Individual Healthcare Record. Five staff were interviewed, and all indicated they are notified of medical alerts daily during shift briefings and by viewing the alert board. Two staff indicated they also review the logbook for the last two shifts.

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

The program has a policy and procedures regarding youth orientation to healthcare services, which states all youth admitted shall be oriented upon admission or at the next available opportunity to the program's health care systems. The orientation/admission health education shall be provided by health care staff, in writing and during an individual session. A review of five youth medical records validated each youth received an orientation to healthcare services at the program. Each youth and the registered nurse (RN) signed the Health Care Orientation Form on the day of their admission. All required healthcare topics were included on the orientation form, as well as the orientation packet given to the youth. A review of the program's healthcare contacts validated they were accurate.

4.10 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's policy and procedures indicate every youth, upon admission, is referred to the designated health authority (DHA), regardless of any medical conditions, and are to be seen the next time the DHA is on-site. A review five youth medical records validated four youth were

admitted with a chronic condition and the DHA was notified by telephone upon admission for each youth; DHA notification was documented on the nursing chronological/notification progress note, documenting the date and time of contact. None of the youth required emergency care during the admission process.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

A review of five youth medical records validated two of the youth had a change in physical custody, requiring a healthcare admission rescreening. Each rescreening was completed on a new Facility Entry Physical Health Screening (FEPHS) form upon their return. Both were completed by a registered nurse.

4.12 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.	

A review of five youth medical records validated a new or updated Health Related History (HRH) form was completed for each youth on the day of admission, which meets the required seven-day timeframe. The most recent Department HRH form was used. All HRH forms were completed by a registered nurse (RN). The designated health authority (DHA) reviewed each of the five HRH forms which was documented on each of the comprehensive physical assessments (CPA). Each HRH was completed prior, within a few days, to the completion of the CPA for each youth.

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

A review of five youth medical records validated each record contained a completed comprehensive physical assessment (CPA). The CPA was completed by the designated health authority (DHA) for each youth. The CPA was completed in its entirety and the Department's Problem List was reviewed and updated for each youth. Each CPA was completed in accordance with Florida Administrative Code 64M, documenting all required elements. None of the youth refused any part of the assessment.

4.14 Female-Specific Screening/Examination	Satisfactory Compliance
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

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

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

The program has a policy and procedures regarding tuberculosis screening (TB) and the control of infectious and communicable diseases, which states the program shall follow guidelines and recommendations of the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA). A review of five youth medical records validated each youth had at least one verified tuberculin skin test (TST) documented. The Tier I TB screenings were completed within seventy-two hours of admission and each youth was assessed prior to placement in general population. Two of the youth's TST test results expired while the youth were in the program and each were re-tested prior to the expiration of the last test.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

A review of five youth medical records validated each youth was referred for sexually transmitted infection (STI) testing, the test was ordered, and results were documented in each youth's medical record. Referrals for the youth were documented on the Comprehensive Physical Assessments (CPA), Infectious and Communicable Diseases (ICD) forms, and progress notes, except for one youth, who did not have documentation in the progress notes. The lab results were filed in the lab results section of each youth's medical record.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

A review of five youth medical records validated each youth was offered counseling, testing, and referrals for treatment for human immunodeficiency virus (HIV) infection. Each youth signed a consent form, consenting to a HIV test. All of the youth received testing and each youth's results were in a sealed enveloped marked "confidential," which was placed in their medical record. The program utilizes Metro Wellness for all HIV testing and counseling. The program provided a copy of the Metro Wellness counselor's 500/501 certification issued by the local Department of Health (DOH). Documentation of pre/post-test counseling was documented on each youth's health education record and in the nursing progress notes. The program does not enter an alert for HIV status. None of the youth signed a release for the results to be provided to other individuals. Five youth were interviewed, and each indicated they could ask for an HIV test.

4.18 Sick Call Process – Requests/Complaints	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.	

Sick call hours are posted outside of medical; noting the daily hours of 7 a.m. – 9 a.m., 1 p.m. – 3 p.m. and 5 p.m. – 7 p.m., which is in accordance with their contract. Only licensed clinical staff conduct sick call. The health services administrator (HSA) is contacted for guidance when a licensed nurse is not on-site for sick call. If the computerized system is not available, the program uses paper forms as a back-up. All sick calls for July 2018 through January 2019 were

documented on sick call referral logs, utilizing one form for each month. A review of five youth medical records validated none of the youth presented with similar sick call complaint three or more times within a two week period; nor did any of the five youth complain of severe pain. The completed sick call forms for each youth was filed with the progress notes in their medical records in reverse chronological order.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

A review of five youth medical records found none of the youth were seen by non-licensed staff for sick call. Each sick call form (form HS 030) was documented in accordance with the Florida Administrative Code 63M and included information such as, but not limited to, vital signs, treatment, education, and follow-up procedures. All of the youth signed the sick call form validating they were seen for the sick call. Each sick call form was filed in their respective medical record, in reverse chronological order and documented on each applicable youth's Sick Call Index. Blank sick call forms are available to youth and located outside of the medical station.

One sick call encounter was observed during the annual compliance review with the youth's consent. The youth was brought to medical by a direct care staff, allowing the nurse to focus on the medical process, while the direct care staff maintained safety and security of the youth. The youth indicated the reason he requested a sick call. The youth signed the sick call form. No other youth were present, allowing the youth privacy. The youth was both interviewed and examined by the registered nurse (RN), while the youth was on the exam table. The direct care staff remained just outside the medical door, with the door cracked open. Five staff were interviewed and indicated the nurse conducts sick calls. Additionally, two staff indicated shift supervisors can also conduct sick call.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

Room restriction/controlled observation is not utilized at the program; therefore, this indicator rates as non-applicable.

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

A review of five youth medical records validated two of the five youth were seen for episodic care by non-healthcare staff; resulting in three visits. Both youth records validated each instance of episodic care was documented on the Report of On-Site Health Care by Non-Health Care Staff form, which included all required elements. Each of the youth received follow-up case by a licensed staff the following morning in all three instances. Three of the five youth medical records validated the youth were seen for episodic care by a healthcare staff member. The heath care staff member completed and documented the episodic care in SOAP (subjective, objective, assessment, and plan) format. All episodic care for July 2018 through January 2019 is documented on episodic care referral logs, utilizing one form for each month, documenting all

episodic and emergency care. A review of episodic and emergency care procedures was completed during the annual compliance review. Youth have access to emergency medical and dental care twenty-four hours a day, seven days a week.

The program has nine first-aid kits; two of which are used for transportation. During the annual compliance review, three firs aid kits were opened and found all necessary items were in each kit and no items were expired. First aid kits are inspected weekly by a registered nurse (RN) and documentation was reviewed for the last six months to validate this practice. Five youth were interviewed and asked if they could see a dentist for tooth pain or see a doctor if needed, and each indicated they could.

4.22 Emergency Care	**Satisfactory Compliance**
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The program has one automatic external defibrillator (AED), which was observed, and the instructions and guide were enclosed. The nurse conducted an AED test in front of the review team member. Battery and pad checks were completed for the AED, and found the battery expires November 2020 and the pads expires May 2019. The batteries were installed November 2016 and the pads were installed May 2017. A review of the program's Emergency Equipment Monthly Inspection Logs for the last six months validated a registered nurse checked the AED monthly. The program's AED is located in the hallway off the dayroom in a secure area, accessible by staff.

All emergency drills and trainings for direct care staff were reviewed for the past six months and found all drills and trainings were completed, as required. An emergency drill was conducted every month for every shift over the last six months; and once a quarter, the emergency drill included cardiopulmonary resuscitation (CPR)/AED demonstration. Emergency numbers are located in the administration area and medical clinic and are not accessible to youth. When a youth requires the use of an epinephrine auto injector, all healthcare and direct care staff must be trained on the administration of the epinephrine auto injector. A review of medical drills completed for the past six months, found program staff completed an epinephrine auto injector scenario for the drill; in addition, received appropriate training for administration of the epinephrine auto injector. There have not been any youth within the last six months who were prescribed an epinephrine auto injector nor were there any incidences of needed use. Five staff were interviewed and indicated they could call 9-1-1 if there was a medical emergency.

4.23 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.	

A review of five youth medical records found none of the youth required off-site emergency care or first-aid; however, the program was able to the only other applicable record for review. The youth went off-site for emergency care at a local hospital. Prior to the off-site care, the youth was assessed by the on-site registered nurse (RN), which confirmed a laceration to his inner lower lip as a result of youth-on-youth altercation. The nursing progress notes documented notification to the parent/guardian; healthcare staff and youth care worker witness signatures were documented. The summary of off-site care form was completed prior to the youth leaving

the program and filed in the youth's medical record. The regional health services administrator (HSA) indicated a copy was sent with youth when he went off-site; however, the youth was not discharged back to program with the summary of off-site care form completed by hospital staff. The discharge report from the emergency room was reviewed, signed, and dated by the designated health authority (DHA) which included the off-site findings, instructions, and information. The youth's medical record contained documentation of physician orders completed by the DHA upon review of the discharge paperwork from the off-site visit. Further review of the youth's medical record also indicated the parent/ guardian was notified upon the youth's return. The youth received timely follow-up care with the DHA, as needed.

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

A review of five medical records validated three youth were identified with chronic conditions upon admission. One of the five youth medical record validated the youth was not identified with any chronic conditions at the time of admission; however, was identified with chronic condition after admission and was added to the internal alert log. Each of the four youth were placed on the internal alert log. Periodic evaluations were conducted, as required, for each youth and were maintained in each of the youth's Individual Healthcare Records (IHCR) and found there was no indication of lapse in care or missed periodic evaluations for any of the four youth. The program's assistant facility administrator was interviewed and indicated all medical issues are discussed in monthly formal treatment team reviews, and recorded on the internal alert board, which is reviewed daily. The program's designated health authority (DHA) was interviewed and indicated he is informed of all new medical developments, as needed, and he meets quarterly with program administration. Nursing staff indicated once a youth is identified with a chronic condition at admission or by the DHA, the youth is placed on a tracker for monitoring and tracking of periodic evaluations due dates.

4.25 Medication Management – Verification	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

A review of five youth medical records validated two of the youth were on medications upon admission. A review of each youth's Facility Entry Physical Health Screening (FEPHS) form validated medications were verified and the designated health authority (DHA) was contacted by phone during the admission process; licensed healthcare staff documented this process on the nursing chronological progress notes. One youth was on medication upon admission but did not enter the program with the medication; therefore, the DHA ordered a refill on his current prescriptions. When applicable, notification was made to the youth's parent/guardian and documented in the progress notes. The program's policy and procedures indicate trained non-licensed staff must verify the medication when youth are admitted to the facility and licensed health care staff are not on duty.

4.26 Medication Management – Orders/Prescriptions	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

A review of five youth medical records validated all five youth were on medication. Two of the youth were on medication upon admission and were continued on the medications at the direction of the designated health authority (DHA). Two of the five youth were prescribed new psychotropic medications and each order was documented on the Physicians Order form. One youth was on medication upon admission but did not enter the program with the medication; therefore, the DHA ordered a refill on his current prescriptions. All of the youth were given over-the-counter medications not listed on the authority for evaluation and treatment (AET), in accordance with their approved protocols. The DHA order, as well as the chronological notes, documented each youth's medication regimen.

4.27 Medication Management – Storage	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

A review of all medications and the storage process was verified. There are currently no narcotics on-site; however, when they are, the location for storage of these medications is in a locked drawer, within a locked medication cart. Oral medications are not stored with injectable or topical medications. Syringes and sharps are secured in a locked cabinet. Observations of the nursing station and medication cart found both are secure, clean, and organized. All prescribed and over-the-counter medications are stored in a separate secure, locked area, inaccessible to youth. Medication requiring refrigeration is stored in a locked refrigerator, which only stores medication. The nursing staff indicated discontinued medications are disposed of by returning them to the contracted pharmacy and, when needed, controlled medications are destroyed on-site with the pharmacy consultant. A disposal form is completed for all medications destroyed or returned. If medications are destroyed, three signatures are required; the pharmacist, licensed healthcare staff, and the facility administrator or designee. This process reflects the program's policy and procedures for disposal of medication.

4.28 Medication Management – Medication and Sharps Inventory	Satisfactory Compliance
All medications and sharps shall be inventoried as per department requirements.	

The program has a policy and procedures in place to addressing the maintenance of inventories on all medications and sharps. Sharps are counted using a perpetual inventory process and are verified at least once a week. A review of the past six months of perpetual inventory balances for narcotics and controlled medications found there were none on-site, nor had there been for the last six months. Over-the-counter (OTC) medications are inventoried utilizing a perpetual inventory system and are verified at least once a week. A review of inventories for sharps, OTC medications, and youth medications were reviewed and verified for the last six months. The program has a written procedures in place for detecting and responding to inventory discrepancies; in addition to procedures for disposal of narcotics and other controlled substances. A review of three OTC medications, three youth medications, and three sharps found they were each documented on a log and verified with physical count.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a policy and procedures in place for storing, inventorying, and documenting controlled substances. According to the program's procedures, for controlled medications received from the youth, a shift-to-shift perpetual inventory shall begin after receipt and verification of the medication. Shift-to-shift inventory counting of controlled substances shall be conducted under the supervision of a licensed nurse. When no controlled substances are provided, a shift-to-shift count is not required. An observation of designated storage of controlled medications was completed by the annual compliance review team. The location for storage of these medications, when on-site, are secured in a locked drawer within a locked medication cart. A review of the past six months of inventories verified there were not any narcotics or controlled substances on-site.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

The program utilizes a pre-printed pharmacy Medication Administration Records (MAR). Five youth medical records were reviewed, and each documented the required elements on the MARs and validated each youth received medication, as ordered. The MAR does not include the youth's photo on the MAR; however, a large photo is in the current MAR binder for each youth in the front of the current MAR for each youth. Nursing staff reviewed and documented side effects weekly for each of the five MARs reviewed. When applicable, start and stop dates of medication were documented on the MAR. Refusal of medication is clearly documented on the MAR, when applicable, and a refusal form is completed when medication is refused.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

A review of five youth medical records validated none of the youth required parenteral medication. Med pass was observed for one youth during the annual compliance review. The area where med pass was conducted is clean and organized and the nurse had control of the medications and medical cart at all times. The youth approached the licensed staff in a structured manner. The licensed staff verified the Five Rights of Medication Administration and the Medication Administration Record (MAR) prior to the medication administration. The staff verified the youth swallowed his medication by the performance of a mouth sweep and by asking the youth to cough. No medication was pre-poured. Five youth were interviewed and two indicated they take medications. The two indicated when they go to med pass, they must state their name, what medication they are taking, any allergies, cough after taking their medications, and do a mouth sweep. Three of the five stated they do not take medications.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Failed Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program has a policy and procedures in place which allow trained non-licensed healthcare staff to assist youth with self-administration of oral, topical, and inhaled prescribed medications when a licensed nurse is not available on-site. The nurse delegates delivery, supervision, and oversight of youth during self-administration of medications. A review of documentation shows all four delegated non-licensed healthcare staff to administer medications to youth were trained in the administration of medication by the registered nurse (RN). A review of five youth medical records validated three youth were provided medication by non-licensed healthcare staff. When youth refused medication, it was clearly documented on the Medication Administration Record (MAR) and on a refusal form. When non-licensed healthcare staff provided medication to youth, neither the staff nor the youth signed the MAR. The Five Rights of Medication Administration was verified with exceptions noted. Five youth were interviewed and two indicated they take medications; three do not. The two youth indicated the nurse provides them their medications. Five staff were interviewed, and all indicated the nurse provides the medications to the youth. During annual compliance review, there was not a period where non-healthcare staff administered medication to youth; therefore, observations were unable to be made.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

The program has a policy and procedures to address the comprehensive process of monitoring psychotropic medication. A review of five youth medical records validated four of the youth required medication monitoring for psychotropic medications. Two youth entered the program on psychotropic medications and two youth were prescribed the medication while on-site. The designated health authority (DHA) was notified upon admission for each youth, despite being admitted on psychotropic medications, as part of the program's admission process. All five youth were referred to the program's contracted psychiatrist for evaluation. Five records were reviewed for the initial diagnostic interview and each were conducted within fourteen days of admission. Four youth received a psychiatric evaluation within thirty days. One youth had a psychiatric evaluation completed eight months prior to admission, which was reviewed by the psychiatrist the day after admission. All evaluations contained all of the required elements. The regional nursing staff indicated there were no youth who required monthly monitoring of Tardive Dyskinesia, during the last six months. There were no standing orders for any psychotropic medications, emergency treatment orders, or PRN (pro re nata) orders for psychotropic medications. Each of the four youth received weekly medication monitoring, documented on the Clinical Psychotropic Progress Note (CPPN), which exceeded the monthly requirement.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility 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 program has infection control procedures in place which includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as required by Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. A review of the program's infection control procedures validated all required elements were included. Upon review of the program's policy and procedures and the exposure control plan, it was validated staff have access to Hepatitis B immunizations and protective equipment. All staff are trained in infection control procedures. There were no instances where the local health department, CDC, and/or Central Communications Center (CCC) should have been notified for an infectious disease.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

The program has a policy and procedures in place for infection control education. The education plan requires all staff to complete pre-service and in-service training and requires all youth complete infection control education in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. Ten staff training records were reviewed for infection control and exposure control training, five for pre-service and five for in-service. All of the training records validated each staff received infection control training for 2018. All five pre-service and four in-service training records validated each staff received exposure control training in 2018; one staff's in-service training for exposure control training was not completed. Of the five youth medical records reviewed, all documented infection control education, which included prevention of communicable diseases and prevention of blood-borne pathogens and was documented on each youth's health education record.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program's exposure and infection control plan was reviewed and signed by the assistant facility administrator, the designated health authority (DHA), and the provider's corporate office and on December 21, 2018. A review of the program's exposure and infection control plan found the plan included risk assessments, methods of compliance, and a comprehensive process for needle stick post-exposure evaluations. The exposure plan is written in accordance with Occupational Safety and Health Administration (OSHA) standards. The program has not had any youth or staff who experienced a facility or occupational exposure during this annual compliance review period. The assistant facility administrator indicated the exposure control plan is accessible to all staff and is located in his office and is reviewed annually during the general staff meeting. The program's policy and procedures indicate medical records, for youth and staff who have experienced a facility/occupational exposure, shall be maintained by the

program's human resource department. Medical records are confidential and maintained for at least the duration of employment plus thirty years. Through an interview with the program's nursing staff, it was verified there were not three or more cases of any reportable infectious disease needed to be reported to the local county health department and/or Centers for Disease Control and Prevention, nor were there any instances involving the quarantining or hospitalization of at least ten percent of the total population of youth or staff, or six individuals, whichever is less.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

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

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

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

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

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

Standard 5: Safety and Security

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

The program has a policy and procedures addressing youth supervision. The program's contracted staff to youth ratio is 1:8 during awake hours and 1:10 during sleeping hours. Ratios for youth transports and work details are 1:5 and any disciplinary work detail would be reduced to a 1:3 ratio. These ratios were adhered to throughout the program's annual compliance review. A review of the program's logbooks revealed ratios were maintained throughout last six months. Logbooks also revealed staff documented headcounts, line movements, transports, disruptions, incidents, mental and medical alerts, and staff assignments/duties during each shift. The program's policy requires staff to conduct a minimum of six headcounts within a twenty-four timeframe. A review of documentation revealed staff exceeded policy expectations and conducted headcounts hourly and randomly throughout each shift. During the annual compliance review, staff were witnessed maintaining active supervision of youth including interacting positively with youth while engaging in a full schedule of constructive activities. The activity schedule was posted throughout the facility, including in the youth dayroom and dorm areas. The annual compliance review team witnessed staff providing proper supervision during school, lunch, breaks, recreation, daily meetings, hygiene, line movement, and leisure activities. Program staff were interviewed throughout the week and were always aware of their current headcounts and the whereabouts of youth who were not in their presence. All five interviewed staff were aware of the program's procedures to reconcile a headcount if a youth is missing or unaccounted for.

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) employed at the program.*	

The program has a policy and procedures addressing the comprehensive and consistent implementation of the behavior management system to include staff training. The program identifies their behavior management system as a positive performance system (PPS). The program has a detailed written description of the PPS and it is explained to each youth during their orientation process. A copy of the PPS guidelines is in each youth handbook, which is provided during orientation, and posted throughout the program. Each youth signs an acknowledgement form after receiving the handbook and training on the PPS. A copy of this signed acknowledgement form is in the youth's case management record. The PPS is a four tier level system (Rookie, Pro, All-Star, and Hall of Fame). This system utilizes daily point cards, level applications, special treatment team referrals, and a monthly calendar of daily incentives for positive behaviors. According to the policy and an interview with the assistant facility

administrator (AFA), each youth can earn up to two points for each activity throughout the day. Youth must earn a percentage of their daily points to earn a positive day towards completing levels of the PPS. As youth earn higher levels, the percentage of points the youth need to earn for a positive day increases. Daily, weekly, and monthly incentives encourage youth to earn their points throughout the day, week, and month. The system's rewards and consequences extend to the classroom as well. A representative from the program's educational department is invited to daily management meetings to discuss any issues with the PPS. Educational staff assist the management team with youth expectations, incentives, rewards, and consequences for classroom behaviors. Youth can earn or fail to earn points on their daily point cards for behavior in classrooms. Interviews with five youth and five staff revealed all understood the PPS and could identify rewards and consequences for positive and negative behaviors in addition to the requirements to advance to a higher level. All interviewed staff members could explain all elements of the PPS including levels, point sheets, location of PPS postings, and youth training. Staff understood how youth failed to earn points and could explain the process of notifying youth when they failed to meet expectations. Staff members could also explain how point sheets are reviewed daily by the supervisory staff members. All interviewed staff and youth acknowledge youth are not permitted to impose consequences on other youth. The program provides a variety of rewards/incentives to encourage youth participation in the program. These incentives range from daily incentives including edible incentives and video games to monthly incentive including off-campus outings, extra canteen points, additional phone time, and movie parties. A review of five pre-service and five in-service staff training records revealed all staff were trained in the program's PPS upon being hired and every year thereafter. A program daily meeting was able to be observed, which were held at 2:00 p.m. each day and found the team discussed the youth's daily PPS progress and gave group and individual praise to youth who performed throughout the day. All staff, including administration, attend this meeting and are expected to add input and provide praise for positive behavior. An interview with the assistant facility administrator validated the review team's findings and indicated a review of all point sheets on a daily basis is the key to monitoring fidelity. Daily incentives were observed being distributed to youth during the annual compliance review. Incentives included snacks such as noodles, candy, and chips. Youth were also provided video game time for making positive days.

In an interview the AFA, he indicated rewards are implemented daily, weekly, and monthly. Staff are encouraged to praise youth informally throughout the day, as well as encouraged to complete a positive citizen slip. Positive citizen slips are acknowledged during daily meeting and put into a drawing for an additional incentive. The drawing occurs on Fridays. Additionally, the AFA indicates the program director utilizes the corrective discipline process to coach and improve overall implementation of the PPS, when necessary.

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 in place addressing behavior management system/positive performance system (PPS) infractions and system monitoring. The program's PPS includes a process wherein staff explain to the youth the reason for any sanction imposed. This process occurs at the time the sanction is given and during daily meetings. For major infractions, a youth will receive a referral for special treatment team (STT). STT meetings occur within twenty-four hours of the infraction/behavior (excluding weekends and holidays). At the STT meeting, youth are given an opportunity to explain their behaviors to the treatment team. STT referrals are discussed daily during the program's daily management meeting with all department heads and administration. After the details of the incident are discussed with the management team members, the team then meets with the youth who committed the infraction to allow the youth to have an opportunity to explain his behavior and participate in creating a plan to help promote positive behaviors. Although the program does not currently have a recreational therapist (RT), the RT is responsible for reviewing STT referrals and point sheets at the end of each day to ensure points and referrals are completed appropriately and fairly. Any discrepancies found on point sheets or referral are presented to the management team to be corrected prior to the STT. The program director has assumed this role of PPS monitor until a RT is hired. The program does not utilize room restriction as a part of their PPS. Interviews with five youth and five staff reveal both understand the process which allows both youth and staff to discuss sanctions imposed, consequences and alternative acceptable behaviors. Youth interviews revealed four of the five youth believe the program's PPS is fair. One of five youth believe the PPS is unfair. Neither staff nor youth interviews revealed the program's PPS is used to solely increase a youth's length of stay, deny a youth basic rights or services, promote the use of group punishment, allow youth to sanction other youth, or include disciplinary confinement. Staff members receive feedback on their application of the PPS on an annual basis, but also receive coaching and feedback from both supervisory staff and administration, as needed. A member of the review team witnessed one staff member being coached on implementation of the PPS during the annual compliance review.

An interview with the assistant facility administrator indicated consequences occur when youth are not able to earn points for not completing an activity as expected or because of a STT. Consequences are monitored by the program director.

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 which address ten minutes checks for youth housed in their sleeping quarters. The program utilizes a twenty-six camera digital video recorder (DVR) system which is housed in the staff office located at the east end of the youth dorm area. At the time of the annual compliance review, eighteen cameras were operational and the DVR system has a thirty day recording capability. Cameras are operational in all main areas in which youth occupy. Repair will be addressed by the Department during the transition of this program. Staff document room checks on a form entitled Room Check Sheet. Supervisory staff are required to conduct room checks at three random times during the shift. Each supervisory room check is documented on the form in red ink. Reviewed room check sheets revealed supervisory checks have been conducted according to policy for the past six months. All checks were documented properly and were within the required ten minute timeframe. All checks documented since mid-September 2018 have been within a six minute timeframe. Video review revealed staff conducted room checks every six minutes when youth were housed in sleeping rooms. Six various timeframes were reviewed, within the last thirty days, to ensure room checks were conducted appropriately. Each observed room check revealed staff members utilized a flashlight to observe youth in dorm rooms, paused at each room door to view youth, and documented the room check on the room check form. Five staff interviews revealed all staff were aware of room checks being conducted every six minutes. Video review and room check forms had identical time stamp documentation.

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 practicable 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 policy and procedures which address population census, counts, and tracking of youth. The program utilizes their master logbook to document youth counts and movements. The logbook is utilized to keep a chronological record of events as they occur. The program's policy indicates head counts will occur and be documented at a minimum of six times within a twenty-four hour period. The program headcounts are conducted by supervisory staff at the

beginning of each shift to verify accuracy and all other counts are conducted at least hourly and documented in the logbook. Counts are also conducted at beginning of shift, end of shift, and after outdoor activities and emergency situations. The logbook also tracks youth intakes, releases, and movement outside of the facility. The program utilizes an alert board which tracks the daily count of all youth in and out of the program. Counts were observed being conducted during the week of the annual compliance review. Staff members were aware of all youth whereabouts and gave the reviewer proper counts during the shift when asked by annual compliance review team members during the review week. Five staff were interviewed, and all were able to verbalize count procedures, as required by program policy, including what to do in the case of an unsuccessful count.

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

The program has policy and procedures in place addressing logbook entries and shift report reviews. The program maintains a chronological record of events, incidents, and activities in a living unit logbook in accordance with Florida Administrative Code. Logbooks utilized by the program during the last six months were reviewed. Each reviewed logbook is bound with numbered pages. Logbook entries are legible and included the date, time of 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. Entries included youth movements, admissions, releases, emergencies, security risks, incidents, transports, and staff assignments. Further review of logbooks revealed each on-coming staff member participates in a shift briefing and signs the logbook acknowledging they are aware of all information from the last two shifts and alert changes. The logbook is maintained by the shift supervisor and is available for all staff to review whenever needed. The program had thirteen incidents reported to the Central Communications Center during the past six months. Twelve of the thirteen reviewed incidents were noted in logbook. The program had two separate escape incidents since the last annual compliance review and all information relating to both incidents were documented in the logbooks.

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

The program has a policy and procedures in place to address key control. The policy addresses key assignments, inventory and tracking of keys, storage of keys, procedures addressing missing or lost keys and reporting and replacement of damaged keys. Staff keys are locked in two locked key boxes located in the administration/master control area in front of the assistant facility administrator's (AFA) office. Keys are secured in a lock box when not in use and staff members have limited access to the boxes. Only the program director (PD), AFA, maintenance

manager, and shift supervisors have access to key lock boxes. All keys are counted daily, and results are documented in the program's daily key log binder. All visitor (including volunteers) keys are also collected by program staff when entering the program. Visitor keys are collected by staff and exchanged for a numbered visitor's badge. The visitor's keys are placed on a corresponding key hook until the visitor's badge is returned and visitors keys are returned. A member of the review team observed staff shift change and the collection of visitor key during the week of this annual compliance review. The key collection and distribution was conducted by the shift supervisor. All staff keys were collected and locked in staff key box. Staff members signed the key log acknowledging they received a set of program keys and included printed name, date, time, key type, and key number, and the shift supervisor/designee signs key log, ensuring the information is accurate. Program keys are also inventoried when staff return program keys and are issued back their personal keys. The PD and shift supervisor were interviewed on key control procedures; both staff were knowledgeable of the program's policy on key control. Staff members explained the process for restricting usage of keys for medical, mental health, case management, and vans. Random key rings were observed and all keys matched key information on the tab. All keys were secured on a tamper-proof key ring to ensure keys were secured. Observations of the key storage area and key area verified they were properly secured. Staff interviews with five staff revealed each staff understood the proper procedures to take if a key is lost, stolen, missing, or damaged. A random check of staff during the annual compliance review revealed no staff had personal keys on the secure floor. All staff's personal keys were secured in the key lock box.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.* *The program shall document the confiscation of any 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.*	

The program has a policy and procedures addressing contraband procedures. The policy list items considered contraband and the process to be followed if contraband is discovered in the facility. The program utilizes room, facility searches, frisk searches, and visual searches to prevent the introduction of contraband to the facility. The program has a system in place for documenting confiscated items. The youth are given a copy of prohibited items and the consequences of having these items within the program. This list is given to the youth during the intake process. According to a report on file with the Central Communications Center (CCC), during the program's routine (scheduled) random room search, on January 6, 2019, a staff person discovered a lighter inside a youth's storage drawer. The item was confiscated and according to the program, their internal investigation did not yield results as to how and when

the item got into the program. The CCC incident is currently open and under investigation by the Department. No findings have been assigned at the time of the annual compliance review. The program documented the confiscation of the contraband and the manner of disposition in the search log. The item was turned over to and is secured in the assistant facility administrator's (AFA) office until conclusion of the investigation.

Interviews with five youth revealed all interviewed youth reported being searched when returning from off campus, after work details, after meals, after recreation, after an item is discovered to be missing. A review of room search logs revealed room and facility searches are conducted weekly as policy requires. In his interview, the AFA indicated if contraband is recovered at the program it is reported to the facility administrator and the regional director. The administrator will secure the items and make a call to the CCC to report the program's findings. If the contraband is illegal, local law enforcement will be called for them to take possession of the illegal contraband.

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 in place addressing searches and full body visual searches. The program conducts searches as a method to prevent the introduction of contraband and unauthorized items into the facility. Policy indicates searches of youth are conducted after off-site transports, after visitations, before moving youth from an outside area (classroom, recreation, weight room) into the building and prior to moving youth from the building to an outside area. The program had no off-site transports during the week of the annual compliance review. The review team observed several youth searches during week of the annual compliance review. Searches were conducted with each movement of youth returning to and/or exiting the main building. Search procedures and expectations were properly explained to all youth before searches were conducted. Searches were conducted by staff members of the same gender as the youth, while a second staff member assisted with supervision. Searches were thorough and done in a manner which did not degrade the youth. All searches were documented in the program's shift logbook. A full body visual search (FBVS) could not be observed during the week of the annual compliance review. Although a FBVS was not observed, youth and staff interviews revealed all parties were aware of proper search procedures. Five youth were interviewed, and all indicated searches are conducted consistently by program staff when youth are returning from off campus activities, after outdoor activities, when items are missing, after visitation, after meals and after work detail projects. Five interviewed staff were able to identify when and how youth searches are conducted.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 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 in place addressing vehicles and maintenance. The program utilizes one vehicle for youth transports. The vehicle received a successful annual inspection on January 28, 2019, which was one year after the last documented inspection. The vehicle is also inspected weekly by the maintenance manager and/or the program director. Results of weekly inspections are documented and stored in program's vehicle maintenance log/binder. A member of the annual compliance review team inspected the vehicle and all required equipment was observed in the van during inspection (seat belt cutter, window punch, and fire extinguisher). The first aid kit is not stored in the van to preserve the items inside of the kit. Staff check out a kit before transport and return it back into the program upon return. Staff are required to check out a first aid kit each time the program van is utilized for transport. The first aid logs were reviewed to verify kits are checked out during transports. The log verified first aid kits were checked out by staff members when vans were utilized for transports. All seatbelts in vans were in proper working condition. No transports occurred during the annual compliance review, so observations could not be completed; however, informal staff and youth interviews revealed the transport van is inspected before each transport and youth and staff are both required to wear seat belts at all times.

5.11 Transportation of Youth	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns 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 in place addressing transportation of youth procedures. The program's policy outlines staff to youth ratio during transports as 1:5.; however, if there are five or less youth, a minimum of two staff members are needed to perform all transports. The program's transport vehicle was inspected by an annual compliance review team member and the vehicle's rear door could not be opened from the inside. The transport vehicle is equipped with a safety screen separating the driver's compartment from the passenger's compartment. The program has an approved transport list which is updated monthly to ensure staff driver's licenses are valid. No transports were scheduled during the week of the annual compliance review, but interviews were conducted with five staff to determine the program's process. All staff confirmed they are issued a cellular phone before transport, both youth and staff wear seat belts during transport, youth are not left unattended during transportation and staff do not conduct transports in personal vehicles. A review team member observed a shift supervisor conduct a routine check of all personal vehicles in the parking lot including the program's transport vehicle. All vehicles were found locked and secured.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns 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 weekly safety and security audits. The policy includes procedures which address: who will conduct weekly safety and security audits, the frequency of the audits, and the documentation of audit results. The program has designated the plant manager as the individual responsible for each week's audit; however, each shift supervisor is required to conduct a thorough visual inspection of the program's perimeter inside and outside to ensure all items are in good repair and operating properly. These inspections are documented each day in the program's shift logbook. Weekly safety and security audits are documented by the plant manager on a separate form. To correct deficiencies discovered during safety and security audits, the results of each audit are monitored through the daily management meeting. Any deficiencies and work orders are monitored by the management team in addition to the plant manager. This process also serves as their internal system to verify deficiencies are corrected and existing systems are improved, or new systems are instituted. A review of logbooks and audit forms, for the last six months, show all checks have been completed and results forwarded to management. In his interview, the assistant facility administrator described the program's process and was able to provide a list of work orders submitted to and pending with the Department, in addition to the program's attempts to correct noted deficiencies. The provided documentation verifies the program has a process in place to address any deficiencies identified through the weekly safety and security audits. Building improvements were taking place during the week of the compliance review. The review team observed vendors install all new windows, frames, and doors.

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

The program has a policy and procedures to address tool inventory and management. The policy addresses the issuance, inventory and control of equipment and tools. The program has identified their plant manager as the program's tool control manager. The policy classifies tools into two categories: class A tools and class B tools. Class A tools are hazardous with sharp edges or points and has a high potential to be used as a weapon to inflict serious bodily harm (i.e. knives, hammers, screw drivers, and electric drills). Class B tools do not have sharp edges or points such as brooms, mops, and scrub brushes. All tools are secured behind a locked door and are either outlined on the wall to verify location or are placed beside a photo of the tool to identify proper placement. Class A tools are secured in the plant manager's office, which is a portable shed, outside of the main building. Upon observation, the plant manager's office was neat, clean, and organized. All class A tools were outlined in his office and accounted for. All of the program's class A tools are inventoried daily by the plant manager except on days when the maintenance office is not accessed (weekends and holidays). Class B tools are inventoried daily by program staff. All program tools are signed out by staff members before use and signed back in once they are returned to their proper location. In an interview, the plant manager revealed he understood proper procedures to follow if tools are missing or damaged. The plant manager stated no tools are currently damaged or out of use. All tools were properly identified during inspection by the reviewer. Five staff and five youth were interviewed and each of them confirmed youth are only allowed to use a mop, broom, and scrub brush. A review of five youth

case management records revealed all youth receive tool training during orientation process before youth can use any tools. A review of five staff training records revealed all five have received tool control training during pre-service training. Since the program subcontracted out food service in November 2018, the kitchen has not been used to cook or prepare food. Although the kitchen is not being used, kitchen tools remain on a shadow board in a locked box. Kitchen tools are inventoried even though they are not in use.

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

The program has a policy and procedures addressing youth tool handling and supervision. The policy outlines proper procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries to youth and staff. Although no youth were observed handling tools during the annual compliance review, staff and youth interviews support youth are only permitted to use class B tools. During a work project the program will use a staff to youth ratio of 1:5. Five youth case management records were reviewed, and all records indicated youth have been trained on the proper usage of tools during their orientation process. Youth sign an acknowledgement of tool training during orientation process. The signed acknowledgement form is filed in each youth's record. Although each youth receives a risk assessment monthly, during the week of the annual compliance review there were no work projects which involved youth and the use of tools. Five staff were interviewed and each of them confirmed youth are only allowed to use a mop, broom and scrub brush

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 in place which address outside contractor's protocols. The program has established guidelines for outside contractors which includes information regarding tool control and restrictions. The program has a form to be signed by outside contractors which addresses: how tools will be checked upon arrival to and departure from the program, youth restrictions to work area, immediate reporting of missing tools, restriction of personal cell phones and/or equipment capable of taking pictures and/or recording audio/video in secure areas. The form also requires contractors to list each tool brought into the facility. This list is reviewed by the plant manager or designee before the contractor has access to a secure area. This list is again reviewed before the contractor exits the program. The contractor's failure to sign this form prohibits access to work within the program. Outside contractors are escorted and supervised by plant manager or designee any time they are within the facility. These procedures were observed by a review team member during the annual compliance review. The review team member was able to observe tool sign-in, sign-out and staff supervision of outside contractor's. Policy and procedures were followed with no discrepancies. Sample size of program invoices were cross checked to ensure outside contractor agreements were signed on the dates of service. All invoices and contractor agreements matched, and no discrepancies were found.

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

The program has a policy and procedures to address fire, safety, and evacuation drills. The program conducts 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. Drills are consistent with the program's Continuity of Operations Plan (COOP). A review of drills revealed thirty-one drills were conducted over the past six months (eighteen fires drills, five escape drills, seven disaster drills, and one riot/disturbance drill). All drills were properly documented in the facility shift logbook. All drills were documented on a drill form which contained the type and description of drill, date and time of the drill, staff recommendations, and staff signatures. An interview with the assistant facility administrator verified the frequency of program drills. Additionally, he also revealed fire drills are conducted once a month for each shift and COOP drills are conducted at least annually. Five interviewed youth acknowledged they all participate in monthly fire drills. Five interviewed staff all acknowledge they participated in monthly fire drills and other COOP/disaster drills. No drills were conducted during the week of the annual compliance review.

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.	

The program has a policy and procedures addressing the Continuity of Operations Plan (COOP). The program has a COOP which ensures basic care and custody of youth in the event of an emergency or disaster. The COOP was submitted to the Departments central region residential services COOP coordinator and regional director, and was approved May 1, 2018. The plan addresses alternative housing plans and current delegation of authority, cooperative agreements, vendor contact list, emergency staff contact numbers and the county cooperation checklist. A copy of COOP is available in the assistant facility administrator's office and available at all times for a staff member's review.

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

The program has a policy and procedures in place addressing storage and inventory of flammable, poisonous, and toxic items and materials. The program's flammable, poisonous and toxic materials are stored in the plant manager's office in a flame-resistant cabinet. The only chemical located in the cabinet at the time of the annual compliance review was WD-40. All flammable, poisonous, and toxic items are all inventoried by the plant manager. The program has a list of staff positions authorized to handle these items. All other chemical/cleaning supplies are stored in the locked laundry room, chemical shed, and maintenance shed. All items have a corresponding Safety Data Sheets (SDS) located in the same area as the listed chemical.

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

The program has a policy and procedures addressing youth handling and supervision of flammable, poisonous, and toxic materials. The policy prohibits youth from handling flammable, poisonous, and toxic items and materials. Youth do not have access to the storage of these items in the plant manager's office and they are supervised by staff members during daily cleaning. Although youth were not observed participating in facility clean-up during the week of this review, five youth were interviewed and four stated they are prohibited from using chemicals/cleaning products; however, one youth stated he has used laundry soap.

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

The program has a policy and procedures addressing disposal of all flammable, toxic, caustic and poisonous items. Policy prohibits chemicals from being poured on the grounds or being disposed of by any method other than what is outlined by the biohazard guidelines. The program's plant manager was interviewed on proper procedures of disposing chemicals and he stated all items for disposal are to be brought to the East County Hazardous Waste Collection Center in Tampa, FL. The plant manager further stated he has not needed to dispose of any chemicals since the last annual compliance review. An interview with the assistant facility administrator validated this practice.

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

The program has a policy and procedures to address recreation and leisure activities. The program provides a variety of recreation and leisure activities for youth. The program has a posted daily schedule of recreational and leisure activities, allowing youth to have at least one hour of structured large muscle activities each day. Structured large muscle activities for youth include basketball tournaments, weight training, football, track and field, volleyball, gator-ball, tag, and group workout. Leisure activities include letter writing, reading, and video/board games. Five staff were interviewed and asked what types of recreation and leisure activities are provided to the youth. Four staff indicated they participate in these activities for at least an hour. One staff works the night shift and was unsure of the scheduled times. Staff mentioned several of the activities confirmed by youth and the schedule. Five interviewed youth state they get at least one hour of physical and leisure time and perform activities such as basketball, football, workout in weight room and pull-ups.

The program's recreational therapist resigned December 21, 2018 and the program has been actively recruiting and interviewing to hire a new one. Efforts to solicit a new therapist over the past four weeks was provided to the annual compliance review team (copies of job posting on the internet and results from interviewed candidates since December 21, 2018). Since her departure the program has been using the recreation activity schedules previously developed prior to her departure. Five youth mental health and substance abuse records were reviewed, and each youth's individual treatment plan contained a recreation goal which was monitored monthly during treatment teams. A review of logbooks for the last six months revealed the activity schedule was followed and recreation was provided to youth for at least an hour.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program has a policy and procedures outlining the guidelines for visitation and communication for youth while in the program. The program's visitation policy establishes procedures which provide the youth with opportunities to re-establish and maintain family and community ties while at the program. The program's communication policy indicates youth shall be provided with opportunities to establish and maintain family, court, and community ties through correspondence. The policy further states the program shall provide writing materials and postage to youth for mailing at least two letters a week.

A review of the program's posted schedule indicates visitation occurs every Saturday and Sunday from 1:00 p.m. to 4:00 p.m. The program maintains a visitation log for each day visitation occurs, documenting the name of the visitor, the youth the visitor is there to see, verification the visitor is on the youth's approved visitor list, signature of the visitor, time admitted, and the time they left. The visitation log also indicates each visitors' identification was verified using state-issued identification, they were searched prior to entry, and the rules of visitation were explained to them prior to admission. The program's visitation binder also includes a youth search form indicating the youth was frisk searched and a full visual body search was conducted after visitation and prior to the youth being released back to regular program activities.

The program schedule also provides the youth with free time daily, which allows the youth time to prepare written letters to individuals on their approved correspondence list. A review of five case management records confirmed each youth had an approved visitation and correspondence list, created by the case manager. An interview with a case manager indicated each youth is notified upon admission of their right to communication through mail with the approved individuals on their list and there was documentation in all five reviewed records the youth signed an orientation checklist indicating they were made aware of the policy. The case manager also indicated each youth is provided with a weekly phone call to individuals listed on their approved correspondence list. The case manager indicated they are present when the youth make those calls and ensures the youth are speaking only with individuals on their approved list. A review of five youth case management records revealed each youth's weekly phone calls were provided to them and the calls were documented in the case manager's chronological progress notes, and on a youth call log located in each youth's record. The case manager also indicated each youth is present when the case manager opens mail they have received from approved individuals on their list. The case manager indicated they open the letter in front of the youth, read it and, if appropriate, they provide the letter and envelope (with stamp ripped off) to the youth. When the youth wants to mail out a letter to an approved individual, they bring the letter to the case manager for review and if it is appropriate, they mail it out. The case management staff maintain a correspondence log for each youth, by month. When a youth gets a letter from someone it is documented on the log and when they mail out a letter it is also documented on the log.

During an interview, the case manager indicated visitation occurs regularly as scheduled; however, when extenuating circumstances occur the case manager works with program administration, juvenile probation officer and family to allow for special visitation. Five youth were interviewed, and all youth indicated they were given the opportunity to communicate with family by mail or visitation.

5.24 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, procedures, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

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

5.26 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, procedures, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

Program Name: Les Peters Academy
Provider Name: TrueCore Behavioral Health Solutions LLC.
Location: Hillsborough County / Circuit 13
Review Date(s): January 31-February 1, 2019

MQI Program Code: 1282
Contract Number: 10098
Number of Beds: 24
Lead Reviewer Code: 146

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.08 In-Service Training	1.17 Advisory Board
	4.32 Medication - Medication Provided By Non-Licensed Staff