STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Les Peters Academy

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

Review Date(s): March 10-13, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Stephanie Lobzun, Office of Program Accountability, Lead Reviewer (Standard 1)
Brown, Kara, Office of Program Accountability, Regional Monitor (Standard 2)
Goldstein, Felicia, Office of Program Accountability, Regional Monitor (Standard 4)
Johnson, Melissa, Office of Program Accountability, Regional Supervisor (Interviews)
Nelson, Amanda, Office of Program Accountability, Regional Monitor (Standard 5)
Saint-Louis, Darby, AMIkids YES program, Designated Mental Health Clinician Authority (Standard 3)
Shay, Stephanie, Office of Program Accountability, Deputy Supervisor (Shadowing Standard 5)
Thompson, Jonathan, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Les Peters Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Hillsborough County / Circuit 13
Review Date(s): March 10-13, 2020

MQI Program Code: 1282
Contract Number: 10098
Number of Beds: 24
Lead Reviewer Code: 140

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.13 Suicide Prevention Training *	5.03 Behavior Management System Infractions and System Monitoring
5.07 Key Control*	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

* 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 4: Health Services
Residential Rating Profile

Indicator Ratings

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

* 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 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	Failed
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*	Limited
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Limited

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

Program Overview

Les Peters Academy is a twenty-four bed program, for fourteen to eighteen year old females, located in Tampa, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program provides intensive mental health services and substance abuse services.

In addition, the program fosters each youth by providing Impact of Crime, Female Healthy Relationship Bundle: Teen Relationship Workbook, Voices: A Program of Self-Discovery and Empowerment for Girls, Mindfulness Movement, Social Rhythms, Dialectical Behavioral Therapy (DBT) via Media Therapy, and Matrix Model. Additional treatment services provided includes family therapy, individual therapy, group treatment, and recreational therapy. Program administration is comprised of a facility administrator, assistant facility administrator, program director, director of clinical services, assistant director of clinical services, health services administrator, and director of case management. The health services administrator, the CBA-certified behavioral analyst, and the psychiatrist positions are shared with the Tampa Residential Facility. Case management services are provided by two case managers and one transitional services manager. Mental health staff at the program includes two therapists, a part-time certified behavioral analyst, recreational therapist, a psychologist and a psychiatrist. Medical services are offered daily and nursing staff are on-site for sixteen hours a day, seven days a week. The program's medical team is comprised of a designated health authority, five part-time nurses and two full-time nurses. All the nurses' licenses are clear and active in the State of Florida. One full-time nurses license expires on April 30, 2020 and the second full-time nurses license expires on April 30, 2021. Three of the five part-time nurses' licenses expire on April 30, 2021 and the remaining two nurses' licenses expire on July 31, 2020. Educational services are provided by the Hillsborough County School Board. The layout of the program includes one main building, three portables, four sheds, and one unused autobody shop.

The program has forty-seven operating security cameras providing coverage throughout the program all of which were operable during the annual compliance review period. The camera system has a digital recorder, which records up to thirty days of footage.

At the time of the annual compliance review, the program had four vacant youth care worker I positions.

Strengths and Innovative Approaches

- Yoga for Change: The Mindfulness Movement curriculum is an experiential and activity-based curriculum which focuses on the use of yoga practices and mindfulness skills and the program provides the group twice a week. These exercises and activities do not have to be used in chronological order; therapists and facilitators will work in using integrated movement and thematic instruction to address the needs of the group. These skills learned in the group will be used to develop mind-body awareness, self-regulation skills, and overall physical health.

- More Too Life has partnered with the program to offer additional mentoring services for Commercial Sexual Exploitation of Children (CSEC) victims by human trafficking survivors. Mentors come in once a week and have been working with two young ladies. Youth report feeling more connected to the mentors than other people who have discussed trafficking with them and each girl looks forward to their weekly visits. More Too Life is working with the young ladies on exploring education, career skills, goal setting, gender studies, mutual respect, human trafficking, pimp culture, and various forms of sexual violence prevention. They are also are helping the girls gain an understanding of how each of the listed skills play a part in the lives of society, pop culture and victimization. The primary purpose of the mentorship is for the victims to begin to discover who they are and move beyond their trauma to achieve a more purposeful and productive life. A More Too Life representative also holds a position on the program's community advisory board.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures in place indicating all potential staff and volunteers shall receive a criminal background screening in full compliance with Department background screening rules and regulations. A review of the program's staff roster indicated the program had eighteen new employees and two new volunteers since the last annual compliance review. A review of the Florida Agency for Health Care Administration website, also referred to as the Clearinghouse, revealed all employees and volunteers received an eligible rating screening prior to working with youth. All employees were listed on the program's roster in the Clearinghouse website.

The program uses an ergometric pre-employment assessment tool for all direct care staff. The program indicated staff must have a score of sixty-five percent to pass the video portion of the assessment and a sixty percent on the reading portion of the assessment. A review of the eighteen employee records revealed nine of the employees were being hired for direct care positions and the applicable employee records revealed all employees passed both portions of the pre-employment assessment tool. There was evidence in all employee records the hiring authority reviewed the Central Communications Center system, Staff Verification System, and reviewed the Florida Department of Law Enforcement's Automatic Training Management System as part of the pre-employment background screening process.

The program submitted the program's and the Hillsborough County School Board's Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's background screening unit on December 10, 2019.

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

The program has a policy and procedures in place indicating all staff and volunteers shall receive a new background screening every five years after their date of hire. A review of the program's volunteer and staff roster indicated there was one contracted staff who required a five-year background re-screening since the last annual compliance review. A review of the

Florida Agency for Health Care Administration website revealed the staff received an eligible five-year background re-screening prior to their five-year hire anniversary date. There was also evidence the screening was submitted by the program's human resource department at least ten business days prior to their five-year anniversary date. The program did not have any volunteers who required a five-year rescreening since the last annual compliance review.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trama responsive practices.* • *The program shall complete or schedule a TRACE self-assessment.*	

The program has a policy and procedures for the provision of an abuse-free environment and unhindered access to report allegations of abuse. The program also has multiple policies addressing ethical practices, youth rights, and employee standards of conduct and performance. All staff review and sign a code of ethics during the hiring process, which clearly articulates expectations for ethical and professional behavior. The program's code of ethics indicates staff are committed to high ethical standards to maintain the integrity of the organization. The program also has a code of conduct with includes the expectations for staff interaction with youth in a manner which promotes their emotional and physical well-being. A review of eighteen staff records indicated each staff signed and reviewed the program's code of conduct, as well as code of ethics.

The program had postings of the Central Communications Center number, and Florida Abuse Hotline number throughout the facility. The postings were observed during the facility tour in the youth dormitory area and in the multi-purpose room. A review of the program's internal investigations and incidents revealed there were three incidents related to abuse called in since July 1, 2019; however, all incidents were unfounded by the Department of Children and Families. During the annual compliance review, the review team did not observe any physical, emotional, or psychological abuse while on-site. The program has started the TRACE self-assessment process on February 28, 2020.

An interview with the assistant facility administrator (AFA) indicated all staff are mandated reporters and can contact the Florida Abuse Hotline at any time. The AFA also indicated youth who request to contact the abuse registry are provided with the opportunity to do so. The youth use the shift supervisor's cell phone, which is always on-hand or have access to one of the many office landlines to complete the call. The AFA also indicated staff receive training in abuse reporting and Central Communications Center reporting during their pre-service training. Staff also receive annual training on incident reporting and abuse. Any Central Communications Center or abuse incidents are reviewed and reported during the program's morning management meeting and inputted into the morning meeting database for tracking. Interviews with five youth were conducted and all youth indicated they felt safe at the program. Two youth expanded further on their answers; one indicated they feel safe now since certain youth are gone; and the other youth indicated they sometimes feel uncomfortable with nightshift staff because they never know what to expect when they come on-duty. The youth indicated they talked to the AFA about the nightshift and the program was supposed to discuss the issue during their daily circle, but it still has not taken place. Five youth were interviewed and asked if they had ever been stopped from reporting abuse and three indicated they had not. Two youth indicated they were stopped from calling abuse. One youth indicated they were jumped by other youth and the regional director would not let them call abuse or law enforcement. The youth did indicate when they called in another incident, they reported the one they were not allowed to call in. The second youth indicated when they first arrived at the program, they had asked staff to call the Florida Abuse Hotline and they were told by the staff they would notify someone by text and they would be able to make the call the next day. The youth did indicate they were able to make the call but not right away. Two of the five interviewed youth indicated they have never heard staff curse, while two youth have heard staff curse occasionally and one youth indicated the staff often curse. Two of the five interviewed youth indicated staff are respectful while speaking with them. One youth indicated the staff have their days and they get frustrated, but they should be respectful consistently and not just when quality improvement is around. A second youth indicated the night shift are not respectful as they are loud, and sleep while on duty. A third youth indicated they had problems with one staff member not being respectful in the past.

Five staff were interviewed and four of the staff indicated they would allow the youth to make an abuse call when requested. The fifth staff member indicated they would notify their supervisor and have the supervisor make the call with the youth. None of the five interviewed staff indicated they had seen a co-worker advise a youth they could not contact the Florida Abuse Hotline. Four of the five staff indicated they had never heard another co-worker use profanity when speaking with the youth, using threats, intimidation, or humiliation when interacting with youth. The fifth staff member indicated a curse word may slip out every now and again but no threats.

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

The program has a policy and procedures in place for how they respond to allegations of abuse, and violation of policy. The program had five incidents of allegations of abuse, and/or violation of policy since the last annual compliance review. The program's management team investigated each incident and cooperated with the Department, who was also investigating the

allegations. The program provided documentation to support they investigated each incident. The documentation also supported the program suspended each staff member pending the findings of the investigation. Two of the staff's suspensions were lifted and they returned to work after the allegations were found to be unsubstantiated. The remaining three staff were suspended, removed from their position, and ineligible for rehire based on the program's internal investigations.

During an interview with the assistant facility administrator (AFA) indicated the program complies with general standards of conduct and performance. The standards are categorized into three levels; minor offense, major offense, and critical offense. The AFA further indicated, failure to follow a standard of conduct may result in disciplinary action from an oral warning to termination of employment. The severity of the penalty depends on the frequency and nature of an offense. Furthermore, the AFA indicated the standards are not all-inclusive but are intended to be illustrative of the minimum expectations for acceptable work performance and workplace behavior. The system is progressive, and the company may at its sole discretion deviate from any order of actions and use whatever form of discipline deemed appropriate under the circumstances, up to and including immediate termination of employment.

1.05 Incident Reporting (CCC) (Critical)	**Satisfactory Compliance**
The program shall notify the Department's Central Communications Center (CCC) within two hours of the incident occurring, or within two hours of any program staff becoming aware of the reportable incident.	

The program has a policy and procedures in place to ensure program-related occurrences which place the program at risk, or have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff or visitors, the security of the facility, or the reputation of corporation are reported and handled appropriately and in a timely fashion. The policy further states the facility administrator (FA), assistant facility administrator (AFA), and program director (PD) are the only staff authorized to make reports to the Central Communications Center (CCC). A review of the CCC database indicated the program had eighteen incidents reported in the six months prior to the annual review. A review of five of those incidents indicated all were reported to the CCC within two hours of the program's knowledge of the incident. Two of the five incidents were described as youth behavior incident and complaints against staff, two were listed as complaints against staff, and one was described as a program disruption. All five incidents were required to be documented in the program's logbook. A review of the applicable program logbooks revealed all incidents were documented in the logbook on the day the incident occurred.

Since the program opened on July 1, 2019 and this is the program's first annual compliance review as an intensive mental health program for female offenders, the review team was unable to determine if there was an increase in CCC incidents. A review of the program's internal incident reports and grievances did not reveal there were any incidents which should have been reported to the CCC and were not. An interview with the AFA indicated when the program has a reportable CCC incidents the AFA, or PD is notified of the incident and if they determine the incident is reportable, they will contact the CCC. The AFA or PD will obtain necessary information and contact the CCC within the two hour time frame. Also, they will contact the CCC with updates, when necessary. The AFA further indicated youth who are eighteen years of age or older are permitted to contact the CCC, upon request, to report incidents of abuse or neglect.

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

The program has a policy and procedures outlining the requirements of physical intervention and restraint techniques using the three levels of the Protective Action Response (PAR). There were twelve PAR incidents in the six months prior to the annual review. Since the program opened on July 1, 2019 and this is the program's first annual compliance review as an intensive mental health program for female offenders, the review team was unable to determine if there was an increase or decrease in PAR incidents. The program has a PAR plan which was reviewed and approved by the residential regional director in March of 2019. The program's PAR rate during the annual compliance review period was 6.92, which is above the statewide average of 2.41.

Five PAR reports were reviewed for compliance and four of the reports contained statements from all staff involved and were completed by the end of the staff's workday. The fifth report was missing a statement from one of the staff members involved in the PAR incident. One of the five reports indicated the program used mechanical restraints on the youth and the report contained a mechanical restraint supervision log. None of the five PAR incidents resulted in injuries to the youth or the staff, and there was no need for the program to contact the Florida Abuse Hotline. All five PAR incidents contained a review by a PAR certified instructor/supervisory staff. Two of the five incidents required a post-PAR medical review and there was only documentation in one of the incidents the post-PAR medical review was completed. Four of the five reviewed PAR reports contained post-PAR interviews conducted with the youth within the required thirty-minute time frame, The remaining PAR report did not have a post- PAR interview completed.All five PAR reports were reviewed by administration within seventy-two hours of the incident, as required. Two of the five reviewed PAR reports lacked the signature of the lead staff member on shift during the PAR incident and the signature of the shift supervisor. During the debriefing process, the program acknowledged the lack of signatures by the shift supervisor, and lead staff member. The program also acknowledged the missing staff statement and post-PAR interview. The program advised the annual compliance review team they had previously identified issues with the completion of PAR reports and implemented a performance improvement plan (PIP) on September 6, 2019. The program also indicated they had corrected the identified issues and closed out their PIP on December 23, 2019. A review of the five reports revealed the two PAR reports which contained the errors above were completed prior to or just after the implementation of the PIP. The remaining three reports were completed after the implementation of the program's PIP and contained no errors.

The program maintains a PAR binder, which is where they maintain a copy of the monthly PAR reports sent to the Department's residential services, along with the original PAR reports. An interview with the assistant facility administrator (AFA) indicated PAR reports are reviewed during the program's morning management meeting and reported for tracking in the morning meeting database. The AFA indicated the program director (PD) conducts video reviews of all incidents to ensure proper PAR procedures were followed; and the PAR response was conducted at the necessary level and response. Staff involved in any PAR are required to complete a PAR report prior to the end of their shift and submit it to PD for review.

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

The program has a policy and procedures in place which states staff shall be provided with the necessary amount of training and the appropriate curriculums essential to comply with applicable standards within the company's contract for the operations of the facility and program. The policy further states all newly hired staff will receive a minimum of 120 hours of training in numerous topics utilizing web-based and/or instructor led trainings. The program submitted, in writing, a list of pre-service trainings to the Department's Office of Staff Development and Training on March 19, 2019 for the fiscal year of 2019, and it was approved on April 12, 2019.

A review of five staff training records indicated all staff completed 120 hours of required training within the first 180 days of employment. The program's contract requires twenty-six additional staff training topics and a review of each of the five staff training records revealed each staff received training in the additional topics. All training was documented in the Departments Learning Management System, SkillPro.

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

The program has a policy and procedures in place ensuring staff are provided with the training and the appropriate curriculums essential to comply with applicable standards and contractual requirements for the operation of the facility and program. The program submitted, in writing, a list of in-service trainings to the Department's Office of Staff Development and Training on March 13, 2019 for the fiscal year of 2019, and it was approved on April 12 ,2019.

A review of five staff training records indicated all staff have training in first aid, cardiopulmonary resuscitation, automatic external defibrillation, professionalism and ethics, Prison Rape Elimination Action, suicide prevention training, and human trafficking. All five reviewed staff exceeded the required twenty-four hours of in-service training. Four of the five staff reviewed for annual training were supervisory staff. Three of the applicable staff members exceeded the required eight hours of required supervisory training and had training in management, leadership, personal accountability, employee relations, and communication skills. The fourth supervisory staff member was promoted two weeks prior to the annual compliance review and has yet to complete any supervisory training. All in-service training was documented in the Departments Learning Management System, SkillPro. All instructors and facilitators of the training provided to staff were qualified to deliver the specific training.

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 outlining the program's grievance process. The policy indicates the process is a three-tiered system with an informal phase, formal phase and an appeal phase. The informal phase encourages the youth to resolve the question, dispute, and/or complaint through informal communication with program staff. The staff are to make reasonable efforts to discuss the youth's concern or complaint and assist the youth to informally resolve the issue. The informal phase is used to encourage and promote open communication and to assist the youth in the development of problem resolution skills. Informal complaints are to be handled as expeditiously as possible, but no later than twenty-four hours from when the youth submitted the informal complaint. As part of the informal phase, the program uses 'chatty cathy' forms as an alternative informal request process, which is not considered a formal grievance. If a youth is not satisfied with the resolution from the informal phase, they may submit a formal grievance form. A review of the program's informal grievance binder indicated the youth had completed thirty-eight 'chatty cathy' forms since the program opened on July 1, 2019. The program's policy indicates if the youth requests assistance in filling out the grievance form the staff, family, peers, or other advocates can help the youth fill out the form or fill it out for them. The policy further indicates the youth are to place the completed grievance in a locked grievance box for the grievance officer to handled. Grievance and 'chatty cathy' forms are maintained by the staff in a youth supervision binder and they provide the youth with a form whenever they want one. The program's grievance box is attached to the case manager's office door.

The program's assistant facility administrator acts as the program's grievance officer. Once a youth submits the grievance, the grievance officer has seventy-two hours to investigate and render a decision in writing to the youth. If the youth is still dissatisfied with the outcome of the grievance, they may submit their grievance to the facility administrator (FA) as the final appeal. The FA has seventy-two hours to review the findings of the grievance officer and determine whether the grievance was handled appropriately or if there should have been a different outcome. An interview with the assistant facility administrator (AFA) confirms they are aware of the steps in the program's grievance process and the AFA could articulate the process to the reviewer. A review of ten staff training records revealed all staff have received training in the program's grievance process.

A review of the program's grievance binder indicated the program maintained all grievances since the program opened July 2019. The program had twenty-one grievances filed by the youth in the six months prior to the annual review. A review of five of those grievances indicated all were handled in the formal phase of the grievance process. Each youth signed the grievance, indicating they agreed with the outcome of the grievance in the informal phase of the process and did not want to appeal the response from the grievance officer.

Five youth were interviewed about the youth grievance process and all youth indicated they were aware of how to get a grievance form and they were able to ask for assistance in filling out the form. One youth indicated youth can ask for a grievance form and they knew someone was supposed to talk to them about it, but they were unsure about how long the program had to

respond to their grievance. A second youth indicated the program takes days to weeks to answer a simple question and they have put a grievance in the box and have never been spoken to about it. The same youth indicated they wrote a grievance on the night shift but when she spoke to the AFA about it, they indicated no grievances were found in the grievance box about the night shift. The youth further indicated all shift supervisors have a key to the grievance box. A third youth indicated they filed a grievance in the past but was never seen for it, so they stopped filling them out; however, the youth did indicate two of her grievances were addressed a while back. The fourth and fifth youth indicated grievance forms are maintained by staff and youth must ask for one, fill it out, and the staff will get back to you within seventy-two hours or forty-eight hours. An interview with five staff confirmed they are all aware of the program's grievance process and could articulate the steps in the process.

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

The program facilitates Dialectical Behavioral Therapy (DBT), a promising practice; Impact of Crime (IOC), a practice with demonstrated effectiveness; Female Healthy Relationships, Mindfulness Movement, a group curriculum; Social Rhythms, a group curriculum; Matrix Model, group substance abuse treatment; and VOICES: A Program of Self-Discovery and Empowerment for Girls, which is a group curriculum for girls.
The program currently has eight staff trained in one or more of the interventions listed above. A review of the staff training records revealed three staff are trained to facilitate IOC, and five staff are trained to facilitate VOICES, DBT, Female Healthy Relationships, Mindfulness Movement, Social Rhythms, and the Matrix Model. Three of the eight facilitators are licensed professionals, five have master's degrees, and three have a bachelor's degrees. A review of each facilitator's staff records confirmed all facilitators had the required experience working with adult or juvenile offenders prior to being hired and/or training to facilitate delinquency interventions. A review of the program's contract indicated the program has staff trained to provide all of the required delinquency interventions, as well as their mental health and substance abuse groups. A review of the group sign-in sheets confirmed the program is providing all the interventions and groups listed in their contract.

A review of five youth case management records, five mental health and substance abuse records, and sign-in sheets indicated the youth have either participated in or completed one or more of the delinquency interventions listed above. A review of the same five youths' performance plans revealed each youth's plan contains a goal for the youth to complete one or more delinquency intervention group, and the plans further indicate at least one of each youth's top criminogenic needs will be addressed by their participation in the interventions. A review of the program's posted schedule, as well as a review of the program logbooks indicate at least sixty percent of the youth's awake hours are filled with structured, planned programming and activities. An interview with the assistant facility administrator (AFA) confirmed only staff with master's and bachelor's-level education degrees provide life skills training and groups to the youth at the program.

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

The program provides youth with interventions and instruction focused on developing life and social skills. The program's case management and mental health staff provide life skills groups and instruction to the youth at the program. The program provides the evidence-based curricula and group treatment entitled Impact of Crime, Mindfulness Movement, and Social Rhythms. The program's week-day schedule indicates groups are held daily from 2:30 p.m. to 3:30 p.m., and from 3:30 p.m. to 4:30 p.m. The program's weekend schedule indicates groups are held daily from 9:00 a.m. to 12:00 p.m. The program's transitional services manager (TSM) also teaches the youth employability skills, resume building, job seeking skills, fire safety, good hygiene habits, cardiopulmonary resuscitation and first aid, Safe Serve, conflict resolution, and about female-specific issues such as understanding their menstruation cycles. The TSM finds beneficial life skills materials at the local library, bookstores, and on-line resources to help educate the youth on the topics above. The TSM conducts a Daniel Memorial Assessment on each youth, which identifies each youth's life skill goals and objectives. The TSM then uses the resources they have collected to help the youth accomplish their goals and objectives. A review of five youth records confirmed each youth received this assessment during the annual compliance review period.

A review of the program's contract indicates the program has staff trained to provide all their required life skills and intervention groups, as well as their mental health and substance abuse groups. A review of groups sign-in sheets confirmed the program provided all the groups listed in their contract to the youth at the program. A review of five youth case management records revealed all youth received groups, as outlined in their treatment plans and performance plans.

An interview with the assistant facility administrator (AFA) indicated the youth attend delinquency and life skills groups daily. Interviews with five youth indicated they are all participating in group treatment daily. The interviewed youth indicated they are attending the VOICES group, teen relationships, substance abuse treatment, Impact of Crime, and sex offender treatment (through a contracted provider). Four of the interviewed youth indicated they have learned new skills from attending the groups. The fifth youth indicated she has not learned any new skills or behaviors since arriving at the program because she has previously been committed and learned the skills before. The four youth who indicated they have learned new skills stated they are learning to keep self-activities, warning signs of a relationship, stay busy and substance abuse free, how crime affects others, past trauma, coping skills, and how to pay attention to their bodies versus what their mind is telling them (mindfulness). Four of the five interviewed youth indicated they have been able to practice the skills they learned in group while at the program, especially when dealing with the other youth. The fifth youth indicated they had not yet practiced anything.
During an interview, the AFA indicated youth are matched to a therapist and case manager based on their individual needs identified in the pre-classification meeting prior to admission. Upon completion of the Youth Needs Assessment, any necessary changes can be made to ensure the needs of the youth are met. For placement in intervention groups, the youth's residential assessment for youth (RAY) is reviewed to determine which group is most beneficial based on their individualized needs. A youth's level of understanding and maturity is also considered to ensure they will benefit from the group curricula.

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 uses the Impact of Crime (IOC) curricula to teach and reinforce the idea of restorative justice awareness to the youth in the program. IOC is facilitated two day a week, Tuesday and Thursday, from 11:30 a.m. to 12:30 p.m. A review of staff training records verified three staff are trained to facilitate IOC. A review of five youth case management records, and group sign-in sheets confirmed all youth were participating in IOC groups. Furthermore, the Department's Juvenile Justice Information Systems evidence-based services database indicated all five youth have received IOC groups. The program had a volunteer, who has changed their life for the better, come to the program and speak with the youth about their experiences, how their experiences impacted their lives, and how they were able to make a positive change in their life.

An interview with the assistant facility administrator (AFA) confirmed the program uses the IOC curricula as their main restorative justice group and the group is held Tuesday and Thursday. The AFA further indicated the group curriculum, as well as the community service activities the youth are exposed too are designed to assist with the reparation to the community. The AFA also indicated the program invites victims to the program to speak to the youth about their experience as a victim of a crime and how it has impacted them overall. In addition, community service activities are completed on-site and off-site to engage the youth in giving back to their communities. The youth at the program have participated in feeding the homeless at Metropolitan Ministries, passing out water at the Gasparilla Race, and community clean ups. The program's past IOC group also held a donation drive to collect hygiene and clothing items for the homeless. The items were donated to Steadfast Ministries Homeless project where they provide thousands of items to the homeless year around. The AFA also indicated the youth watch on-line videos which show the effect crimes have on victims.

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

The program uses VOICES: A Program of Self-Discovery and Empowerment for Girls (VOICES) as their main gender-specific treatment service. Each youth in the program attends and completes the VOICES curriculum prior to being released. The program also uses the therapeutic group Female Healthy Relationships curricula. A review of five youth case management records and group sign-in sheets revealed each of the youth were participating in the VOICES and Female Healthy Relationship groups.

The program uses the Girls 4 Success Model, which identifies signature strengths, such as volunteer and family-focused services, in addition to therapeutic support, health, and wellness, academic, and life skills services. The program's positive performance system was developed through a partnership with the National Council on Crime and Delinquency Center for Girls and is focused on a girl's center perspectives. The program has a boutique, which contains gender-specific items youth can purchase with points earned by the positive performance system.

The program also uses the 'Savvy Sisters' curriculum, which is tailored to the unique needs of the female youth population. Gender-specific treatment focus areas address sexual abuse, trauma, substance abuse, crime specific topics, as well as relational and emotional topics. The program also conducts gender-specific health education with the youth at the program and covers topics such as self-breast examinations, pregnancy monitoring, eating disorders and reproductive health. An interview with the program assistant facility administrator (AFA) confirmed the program uses VOICES, Savvy Sisters, and the Girls 4 Success Model as gender-specific programming. The AFA also indicated the program provides youth with personal items which allow gender expression.

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 in place to ensure all staff are made aware of youth medical and/or mental health issues which may affect the safety and security of the youth in the facility and which may necessitate the need for emergency medical or mental health services. The policy further indicates the assistant facility administrator (AFA), in consultation with the health services administrator and mental health treatment director, shall develop and maintain an on-going alert system for the program which ensures information concerning a youth's medical (including physical restrictions) and/or mental health condition, allergies, common side effects of prescribed medications, foods and medications that are contraindicated, other pertinent treatment-related issues, suicidal ideations or verbal threats, and security issues are effectively communicated to staff in a manner which preserves the youth's privacy.

The program maintains an internal alert white board in the program's shift supervisor's office, where shift briefings are held. The internal alert board contains a photograph of each youth, their Department identification number, date of birth, alert status, and any notes pertaining to the youth. The program also maintains a grease board in the administrative area indicating the number of youth in the program and any other pertinent information the staff should be reminded about throughout the day, such as youth on precautionary observation. A review of five youth alerts confirmed the program's internal alert board matched what was documented in the youth's record and the Departments Juvenile Justice Information System (JJIS). Twenty-six specific alerts were reviewed for five youth. Twenty-five of the alerts were noted in JJIS and the twenty-sixth alert was for a vision deficit; however, the alert was closed in JJIS but active on the program's internal alert system. A review of twelve of the alerts indicated they were required to be documented in the program's logbook, and eleven of the alerts were documented on the appropriate date and shift in the logbook. During the debriefing process the program acknowledged the one alert was missing from the logbook.

An interview with the AFA indicated the program's department heads meet Monday through Friday for their morning management meeting at which time they discuss youth alerts and concerns. Any alert status changes are discussed and then updated on the internal alert board for staff to review during their shift briefing and the department heads will then update JJIS. The AFA further indicated the program maintains an internal alert tracker which is updated daily and reviewed during the morning management meetings. Five staff were interviewed about how they are informed of youth alerts and three of the staff indicated they learn about youth alerts during their shift briefings. Two of the staff indicated they review the alerts in the program's logbook and on the internal alert boards.

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

The program has a policy and procedures in place for the management of all youth records. The policy indicates the program shall maintain two official youth case records for each youth, one which is comprised of a medical, mental health and substance abuse information and another which is comprised of case management information. The program maintains two official records for each youth, which are entitled case management record and individualized healthcare record. The individualized healthcare record is then further broken down into two separate records, one which contains the medical information and the other contains the mental health and substance abuse information.

A review of five youth case management records, five individualized health records, and five mental health and substance abuse records all contained a tab with the youth's name, Department identification number, date of birth, county of residence, and committing office. All individualized case management records contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All reviewed records were labelled as "confidential" and were maintained in lockable filing cabinets in lockable room when not being used by the appropriate staff. All filing cabinets where youth records were maintained were marked as "confidential" to indicate confidential records were held within them.

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

The program has a youth advisory board, which meets, on average, twice a month. A review of the program's youth advisory board binder indicated the youth advisory board met twelve times in the six months prior to the annual compliance review. The youth must submit a youth advisory board application to become a member of the advisory board. The youth must meet the following criteria to become a member of the advisory board: be in the last two phases of the program, have a 'C' average in education classes and maintain good behavior in school, have thirty days of pro-social behavior and have four consecutive positive treatment team meetings. Each youth also must get the support of a peer, shift manager, case manager, therapist, another advisory board member, nursing staff, clinical director, direct care staff and the facility administrator. The youth advisory board meets with administration and discusses program issues, youth concerns, youth leadership, mentoring, innovative ideas and activities, monthly

incentive calendar, and any other issues or concerns the youth may have. The youth advisory board brings issues, concerns and ideas from all the youth in the program to the meeting and acts as an ambassador for all the youth. The program also holds a daily meeting on the weekdays with the youth, administration, and program staff at 2:15 p.m., which addresses minor community issues and promotes communication between the youth and staff. On the weekends the program staff have a meeting with the youth called 'feelings check' at approximately 1:45 p.m., which gives the youth an opportunity to communicate with staff currently supervising them and share their feelings. The youth also can put their concerns and ideas in the form of a 'chatty cathy,' which the assistant facility administrator or designee reviews and addresses within seventy-two hours of submission. The program also has the formal grievance process which allows the youth to remedy concerns or situations where they felt they were treated unfairly.

The program also completes quarterly random surveys on a minimum of ten youth through 'surveymonkey.' The surveys ask the youth for input on their admission, services provided, rights afforded them, the quality of living, staff conduct, safety issues, and allows the youth to provide comments/suggestions about the program and how they could improve.
During each youth's formal treatment team meetings, youth are asked a series of questions regarding their well-being in the program such as access to report abuse, access to grievances, have they been threatened or intimidated by anyone, have they had visitation, do they have any medical or mental health concerns, and do they feel safe in the program.

Five youth were interviewed about what the program's process is for allowing them to provide input about what happens at the program. Three youth indicated they would bring any ideas or concerns up to the youth advisory board, who would then discuss the issues with the program administration. One youth indicated they would fill out a 'chatty cathy' form and have management address their concerns. Another youth indicated they did not really know what they would do but they thought they would go to the assistant facility administrator (AFA) or program director; however, they were unsure if they would listen. An interview with the AFA indicated the program has the youth provide input into the program by participating in the youth advisory board, completing 'chatty cathy' forms, grievance forms, and discussions during the program's afternoon daily meeting with the youth. The AFA further indicated the daily meetings allow the youth to be able to express issues, concerns, provide positive and negative feedback about things going on in the program.

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

The program has a community advisory board which meets once a quarter. A review of the program's advisory board binder indicated the program has held advisory board meetings quarterly since the program opened in July 2019. The program maintains an agenda, minutes, and sign-in sheets for each meeting. According to the program's advisory board roster, the program has membership from all entities required by Florida Administrative Code. A review of emails and letter invites indicated new representatives are recruited and current members have been invited to each meeting.

During the annual review, an interview was conducted with a business member of the youth's advisory board. The member indicated they have attended the advisory board meetings since July 2019 and during the meetings, the assistant facility administrator (AFA) recaps minutes from the previous meetings, discuss youth and activities going on at the program, as well as

sets up new activities for the youth to do. The board member indicated each board member brings something to the table including community connections, which help enhance the programming received by the youth. The board member indicated they have observed items/activities discussed during the advisory board implemented into the program. An interview with the AFA confirmed the program has a community advisory board comprised of representatives from law enforcement, the judiciary, school board, community businesses, victims, victim advocates, as well as a member from the lesbian, gay, bisexual, transgender, and queer community. The AFA further indicated the board meets quarterly and discusses program updates, events, and how the program can partner with members respective organizations through community service events. The AFA also indicated the program's advisory board members are very involved in the program and host different events or invite the youth to participate in community service events. For example, a board member comes to the program monthly and provides a cooking demonstration while teaching the youth how to use their 'life ingredients' to make a masterpiece.

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

The program conducts monthly all staff meetings, monthly supervisor meetings, and daily management meetings to share information with staff and to enhance program planning. A review of the program's meeting binders indicated the meetings are held monthly or daily and have been held with the exception the of supervisor meetings since July 2019. The program only had documentation to support the program held supervisory meetings in January 2020 and February 2020.

A review of the all staff meeting minutes indicated the program reviews with staff the quality improvement reports, Comprehensive Accountability Report (CAR), red flag issues, medical updates, mental health updates, conducts drill reviews, human resources issues, policy reviews, and discusses safety and security issues. A review of the daily management meetings indicated the management team discusses programming issues, grievances, Central Communications Center reports, incident reports, staffing issues, youth issues, education issues, and human resource issues. The program also conducts staff training during staff meetings. The program further conducts parent/guardian surveys upon the youth's admission and conducts random youth and parent/guardian survey's quarterly. The feedback received from the surveys is discussed with administration and used to enhance programming.

The program has a policy and procedures in place for employment recognition. The purpose of the policy is to recognize employees for their contribution to the company through their performance to create a culture of care. The program recognizes an employee of the month, employee of the quarter, and employee of the year. Each winner is awarded a pre-determined monetary gift. The program also uses a program called the TrueCore Way, which allows supervisory staff or customers to recognize employees for exemplifying the TrueCore way, which is a positive culture, teamwork, and going above and beyond.

An interview with the assistant facility administrator (AFA) indicated the program has experienced some staff turnover with the transitioning of the program from a boys' facility to girls' facility. The challenges came with the change in treatment services provided which affected staff retention. Additional training from TrueCore leadership, the Department, and the behavior analysist were implemented to assist the staff with adjusting to the new population and learning how to better manage their interactions and build rapport. The AFA indicated to

improve staff morale and increase retention, the program administration has hosted monthly spirit weeks. Spirit weeks are typically themed related to a holiday in the month and consist of a week full of activities, staff recognition, and opportunities for staff to appreciate and praise each other. The AFA also indicated their company has provided the program an opportunity to win a monthly scorecard incentive, where each of the company's programs are rated in various areas by the regional team and issued points. The program with the most points wins 200 dollars to use towards staff incentives. There are also quarterly and yearly scorecard incentive winners which are awarded larger monetary prizes.

Five staff were interviewed regarding staff meetings and four of the staff indicated staff meetings are held monthly and one of the four staff members expanded their answer to include meetings are also held as necessary. The fifth staff member indicated staff meetings are held every three months. The interviewed staff indicated the following information is discussed during staff meetings: youth, youth and staff interaction, complaints, general programming, policy and procedures changes, safety and security concerns, and upcoming drills. All staff indicated valuable information is shared during the staff meetings. Two of the five interviewed staff indicated parent/guardian and youth surveys have been discussed during staff meetings, while the other three staff indicated they have not. One of the interviewed staff clarified their answer to include they had recently transferred to the program and had yet to learn of the parent/guardian and youth survey's during the staff meetings. Two of the staff felt communication at the program was very good; two indicated good; and one indicated it was fair. Three of the staff indicated if they wanted to provide input about the program, they would go to the AFA or program director. One staff indicated they would go to their supervisor. Another staff indicated the program has a suggestion box where staff can put in questions, concerns and provide input about programming.

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

The program has a policy and procedures in place indicating the organizational head shall evaluate each staff semi-annually, either directly or through middle management. A staff may receive more than two semi-annual evaluations during a year, as deemed appropriate, by the supervisor. The policy further states performance evaluations shall be placed in the staff's personnel record and a copy given to the staff.

A review of sixteen employee personnel records revealed four staff received an evaluation ninety days after hire and twelve staff received annual evaluations. All evaluations critique each staff on their workplace fundamentals, job-specific criteria, and provide them with goals to achieve during the next evaluation period. All reviewed evaluations were signed by the supervisor completing the evaluation and the staff. The program maintains job descriptions on all types of staff. A review of the program's job descriptions revealed they include a position definition and summary, position expectations and essential functions, position requirements, knowledge, skills and abilities, equipment utilized by the staff in the position, physical requirements of the job, and the working environment for the position. All sixteen reviewed staff records contained a job description, which was signed by the staff upon hire.

During an interview with the assistant facility administrator (AFA), they indicated staff are evaluated within ninety days of hire and annually thereafter. The AFA further indicated staff are evaluation on the performance of their job duties and are provided feedback on their

performance, as well as areas requiring improvement. The AFA indicated staff and supervisors develop goals for the year when they conduct a review of the staff's annual evaluation. Three of the five interviewed staff indicated they receive an evaluation annually. One of the interviewed staff indicated they had never received an evaluation. Another staff indicated they receive an evaluation every six months. One of the interviewed staff also indicated the AFA conducts some kind of annual evaluation.

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

The program has a policy and procedures in place indicating the program shall provide each youth with the opportunity to engage in large muscle exercise at least one hour daily. During the annual compliance review, the team's observations, interviews, and facility schedule postings confirmed the youth were afforded with large muscle activity for at least one hour a day. The youth are provided with activities which explore a variety of interests and provide them with muscular activities. The program's policy states activities are planned to expose youth to a variety of recreational and leisure choices, exploration of interests, constructive use of leisure time, social and cognitive skill development, as well as to promote creativity, teamwork, healthy competition, mental stimulation, and physical fitness. During the annual compliance review, youth participating in outdoor activities were observed to be supervised with staff members taking precautionary measures to prevent over-exertion, heat stress, dehydration, and physical injury. The youth were observed playing volleyball, basketball and walking around the basketball courts. A review of the facility logbook further confirmed recreation and leisure activities took place as outlined in the program's daily schedule.

The program employs a recreational therapist. The therapist has a bachelor's degree in recreation and sports management and is a certified therapeutic recreational specialist. The recreational therapist completes a monthly recreation activity calendar and ensures the youth are provided with a wide array of supervised and structured recreation and leisure activities which include basketball, dodgeball, volleyball, flag football, yoga, cheering, dance routines, workout sessions, bingo, kickball and arts and crafts. Additionally, the recreational therapist is a member of the treatment team and participates in monthly formal meetings.

An interview with five staff confirmed the youth are taken outside daily for large muscle exercise for an hour or longer depending on the weather. Five youth were interviewed, and they also indicated they are provided an hour or more of large muscle activity and the activities provides them with varying degrees of mental and physical exertion. The interviewed youth and staff confirmed the youth participate in an array of activities to include the activities listed above.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures in place which require notification to a youth’s parent/guardian, by telephone, within twenty-four hours admission, and by written notification within forty-eight hours. Five youth case management records were reviewed to validate parent/guardian notification was completed. All five records contained documents which validated telephone contact with the youth’s parent/guardian was completed on the day of admission. Each record contained documentation in the case management chronological notes to reflect the contact occurred. All records reflected staff also mailed a letter to parents/guardians, the court, and the juvenile probation officer (JPO) within forty-eight hours of admission, notifying them the youth was admitted to the program.

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

The program has a policy and procedures in place which dictates the delivery of a program orientation to the youth on the day of admission. The procedures detail all required orientation topics and describes how each youth is to receive the information. The program orientation covers services available, daily schedule, youth expectations and responsibilities, written behavior management system, availability and access to medical and mental health services, access to the Florida Abuse Hotline and/or Central Communications Center (CCC), the program’s zero-tolerance policy regarding sexual misconduct, special accommodations available to youth, items considered contraband, performance planning process, dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, assignment to living unit and room, and medical topics. Each of the five youth case management records reviewed disclosed orientation took place within twenty-four hours of each youth’s admission to the program. All records included youth initials on an orientation checklist which confirmed their understanding of program rules and expectations. The program did not have a youth admission during the annual compliance review; therefore, the program’s orientation was not able to be observed.

Five youth were interviewed, and they all confirmed orientation to the program began within twenty-four hours of their arrival and the program’s rules, procedures, and schedules were reviewed with them. Four of the interviewed youth indicated they received a program handbook on the day of their arrival. The fifth youth indicated they were assigned a youth mentor and they meet with them the day of their arrival and for a week after to assist with any questions while acclimating to the program.

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

The program has a policy and procedures in place which requires 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. Three of the five youth case management records selected for review, were for youth who turned eighteen years of age while at the program or prior to admission. One of the reviewed records indicated the youth refused to grant parental consent for the release of any information. The two other records contained a signed written consent form entitled 'Authorization for Use or Disclosure of Protected Health Information for youth eighteen years of age. Each form was signed by the youth and obtained before releasing any information relevant to the youth's treatment, assessments, and screenings to parents/guardians.

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

The program has a policy and procedures in place which govern the initial classification and reclassification of youth at the program. Youth's initial classification is to be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. Reclassification, if warranted, is conducted prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments may be used as potential weapons or means of escape, or participation in any off-campus activity.

Five youth case management records were reviewed for classification factors, procedures, and reassessments for activities. Initial classification was administered on the day of admission in all five reviewed records. All initial classification assessments included physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, and criminal behavior. All five reviewed records documented risk factors which were assessed and identified such as suicide risk, medial risk, escape risk, and security risk.
All five reviewed records reflected each youth was assessed for sexually aggression or vulnerability to victimization utilizing the Victimization and Sexually Aggressive Behavior (VSAB) screening instrument, which was completed on the day of each youth's admission; however, none of the reviewed VSABs were completed in the Department's Juvenile Justice Information System (JJIS). The program self-identified the issue of not completing VSABs in JJIS on September 25, 2019 and applied an internal corrective action plan (CAP) to resolve the issue.

The CAP dictated all VSABs completed after the correction date will be completed directly in JJIS and the previous process discontinued. During the annual compliance review, the program was able to provide the team with six additional records of youth admitted after the anticipated correction date of the CAP and all six reviewed records had a VSAB completed in JJIS on the same day the youth was admitted to the program.

All five youth records reviewed were applicable for reassessments. The program's practice is to conduct reassessments during each youth's formal treatment team meeting. A total of forty-seven reassessments were reviewed for compliance. Five of the reassessments were not filled out but signed and dated by the program director, therapist, and the case manager; the remaining forty-two forms were completed accurately. All youth who were granted increase in privileges, freedom of movement, and/or have participated in work projects or other activities involving tools had a completed risk re-assessment form which indicated they were appropriate for the activities.

An interview with the assistant facility administrator confirmed youth room placements are based on alerts identified during the VSAB and the admission classification meeting. The AFA also confirmed the program completes a reclassification on youth if they need to be reassigned to a different room.

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

Established policy and procedures require the program to gather and share gang information with law enforcement entities. The program uses a gang affiliation questionnaire which is administered to each youth on the day of admission. The questionnaire is geared to gauge each youth's level of gang involvement. 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 none of the records were applicable for gang notification. The program was able to provide two additional applicable records for review. The program did not have any other applicable youth during the annual compliance review period. One of the two applicable youth identified as having gang affiliation was documented as such prior to their admission; therefore, a JJIS alert was not required as an alert was already in the system. The second youth was identified during the admission process and an internal alert was created, as well as entered into JJIS. Both records also contained the required notification letters to the JPO, local law enforcement and law enforcement in the youth's home county and the letters were completed 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 uses a gang affiliation questionnaire which is administered to each youth on the day of admission. The questionnaire is geared to gauge each youth's level of gang involvement. Youth identified as a criminal street gang member, are affiliated with any criminal street gang, or are at high risk for gang membership, are provided intervention programming. Program policy indicates the facility administrator is personally responsible for ensuring gang prevention and intervention strategies are implemented in the program. The program uses the "ARISE: Gangs 50+ Stories of Fractured Lives" as their main gang prevention and/or intervention curriculum. The program also utilizes chapters involving gang prevention and intervention from the Impact of Crime curricula.

None of the five reviewed youth case management records contained a youth who was identified as a gang member, affiliate or suspected gang member. The program was able to provide two additional applicable youth case management records for review. One of the reviewed records was a youth who was on-site for three days; therefore, no gang intervention services were given, and a performance plan was not completed on the youth. The second youth's individual performance plan contained a goal indicating they would refrain from any gang activities while in the program. The youth also did not receive any gang intervention groups because they were in and out of the program due to receiving additional charges. Since there were no applicable youth who received gang intervention groups, no group sign-in sheets were available for review.

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

The program has a policy and procedures in place which dictates an initial Residential Assessment for Youth (RAY) assessment be completed within the first thirty days of admission and be maintained in the Department's Juvenile Justice Information System (JJIS). Policy also dictates a RAY reassessment is conducted every ninety days after the completion of the first RAY.

Five youth case management records were reviewed, and all contained an initial RAY which was completed within thirty days of admission to the program and was completed in JJIS. All reviewed records were applicable for one or more RAY reassessments, all of which, were completed within the ninety-day time frame, or as-needed if a change in interventions were needed prior to the ninety days. All RAY reassessments were completed in JJIS and a copy was maintained in each youth's case management record.

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

The program had a policy and procedures in place which ensures a Youth Needs Assessment Summary (YNAS) is conducted with each youth within thirty days of admission and maintained in JJIS. Five youth case management records were reviewed, all of which, contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of admission. Each YNAS was completed prior to the required timeframe, a copy was maintained in each youths' case record, and entered into the Department's Juvenile Justice Information System (JJIS).

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

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

Five youth case management records were reviewed for the development of performance plans, each of which, were completed within thirty days of admission. Each treatment team consisted of the treatment leader, youth, an administrative representative, living unit representative, treatment staff, and education staff, as required. Youth performance plans contained signatures from all treatment team members. All five youth performance plans were developed after the completion of the initial Residential Assessment for Youth (RAY). Each of the five plans contained goals which were individualized based on the risk factors and protective factors identified by the RAY assessment. Additionally, all five youth performance plans addressed the youth's top three criminogenic needs. Each of the five performance plans contained action steps for the youth and program staff to complete, target court-ordered sanctions, and transition activities targeted for the youth's last ninety-days in the program. Copies of the completed plans were provided to the youth's parent/guardian, youth, juvenile probation officers, and the committing court within ten working days of the plan being completed.

Five youth were interviewed, and all were able to articulate the program's treatment process and the specifics of their performance plan goals. Each youth stated they were actively involved

in the development of their performance plan. Four of the five youth interviewed reported they received a copy of their performance plans and one youth stated they did not receive a copy.

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

The program has a policy and procedures ensuring each youth's performance plan is revised, as necessary. A review of five youth case management records indicated each youth's plan had been revised based on newly acquired information. None of the reviewed plans were revised based on their Residential Assessment for Youth (RAY) results. All records verified each youth's performance plan was updated when they demonstrated progress or lack of progress towards completing a goal. The program's practice revealed the treatment team meets formally at least every thirty days to discuss each youth's performance plan, and any necessary revisions are made. Three youth records were applicable for being in transition. All three applicable records documented revisions were made to each youth's performance plan to facilitate transition activities during their last sixty days in the program.

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

The program has policy and procedures to ensure the treatment team prepares a performance summary within ninety-days following the signing of each youth's performance plan. A review of five youth case management records indicated each youth had a performance summary completed at least every ninety days following the signing of their initial performance plan. Each summary included the youth's status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment to the program, and any significant positive and negative events. Two reviewed records were applicable for having a performance summary completed prior to the youth's release, discharge, or transfer from the program. Both applicable records had a completed performance summary which included all the above applicable information, as well as justification for release. Documentation reflected all five youth could read and add comments prior to signing their performance summaries. Documentation revealed each youth was provided a copy of their performance summary and the original summary was filed in the youth's case management record. All five summaries were signed and dated by the treatment team leader, staff member preparing the summary, program director or designee, and youth. A review of transmittal documentation in all five records validated each summary was sent to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian within ten working days. None of the five youth were involved with the Department of Children and Families. Interviews with five youth indicated three youth had received a copy of their performance summary sent to the court. One youth said they did not, and one youth was not

applicable as they had not been in the program for ninety days following the completion of their performance plan.

A review of three closed youth case management records indicated the original release summary, along with justification for release was sent to the assigned JPO with the Pre-Release Notification (PRN). All three summaries and PRNs were sent at least forty-five days prior to the planned release date. A signed copy was retained in all three records. The court did not object to the release for any of the three youth. Each record contained documentation showing the program provided written notification to each youth's parent/guardian notifying them of their child's release. Each record contained documentation supporting the Residential Assessment for Youth (RAY) was completed for each youth following approval of their release.
None of the youth were applicable for the sexually violent predator program (SVPP). There was one youth applicable for victim notification and documentation supported the program mailed the victim notification of release letter to the victim at least ten days prior to the youth's release.

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 stating the program will encourage and facilitate involvement of each youth's parent/guardian in the case management process, including the assessment process, development of the performance plan, progress reviews, formal treatment team meetings, and transition planning. If unable to attend, the parent/guardian can participate by phone or give verbal/written input prior to the meeting. An interview with the assistant facility administrator (AFA) indicated each parent/guardian is involved in the above listed areas. The AFA also indicated each youth is allowed a weekly phone call with their parent/guardian. Reviewed documentation indicated a telephone call is made to the parent/guardian upon admission to gather information on the youth's background and family. An admission letter is then sent to the parent/guardian, along with a survey. The lead case manager indicated youth goals are discussed with the parent/guardian and the parent/guardian can provide input to drive the youth's performance plan. A review of documentation in four youth case management records revealed the parents/guardians were invited to all formal treatment team meetings and were able to provide feedback. The fifth record was not applicable for parent/guardian invites because the youth was eighteen years of age and did not grant permission for their parent/guardian to receive any information about their progress in the program. A survey is given to the parent/guardian for their input on transition planning. The program reaches out to parents/guardians by telephone, email, surveys, mail, or through the juvenile probation officer. One treatment team meeting was observed during the annual compliance review and the youth's parent/guardian participated in the treatment team by phone. A call to the youth's father was attempted and a message was left requesting a call back to get an update and provide input. Five youth were interviewed about parental involvement. Three youth reported their parents/guardians are involved in their case management services. One youth stated they were eighteen years old and their parents/guardians were not involved in their treatment. One youth indicated they has not had a formal treatment team yet, so they did not know if their parent/guardian would be involved in the process.

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 ensuring each youth's treatment team includes all pertinent parties. Everyone assigned to each treatment team participates in each youth's formal treatment team meeting to provide input on the youth's goals and progress. The program holds a formal treatment team meeting for each youth at least every thirty days. A review of five youth case management records verified each youth's juvenile probation officer (JPO), parent/guardian, as applicable, and other pertinent parties were invited and encouraged to participate in the youth's treatment team meeting. One youth's parent/guardian was not invited to the treatment teams; however, the youth was eighteen years old and did not consent for the parent/guardian to be a part of their treatment. Each youth record documented the treatment team leader, youth, parent/guardian (when applicable), representatives from program administration and living unit, treatment staff, educational staff, JPO, recreation therapist, and medical representative participated in the treatment team meetings. In one reviewed youth record, the parent/guardian and JPO both missed one treatment team meeting; however, invitations were sent, and telephone contact was attempted to the individuals at the time of the meeting but were unable to be reached. None of the reviewed youth were involved with the Department of Children and Families. One formal treatment team meeting was observed during the annual compliance review and all required individuals attended and actively participated in the meeting. Observations confirmed the youth's parent/guardian was contacted by telephone and participated in the treatment team. A call to the youth's father was attempted but they were unable to be reached and a message was left.

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

The program has a written policy and procedures to ensure each youth's performance plan references or incorporates their treatment or care plans. A review of five youth case management records reflected each youth had additional plans addressing academics, medical, mental health, and substance abuse. Four of five reviewed records contained documentation verifying academic, medical, mental health, and substance abuse goals were incorporated into their performance plans. The fifth reviewed youth's original performance plan did not incorporate the youth's educational, medical, mental health, or substance abuse plans. The program identified the error and later added goals in each area to a revised performance plan. None of the reviewed youth were involved in the Department and Children and Families (DCF); however, one youth has a child in the care of DCF. The DCF case plan for the youth and their child was incorporated into the youth's performance plan. The program only had one additional youth who was in DCF custody and the program provided the record for review. Reviewed documentation in the record found the youth's DCF case plan was incorporated into the youth's performance plan.

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

The program has a policy and procedures to ensure informal treatment team meetings are held with each youth and their case manager at least biweekly and formal treatment team meetings occur at least once every thirty days. A review of five youth case management records indicated each youth received a formal treatment team review at least every thirty days. Reviewed documentation in all records included signatures for the treatment team leader, youth, representatives from program administration and living unit, treatment staff, educational staff, recreation therapist, and medical representative. The juvenile probation officer (JPO) and parent/guardian's participation, when applicable, was denoted by the statement, 'participated by phone.' One reviewed youth was eighteen years old and did not consent for parent/guardian participation in treatment and there was no documentation to support the youth's parent/guardian received any information.

Five youth case management records were reviewed for documentation of informal treatment team meetings. Documentation in all records revealed informal reviews were conducted as required. All formal and informal reviews were documented in the youth's case management record, and included: youth's name, date of the review, comments from treatment team members, brief synopsis of youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical intervention, and treatment progress. Each formal review included Residential Assessment for Youth (RAY) results. One formal treatment team meeting was observed during the annual review and all required staff were present and participated, and all required information was discussed. Four of five interviewed youth reported staff review their performance, to include progress on performance plan goals, positive and negative behavior, and treatment progress. Four of five youth also stated they were given an opportunity during treatment team meetings to demonstrate skills they have learned in the program. The fifth youth stated they had not had a treatment team meeting yet because they had not been in the program long enough.

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

The program had a policy and procedures in place for career education. The program is a Type 2 career education program and is appropriate for the length of the youth stay. Hillsborough County School District has approved the Personal Career School Development course for youth to earn a half-credit and Florida Ready to Work as the assessment tool to broaden the scope of career choices, based on aptitude, work habits, and accountability skills. The program offers youth training experience in cardiopulmonary resuscitation (CPR) and first aid, and food handling training and the youth earn certificates upon completion of the coursework. The assistant facility administrator and lead educator were interviewed to determine the program's career service focus and they indicated career education services include communication, interpersonal skills, conflict resolution, living skills, and soft skills.

A review of three closed records were reviewed for youth receiving career education services. All records contained a sample employment application, resume, calendar with the career source service appointment, social security card, a state-issued identification card, and training certificates youth earned while in the program. Youth's vocational and educational goals were documented and shared with the youth's parent/guardian, case manager, juvenile probation officer, and the youth, which included continued support and supervision after the youth is released from the program.

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

The program has a policy and procedures in place to ensure youth have access to educational services. The program contracted with the Hillsborough County School Board. The instructional schedule is approved by the school district. The educational and career-related program is distributed over twelve months, 250 days of instruction, and a minimum of twenty-five hours of instruction weekly. The program education staff does use ten days for teacher planning and school district professional development. Youth receive academic credits and certificates earned for training experience. Logbook entries reviewed for specific times and dates reflected youth movement going to and from classes as scheduled with minimal interferences. Three of the five interviewed youth indicated there was not a lot of interruptions during school. The fourth youth indicated some teachers lack of regular attendance and the substitutes used in place of the regular teachers do not know how to teach. The youth also stated when the teachers are not there, we are all together in one classroom. The fifth youth indicated during school the program staff who are supervising them talk.

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

The program has a policy and procedures in place to address the youth’s education transition plan. The program staff was actively engaged and provide the youth services to assess educational needs and post-release goals. The school district personnel provided related transition services to ensure educational records are available and assisted with the youth’s transition back to their local school zone or alternative education program.

A review of three closed youth case management records noted dates and times when each youth participated in their Community Re-Entry Team meeting, transition meeting, and exit meeting. All three records contained a transition plan, educational placement plan, with specific goals for the continuation of education, employment, post-secondary, and career opportunities. All three records contained evidence the youth’s case manager, juvenile probation officer (JPO), and parent/guardian were aware of the educational plans, required documents, and post-release discharge plans.

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

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

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

The program has a policy and procedures in place to ensure an exit portfolio is assembled for each youth to assist them once they are released back into the community. A review of three closed youth case management records confirmed an exit portfolio was discussed and initiated for each youth at the transition conference. Each portfolio was completed by the program, verified at the exit conference, and given to the youth upon release. Each record contained a copy of the youth's exit portfolio, including a State of Florida identification card, copy of the youth's transition plan, calendar with all upcoming community appointments, education or vocational certificates, education records, school transcripts, résumé, and sample job applications. Two of the three records contained a birth certificate and a social security card. The third record was missing both items; however, the program attempted to get the missing items from the parents/guardians, but they refused to provide the items to the program. Reviewed documentation confirmed a copy of the exit portfolio was sent to each youth's juvenile probation officer.

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

The program has a policy and procedures to make certain an exit conference is conducted for each youth, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans. Three closed youth case management records were reviewed, and documentation indicated each youth had an exit conference which was held after the program notified the juvenile probation officer (JPO) of release and at least fourteen days prior to the youth's release date. All conferences were documented in the case management record and included a summary and review of pending transition goals, the date of the conference, and signatures of participants. Participants included the treatment team leader, education representative, youth, and treatment staff. Documentation of parent/guardian and JPO participation was noted as participating by telephone. The program conducts exit conferences separate from transition and community re-entry team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinical authority (DMHCA). The DMHCA is responsible for the implementation and oversight of the mental health and substance abuse services for the program, as outlined in the program's contract. The DMHCA holds an active and valid license in the State of Florida and it expires on March 31, 2021. The DMHCA is on-site forty hours a week and is on-call twenty-four hours a day, seven days a week for emergency consultation. An informal interview with the DMHCA indicated they provide oversight of daily delivery of clinical services in the program to ensure the integrity and fidelity of treatment is maintained, oversees the mental health and substance abuse evaluation and treatment process, and conducts one-hour a week clinical supervision to the non-licensed clinicians.

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

The program has one full-time licensed mental health counselor (LMHC), who serves as the designated mental health clinical authority (DMHCA), one licensed clinical social worker, who serves as the assistant clinical director, and a part-time licensed mental health therapist. All licensed professionals have a clear and active license in the State of Florida and their licenses all expire on March 31, 2021. The program also has a contracted licensed psychiatrist, as well as another licensed psychiatrist which acts as a backup, as needed, for the contracted licensed psychiatrist; copies of psychiatrists' licenses were found to be clear and active in the State of Florida and expire January 31, 2022.

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 non-licensed clinicians providing services to the youth. The clinicians all have master's-level degrees; one has a masters in social work and the other a masters in rehabilitative and mental health counseling These full-time clinicians provide substance services to youth, under the program's Chapter 397 license which expires April 7th, 2020.One of the clinicians is a registered intern with the state. Both non-licensed clinicians have conducted Assessments of Suicide Risk (ASR), and facilitated individual, group, and family sessions. There was documentation to support the non-licensed clinicians received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. All non-licensed clinicians work under the direct supervision of the designated mental health clinical authority (DMHCA). There was documentation to support weekly clinical supervision provided by a licensed clinician for the past twenty-six weeks. The weekly supervision consistently included all requirements, including caseload review, clinical services, and documentation, with directions and recommendations provided to the clinicians. The program's clinical staffing is in accordance with their contract.

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 to address mental health and substance abuse screenings, which requires the completion of an Assessment of Suicide Risk (ASR) for all youth. Each youth is also referred for a comprehensive assessment as part of the program's evaluation procedures. The mental health and substance abuse needs of youth are identified through a comprehensive screening process, ensuring referrals are completed, when necessary. Five youth mental health and substance abuse records were reviewed; all records contained a Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), which was administered by a staff member trained to complete the screening. All five screenings were completed on the day of the youth's admission to the program. Each MAYSI-2 was entered into the Department's Juvenile Justice Information System (JJIS). All the MAYSI-2 screenings indicated a need for further assessment/evaluation. A mental health substance abuse referral summary was completed on the day of each youth's admission to document a review of all commitment paperwork and outside assessments. A completed summary was present in reviewed records. At the time of admission, an ASR was completed on all youth as part of the program's routine procedures. The assistant facility administrator reported the program conducts a MAYSI-2 on all youth to determine risk for mental health and substance abuse problems, as well as risk for suicide. In four of the five records reviewed, all the procedures were followed correctly. The five youth's ASR was time stamped 11:54 a.m., which happened prior to the completion of the MAYSI-2 (time stamped 12:54 p.m.) and the referral summary form (time stamped 1:00 p.m.). The MAYSI-2 showed hits in suicide ideation and the referral summary form stated an ASR was necessary. Another ASR was not completed after these documents were completed. At the daily debriefing the program acknowledged the sequence of

forms were completed out of order and the clinician did not follow the program's typical procedures.

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 policy and procedures regarding mental health and substance abuse assessments. Five youth mental health and substance abuse records were reviewed, and all contained a new mental health and substance abuse bio-psychosocial comprehensive evaluation. Four of the five evaluations were completed within thirty days of the youth's admission into the program. The fifth evaluation was completed six days late and, during the debriefing process, the program acknowledged the lateness of the evaluation. Each evaluation was reviewed and signed by the designated mental health clinical authority (DMHCA) within ten calendar days of completion. Each comprehensive evaluation contained the following: identifying information, the reason for the evaluation, relevant background information, behavioral observations, mental status examinations, patterns of alcohol and other drug abuse, the interview or other procedures used to collect the data, a discussion of the findings, the diagnostic impression, including Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, and recommendations. All five evaluations included an assessment of the youth's substance abuse usage. These substance abuse assessments included the reason for assessment, relevant background information, behavioral observations, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and drug use, clinical diagnosis, and recommendations. Four of the five of substance abuse assessments were completed within thirty days of the youth's admission into the program. The fifth evaluation was completed six days late and, during the debriefing process, the program acknowledged the lateness of the evaluation.

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

The program has a policy and procedures in place to address mental health and substance abuse treatment for the youth. The policy requires the youth to receive group counseling seven days a week, and for all youth to be provided individual and family counseling, with the frequency of the sessions to be determined by the youth's individualized treatment plan. The youth are assigned to a treatment team upon admission to the program. The treatment team is comprised of the facility administration, juvenile probation officer, case manager, living unit representative, therapist, youth, and the youth's parent/guardian. Five youth mental health and substance abuse records were reviewed, and four youth were identified with substance abuse issues and were receiving substance abuse services. All five youth were provided weekly individual, daily group, and monthly family counseling by either master's-level, non-licensed

staff, who were supervised by the licensed therapists. One youth receives specialized sex offender treatment which began in October of 2019 from an outpatient licensed therapist who comes to the program bi-weekly as part of the youth's treatment plan. A valid Authority for Evaluation and Treatment (AET) was found in each of the two youth's records who were under the age of eighteen. The three remaining records contained a signed consent for treatment for youth over the age of eighteen. All five reviewed records contained a Consent for Substance Abuse Treatment form and the Consent for Release of Substance Abuse Treatment Records form signed by the youth on the date of admission. All treatment was documented on chronological notes containing all elements of the Department MHSA 018 form entitled Counseling/Therapy Progress Notes. The chronological notes for mental health and substance abuse groups were reviewed, as well as a group observation conducted. Observations confirmed there were no more than ten youth participating in mental health groups and no more than fifteen youth participating in substance abuse groups. Individual psychotherapy was provided to each youth weekly. Five staff were interviewed, and all reported they do not facilitate any metal health or substance abuse groups. An informal interview was conducted with the designated mental health clinician authority who indicated fidelity checks on all mental health and substance abuse groups were conducted by trained facilitators.

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 regarding mental health and substance abuse treatment and discharge planning. Five youth mental health and substance abuse records were reviewed, and each record contained an initial treatment plan which was completed within twenty-four hours of the youth arriving at the program. Each initial treatment plan was signed by the clinician, who completed the plan, the youth, and was reviewed and signed, by a licensed clinician within ten days of completion. The initial treatment plans consistently contained the signatures of the participating treatment team members. Three of the five youth were admitted to the program taking psychotropic medication. All applicable initial treatment plans included the youth's psychiatric needs including medication, dosage, and frequency of psychiatric monitoring.

Three of the five records contained an individualized treatment plan, which was completed within thirty days of the youth's admission to the program. Two records had individualized treatment plans which were completed later than the thirty-day requirement. Both were completed eight days late; however, it should be noted one youth signed their treatment plan late due to being out of the program for twenty-one days due to new charges. Each individualized treatment plan contained all required elements of form MHSA 016 entitled, Individualized Mental Health/Substance Abuse Treatment Plan. Each treatment plan was signed by the staff completing the plan, a licensed clinician within the required timeframe, the youth, and all treatment team members, who participated in developing the plan. Four of the five youth

were prescribed psychotropic medication during their stay at the program. Each applicable treatment plan included psychiatric services, including the medication and frequency of monitoring by the psychiatrist. All four of the applicable records contained treatment plan reviews, which were completed no more than thirty days apart, or thirty days from the creation of the treatment plan.

Three closed youth mental health and substance abuse records were reviewed for discharge planning. Each closed record contained a mental health and substance abuse treatment discharge summary and each of the summaries included services for daily maintenance of the positive improvements in behavioral, emotional, and social skills made by the youth while in the program. None of the three records documented the youth were released from the program while on suicide risk precautions. The discharge summaries were all discussed with the youth, the parent/guardian, and JPO during the exit conference, and the annual compliance review team was able to observe the practice while observing an exit staffing during the review. All three closed records contained documentation the discharge summary was provided to the youth, the youth's parent/guardian, and the youth's juvenile probation officer. One of the discharged records did not have the youth's signature on the MH/SA discharge summary; however, all other signatures were present on the form. During the debriefing process, the program acknowledged the missing signature, but did not give a reason for why it was missing.

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

The program has a policy and procedures in place to address the provision of specialized treatment services for the youth. The program provides intensive mental health treatment services to the youth at the program. Each youth is provided with an individualized mental health plan, and when appropriate, a substance abuse treatment plan. Treatment includes individual and family therapy, as well as daily group therapy. When needed, the clinical staff conducts crisis interventions and provides supportive counseling. There is a contracted psychiatrist who is on-site weekly and available twenty-four hours a day, seven days a week for psychiatric emergencies. Clinical staff are on-site seven days a week. The mental health staff are supervised by the designated mental health clinical authority (DMHCA), who is a licensed mental health professional and on-site five days a week for a minimum of forty hours. There was documentation to support each clinician's caseload did not exceed twelve youth. The program ensures medical staff are on-site daily, seven days a week. A recreational therapist is also on-site to provide services to the youth. The youth participated in various therapeutic activities, including skills training and psycho-educational instruction. The assistant facility administrator reported intensive mental health services were provided to the youth as specialized treatment services.

An interview with the DMHCA indicated the program provides the following specialized services: Impact of Crime, a restorative justice curriculum; Mindfulness Movement, a delinquency intervention group; Social Rhythms, a delinquency intervention group; VOICES, a gender-specific curriculum, as well as individual counseling. At the program, all youth receive individual counseling weekly, as well as VOICES and Impact of Crime prior to release. The DMHCA further indicated delivery of services are ensured by designating staff to facilitate and following a group intervention schedule and they are responsible for conducting or assigning a designated staff to conduct fidelity monitoring of each facilitator of a specialized service monthly. The staff

conducting the fidelity monitoring has received formal training by a qualified trainer in the specialized service. Additionally, the DMHCA indicated the program provides daily group therapy, weekly individual therapy, and monthly family therapy sessions. For service of individual and family counseling, fidelity monitoring is conducted by a licensed clinician by reviewing the progress notes to verify provision of effective and appropriate interventions in line with the treatment plan.

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

The program has policy and procedures regarding the provision of psychiatric services being delivered to the youth. The program contracts with a licensed psychiatrist to provide these services. The psychiatrist is on-site once a week, and is available twenty-four hours a day, seven days a week for psychiatric emergencies. An interview with the psychiatrist revealed they are on-site one day a week to conduct psychiatric evaluations for all new admissions and medication management monthly for all youth on psychotropic medications. A review of twenty-eight weeks of sign-in sheets for the psychiatrist revealed there were three instances where the psychiatrist was not on-site weekly. The time periods where no psychiatrist was present at the program were the weeks of November 25, 2019, December 16, 2019, and December 30, 2019. It should be noted the program's contract states the psychiatrist is split between Les Peters Academy and the Tampa Residential Facility and does not specify how many hours or how often the psychiatrist must be at one program or the other.

The program's practice is to refer every youth for a psychiatric evaluation within fourteen days of admission. Five youth mental health and substance abuse records were reviewed, and each record contained a psychiatric evaluation, which was documented on the Clinical Psychotropic Progress Note (CPPN), including page three. The psychiatric evaluations contained all required elements, including history, mental status examination, Diagnostic and Statistical Manual diagnosis, and treatment recommendations, and all evaluations clearly indicated it was an initial evaluation on the form. Three youth entered the program with psychotropic medications and were seen by the psychiatrist within the required fourteen day timeframe. The psychiatric evaluation for the youth taking psychotropic medications included a discussion of the prescribed medication, an explanation for the need of the medication, and the frequency of medication management. The program sent written parental notifications, as required, for all medical events. When new medications were prescribed, the program attempted to contact the youth's parent/guardian to provide verbal consent followed by written consent. All applicable records contained the required consents for the provision of psychotropic medications. The psychiatrist conducted medication management for all applicable youth every thirty days which was confirmed through the review of sign-in sheets and notes for the last six months.

An interview with the psychiatrist confirmed they work closely with the DMHC to make sure all youth are properly evaluated and treated while at the program. The psychiatrist indicated they decide the length of time between visits which is a minimum of once a month but frequently more often. They further indicated they help the clinical director supervise the therapists and make suggestions regarding what techniques would work best with individual youth and they

also make suggestions about recreational and arts programming which would be helpful additions to the primary treatment services. The psychiatrist further indicated they see the DMHCA multiple times a week and they see the assistant facility administrator on most Wednesdays at the other program where they confer about the youth at the program. The psychiatrist also confirmed they are available twenty for hours a day, seven days a week by telephone.

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

The program has a written plan to describe the program's procedures for prevention of suicide. The plan was reviewed, signed, and dated by the assistant facility administrator and designated mental health clinical authority (DMHCA) in April of 2019. A review of the program's plan had detailed suicide prevention and precautions to provide a systematic process for timely assessments and provisions necessary to maintain the youth's safety. Due to the special treatment needs of the program's population, every youth receives an Assessment for Suicide Risk (ASR) at the time of admission and upon re-admission. The plan addresses staff training; referrals, communication, notification, documentation, immediate staff response, and review processes. The plan addresses all supervision levels required of youth placed on suicide precautions. An interview with the assistant facility administrator confirmed all staff receive six hours of suicide prevention training upon hire and then annually.

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

The program has a policy and procedures in place regarding suicide prevention services. The program completes a restrictions checklist for youth placed on secure observation, precautionary observation and/or mental health alert status. The checklist includes the level of supervision, and restrictions such as designated safe housing area, youth searches, the clothes the youth are permitted to wear, items youth are permitted to have, and the activities the youth are permitted to participate in. The checklist is signed by a licensed clinician and the assistant facility administrator or designee. Five youth mental health and substance abuse records were reviewed, and each youth received an Assessment of Suicide Risk (ASR) during the admission process. Four youth were stepped down to standard supervision because of the admission ASR and one youth was placed on precautionary observation. The program used form MHSA 004 entitled, Assessment of Suicide Risk to complete each ASR. Three of the five youth were placed on suicide precautions after admission; two of the three youth had been placed on precautions multiple times. In total, nine instances of suicide precautions were reviewed. An ASR was

completed for each of the episodes, using form the correct form. Each ASR was completed by a licensed clinician, or a non-licensed clinician, who had the requisite training to complete an ASR. The ASRs completed by non-licensed clinicians were reviewed within twenty-four hours by a licensed clinician. Each youth was placed on constant supervision until an ASR was completed, which was documented on suicide precautionary observation logs. The youth who were continued on precautionary observation because of the ASR were stepped down to close supervision when deemed appropriate by a clinician using the follow-up ASR form. While placed on precautionary observation, the youth were permitted to participate in activities, and were not limited to their sleeping room. There was a restrictions checklist completed each time a youth was placed on precautionary observation. A follow-up ASR was completed every twenty-four hours until the youth was placed on close supervision, and each follow-up ASR was completed, as required. The youth's parent/guardian and juvenile probation officer were consistently notified of each placement on precautionary observation. Each youth had a mental status exam completed prior to removal from close supervision. The documentation also reflected a conference with a licensed clinician and the assistant facility administrator/designee was conducted prior to reducing each youth's level of supervision. An alert was entered in the Department's Juvenile Justice Information System (JJIS) for each of the applicable episodes. Logbook entries were found for each youth's placement on and removal from precautionary observation and close supervision except in one instance. One youth's precautionary placement was not documented in the logbook when the youth went on precautionary observation on December 1, 2019. During the debriefing process, the program acknowledged the staff did not correctly document the youth's precautionary observations in the logbook. The program does not use secure observations and a review of the five youth mental health and substance abuse records confirmed there were no instances of secure observation.

Five staff were interviewed, and each reported they would contact mental health staff, search room and youth for sharp objects, maintain sight and sound of the youth, and document supervision of a youth who expressed suicidal thoughts. Five staff reported suicide response kits were in the staff duty station and in the administration area of the program. Two of the staff also reported there was a suicide response kit in the medical clinic. The annual compliance review team observed the kits and they contained a knife-for-life, wire cutters, needle nose pliers, and basic first aid supplies. The program's suicide prevention plan indicates the program will complete a review of all serious suicide attempts. During the annual compliance review period, the program did not have any instances of these behaviors, but the plan does indicate the management team would review the circumstances surrounding the event and discuss possible changes to the program's policy and procedures.

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

The program has a policy and procedures in place regarding suicide precaution observation logs. Five youth mental health and substance abuse records were reviewed, and each youth received an Assessment of Suicide Risk (ASR) during the admission process. Four youth were stepped down to standard supervision because of the admission ASR and one youth was placed on precautionary observation. Three of the five youth were placed on suicide precautions after admission. One of the youth had been placed on precautions twice, another was placed once, and the third was placed five times. All incidences of youth bring placed on precautionary

observation included precautionary observation logs. The program uses the Department's MHSA form entitled, Suicide Precaution Observation Log to track the youth's behaviors while under increased supervision. The staff completed checks of the youth every thirty minutes. All observation checks were documented legibly and in real time. The logs were reviewed by supervisors on each shift. When the youth displayed warning signs, the staff did document the signs and their communication with a clinician. All precautionary observation logs were reviewed by a clinician. Each log contained appropriate documentation of safe housing areas. Three youth, who had been placed on precautionary observation were informally interviewed, and all three youth stated while on suicide precautions the staff were present the whole time and never left them alone.

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

The program has a suicide prevention plan, which includes training requirements for the staff. The training records of ten staff were reviewed for the receipt of at least six hours of suicide prevention training, either during pre-service or in-service training. Documentation supported all staff received four hours of instructor-led training and completed two hours of web-based training on suicide prevention. The program recently transitioned to a girl's program on July 1, 2019 and during the annual review, the team only had two quarters of mock suicide drills to review. A review of the ten staff training records revealed eight participated in two mock drills since the program's transition. The remaining two staff have not participated in any mock drills due to being recently hired.

The program is required to conduct mental health drills quarterly on each shift. Ten drills were reviewed and eight of those drills occurred on the first shift and two occurred on the second shift. None of the second shift drills were conducted in the second quarter; therefore, the program did not meet the requirements of having conducted drills on each shift, in each quarter. Reviewed drill documentation included a description of the incident, a synopsis of the response, deficiencies identified, and any needed corrective action. At the time of the annual compliance review, there were thirty staff applicable for drill participation and fifteen staff members were randomly selected for the review of drill participation. Eleven of the fifteen staff have received their required amount of drills for the year; however, the requirement is semi-annually, so the four remaining staff members still have time to complete their required drills. Florida Administrative Code 63N-1.0091 (2) (c) requires mock suicide drills to address a suicide attempt or incident of serious self-injury. One of the reviewed drills did not meet the requirements of the administrative code and did not reflect a suicide attempt or serious self-injury. The drill identified a youth as stating suicidal ideations to a staff and then the staff placing the youth on suicide precautions.

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

The program has a crisis intervention plan detailing the crisis intervention procedures, including notification, alert system, means of referral, self-referral, communication, supervision, documentation, and review. The program's plan was reviewed, approved, signed, and dated by the assistant facility administrator and designated mental health clinician authority in April of 2019.

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

The program has a comprehensive plan to address the completion of crisis assessments. Five youth mental health and substance abuse records were reviewed and only one required the completion of a crisis assessment; however, the program was able to provide two additional applicable records for review. A crisis assessment was completed on the three youth on the day the youth were determined to be in crisis. The reason for the assessment, mental status examination, the degree of danger, initial clinical impressions, supervision recommendation, treatment recommendations, notification to parent/guardian, and alerts were addressed in each crisis assessment. Two of the youth were placed on constant supervision because of the crisis assessment and all procedures were followed. All three crisis assessments were completed by a licensed clinician or were signed and approved by a licensed clinician. There was documentation in all applicable records the crisis assessment recommendations were discussed with the assistant facility administrator.

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

The program has a comprehensive emergency mental health and substance abuse services plan. The plan details the program's emergency mental health and substance abuse procedures and includes immediate staff response, notifications, communication, supervision, authorization

to transport for emergency mental health or substance abuse services under Ch. 394 FS (Baker Act), and transportation, documentation, training, and review process under Ch. 397 (Marchman Act), and documentation, training (including mock drills) and reviews, in accordance with Florida Administrative Rule 63N-1, F.A.C. The program's plan was reviewed, approved, and signed by the assistant facility administrator and the designated mental health clinician authority (DMHCA) in April of 2019.

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 medical doctor to serve as the designated health authority (DHA). The DHA is a medical doctor with a specialty is internal medicine and experience in adolescent health. The DHA's license is clear and active in the State of Florida and expires on January 31, 2021. The program does not use the services of a physician's assistant, or an advanced practiced registered nurse for medical services. The provider employs a medical doctor who is available as a back-up if needed. The program's doctor has a clear and active license in the State of Florida which expires January 31, 2021. It was verified, through weekly physician clinic lists for the last six months, the DHA was on-site weekly, every Monday, for a minimum of two hours, with no exception.

An interview with the DHA validated they are on-site once a week to complete initial intake physical exams, periodic evaluations and referrals to specialists, as necessary. The DHA confirmed notification of each youth's admission by telephone or in person when they are on-site. The DHA indicated the provider's licensed medical director would provide back-up services as needed and confirmed being available twenty-four hours a day, seven days a week for emergency care and consultation; and is available by mobile phone and through their answering service.

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 facility operating policy and procedures (FOPs) validated the assistant facility administrator (AFA) signed all policies on October 18, 2019. The newly appointed facility administrator (shared between the program and Tampa Residential Facility) signed the policies March 11, 2020. Each of the health care FOPs were signed by the designated health authority (DHA) June 19, 2019. Several FOPs were updated after June 20, 2019 and each policy was signed by the FA and DHA. The FOPs outline the program's provision of health care and psychopharmacological services. The DHA and the AFA approved and signed the nursing protocols on July 2, 2019 and October 18, 2019, respectively. The protocols are written and authorized by the DHA and are not delegated to any other person. The nursing staff, including visiting nursing staff, completed an annual review of all policies and protocols after June 19, 2019, which was documented on a signature page. 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 June 19, 2019. Newly hired medical staff are required to participate in on-the-job training and orientation with the use of a comprehensive training plan. The program has hired one RN since the program's population transition and documentation reveals the RN received a comprehensive orientation to the Department's health care policies and procedures. All training was provided by a registered nurse. In an interview, the DHA did not mention their involvement with policy and protocol development; and the DHA comes to the program on Mondays and was not available for a follow-up interview by a review team member.

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.	

Five youth medical records were reviewed for valid Authority for Evaluation and Treatment (AET) forms. Three of the five youth were eighteen years of age or older; therefore, only two records were applicable. The program provided a third, applicable record for review. A review of the three applicable records revealed each record contained a valid AET form and all were copies, with the word "copy" stamped on each. An interview with the health services administrator, indicated they review all projected intakes in the Department's Juvenile Justice Information System to validate the youth's AET form. If a new AET form is required before admission, the case management department will contact the juvenile probation officer to obtain a valid AET form.

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

The program has a policy and procedures in place to address parental notification when there is a significant change in the youth's condition and to obtain consent when new medications and treatments are provided to the youth. A review of five youth medical records revealed two were applicable for parental consent/notification. Three of the five youth were eighteen years of age or older. The program provided a third, applicable record for review. None of the youth were involved with the Department of Children and Families (DCF). All records contained the appropriate Department forms mailed to the parent/guardian regardless of verbal consent with no exception.

Each of the applicable records contained documentation of parental notification for over-the-counter medication beyond those covered by the Authorization for Evaluation and Treatment form. One youth had a chronic condition; in addition to changes in their chronic condition they also had significant changes to their existing medication (non-psychotropic), and discontinuation of a medication prescribed prior to entering the program. For each instance, the youth's record had documented parental consent and/or notification. Two of the three youth had a psychotropic medication prescribed, changed or discontinued post admission and verbal consent was obtained by the parent/guardian in each instance. Each verbal consent was witnessed by another nurse or program staff. In each record, written notification, along with copy of page three of the Clinical Psychotropic Progress Note (CPPN), was mailed out to the parent/guardian. None of the youth required off-site emergency care, hospitalization or invasive procedures. Each of the youth's records contained a copy of their immunization records obtained through the Florida Shots system. None of the youth required additional vaccinations. If a youth is exempt from immunizations the program requires parents/guardians to provide the appropriate form from the Department of Health. An interview with the nursing staff confirmed the program's practice and validated their attempts to get verbal consent from parents prior to sending out a written consent through the mail. Verbal consents are obtained as soon as possible after an order is written by a physician and written notification to parents/guardians is mailed out within twenty-four hours. If a youth has an illness or injury which requires emergency medical services all attempts are made to verbally contact the parent/guardian prior to the youth leaving the program and a call is made upon the youths return with results of the emergency visit.

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

The program has a policy and procedures to ensure youth receive routine health care screenings upon admission and readmission. The procedures indicated all youth see the nurse immediately upon admission or readmission when the youth has been out of the physical custody of the program. Five youth medical records were reviewed, and each record contained a completed Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN) on the day of admission. The program was unable to provide the review team with any additional youth records where the youth's physical custody had changed and a re-screening with the FEPHS was necessary.

An interview with the health services administrator indicates if a RN is not on-duty at the time a youth is admitted or readmitted, a non-licensed staff individual will complete the FEPHS and a licensed professional would review it within twenty-four hours. There were no examples of a FEPHS forms completed by direct care staff available for review.

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

The program has a policy and procedures in place regarding youth orientation to health care services. The program's procedures indicate all youth admitted shall be provided with an orientation to health care services within twenty-four hours of admission. The nursing staff are responsible for providing orientation to each youth in writing and during an individual session. A review of five youth medical records validated each youth received an orientation to health care services at the program on the day of admission. The health care orientation form was signed by both the registered nurse (RN) and youth on the day of the admission. All required health care topics were included on the orientation form. The review confirmed each youth's health education form was used to document the required topics during orientation. A review of the program's health care contacts validated their accuracy.

4.07 Designated Health Authority (DHA)/Designee Admission Notification	Satisfactory Compliance
A referral to the facility's Physician, PA, or ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.	

The program's policy and procedures indicate the designated health authority (DHA) is informed on the admission day of all youth regardless of any medical conditions and are to be seen the next time the DHA is on-site. A review of five youth medical records validated all youth were admitted with a chronic or suspected chronic condition and the DHA was notified electronically and by telephone upon admission. Notification to the psychiatrist was made for each applicable record. Nursing staff documented the DHA/psychiatrist notification on the admission nursing chronological/notification progress note in each record. The progress notes also documented the youth's medication, chronic conditions, and date and time of contact to the DHA and/or psychiatrist. None of the youth required emergency care during the admission process.

An interview with the health services administrator indicated for youth admitted to the program the DHA is notified by telephone or verbally, if on-site. The DHA is informed of the youth's history and chronic conditions once the initial nursing assessments and records review are complete. Practice reveals the DHA is notified of each youth's admission regardless of the youth's history or current health status. Additionally, if a youth has a chronic condition the youth will be placed on the weekly chronic list to see the DHA.

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

Five youth medical records were reviewed, and each record contained a new Health-Related History (HRH) form completed for each youth on the day of admission. The program uses the most recent Department's HRH form and each form was completed by a registered nurse (RN). The designated health authority (DHA) reviewed each of the HRH forms and documented the review on each of the youth's Comprehensive Physical Assessment (CPA). The director of nursing verified the process in their interview and stated the nurse completes the HRH form during the initial nursing assessment on the youth's day of admission and when any new or significant medical event or changes occurs.

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

Five youth medical records were reviewed and each of the records contained a Comprehensive Physical Assessment (CPA) completed within seven calendar days of the youth's admission by the designated health authority (DHA). The program uses the Department's standardized CPA form. All fields on the reviewed CPAs were completed by the DHA and included but not limited to the medical grade, body mass index, visual acuity field, tanner stage, scalp/head, cardiovascular, and the most recent tuberculosis skin test (TST). None of the youth presented with symptoms suggestive of active tuberculosis. None of the CPAs indicated the youth refused examination; however, in each of the records the two parts of the examination not completed had documentation to show they were deferred by the clinician. All sections of the CPA were completed in full, with two exceptions, utilizing an "O" with not applicable with an "X." Two sections of the CPA were not completed; however, the DHA documented these areas were deferred by the clinician because assessment did not indicate the need for examination. Reviewed records validated the Department's Problem List was updated for each youth throughout their stay, when necessary. The Infections and Communicable Disease form in each of the five reviewed records documented TST results. An interview with the director of nursing indicated the DHA completes a new CPA on each youth within seven days of admission and annually regardless of medical grade.

4.10 Sexually Transmitted Infection/HIV Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (STIs) and HIV risk factors.	

The program screens each youth for sexually transmitted infections (STI) on the day of admission by using the Department's STI Screening form. Each of the five reviewed youth

medical records contained a STI Screening form completed on the day of admission. Each youth was referred for STI testing. Each record documented the test was ordered and administered on each youth's day of admission in accordance with protocols and physicians' orders. Referrals for all youth were documented on the Department's STI Screening form and on the ICD forms. Test results were documented in each youth's medical record on the Department's Infectious and Communicable Disease (ICD) form. Lab results were filed in the lab results section of each youth's medical record.

The program contracts with Metro Wellness and Community Centers for all Human Immunodeficiency Virus (HIV) infection testing and counseling. The program provided a copy of the Metro Wellness counselor's 500/501 certification issued by the local Department of Health. The certified counselor conducts all testing and pre-test and/or post-test counseling on-site. A review of five youth medical records validated each youth was offered an HIV test. Each youth's record contained a signed HIV Risk Assessment form and the Department's HIV Antibody Test/Youth Consent form. Three of the five youth refused testing. Both remaining youth received pre-test and post-test counseling and each youth's results were in a sealed enveloped marked "confidential" which was placed in the laboratory section of their medical record. Documentation of pre-test and/or post-test counseling was documented on each youth's health education record. None of the youth signed a release for the results to be provided to other individuals nor was there evidence of information being shared. A review of the internal alert list and each applicable youth's problem list verified the youth's HIV status was not listed. An interview with the health services administrator validated the program's practice. Five youth were interviewed, and each indicated they could ask for an HIV test.

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

The program has a policy and procedures to address the provision of sick call. The procedures indicate all youth shall be able to make sick call requests and have their complaints treated appropriately through an established sick call system. Each youth is oriented to the program's sick call process upon admission. Sick call care is provided by a registered nurse (RN), pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The policy requires a referral to the DHA when a youth presents a serious health issue or complains of the same issue three times during a two-week period. Sick call hours are posted outside the clinic door and throughout the program; noting the daily hours of 7:00 a.m. to 9:00 a.m., 1:00 p.m. to 3:00 p.m. and 5:00 p.m. and 7:00 p.m. The program has a RN on-duty, Monday through Sunday from 7:00 a.m. to 11:00 p.m. According to the program's policy and procedures, when there is not a licensed nurse on-site, the shift manager is to review all sick call requests as soon as possible and determine if the sick call requires immediate attention. The health services administrator, the regional health services administrator and the DHA and/or designee are on-call and available for consultation to determine if the sick call requires immediate attention and for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies. Youth can obtain a blank sick call form from a staff member, or from the box outside of the medical clinic.

A review of five youth medical records reflected each youth completed a sick call request form at least once during their stay. Each of the applicable records contained a combined total of thirty-seven sick call request forms. In each instance, the RN documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. Both forms were present in thirty-five of the thirty-seven instances. In two records the electronic form was filed but the handwritten one was not. One of the five youth were applicable for presenting with a similar sick call complaint three or more times within a two-week period. In the instance, the youth was referred to the DHA. None of the youth complained of severe pain with which staff was unfamiliar. Reviewed records indicated all sick call complaints were documented on the sick call index and sick call referral log. All completed sick call request forms are filed in reverse chronological order in the progress note section of the youth's medical record. Room restriction and controlled observation is not utilized at the program as per policy and procedures.

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 they 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). The direct care staff remained just outside the medical door, with the door cracked open. The RN provided the youth an over-the-counter (OTC) medication in accordance with the nursing protocols. The parent was contacted by telephone and advised of the treatment plan prior to administration of the OTC medication. Five staff were interviewed, and they all indicated a nurse conducts sick call. Four of the staff further indicated nursing staff responds to all sick calls. The fifth staff also indicated staff reviews the sick calls to see if it's an emergency prior to submission to the nurse. Five youth were interviewed about how quickly they can see a nurse after making a sick call request. Three youth said they can be seen immediately; the fourth youth indicated they would be seen within one day; and the fifth youth stated they would be seen within three days.

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

The program has a policy and procedures for the provision of episodic and first aid care. Procedures indicated emergency medical and dental care are available twenty-four hours a day. A review of ten staff training records revealed staff are currently certified in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED) training. All licensed health care staff have a current certification in CPR with AED. The program has one AED which was observed, and the instructions and guide were enclosed with the device. The program's AED is stored in a cabinet on the wall, just off the dayroom, and accessible to staff. The AED's green light was blinking and operational upon observation. The battery and pad checks were completed for the AED and found the battery expires in November 2020 and the pads expire in July 2021. The battery was installed in November 2016 and the pads in May 29, 2019. The program has one AED back-up battery which expires July 2020 and pads which expire in November 2020. The program has six first-aid kits one in the administration/reception area, one in the staff duty station, one in each of the two classrooms, one in the kitchen, and one in the assistant facility administrator's office which is used for transports. During the annual compliance review, four sealed first aid kits were opened and all of them were stocked with approved items, none of which were expired. Documentation indicated first aid kits and the AED are inspected weekly by a registered nurse (RN) and documentation was reviewed for the last

six months to validate the practice. All emergency drills and trainings for direct care staff were reviewed for the past eight months and found all drills and trainings were completed, as required. An emergency drill was conducted every month for every shift, and once a quarter, the emergency drill included CPR/AED demonstration. Drills were reviewed at each monthly staff meeting and staff not present during a drill must have the opportunity to review each scenario to understand the process and respond to the specific scenario. Staff had the opportunity to review mock drills during the program's monthly all staff meetings. Emergency numbers are inaccessible to youth and are posted in the administration area's staff information board and in the medical clinic.

A review of five youth medical records validated all youth were seen for a total of thirty-one episodic care incidents. All care was provided by a licensed health care staff. The program had no examples of care provided by non-licensed staff. The health care staff member who rendered care was a RN. The RN completed and documented the episodic care in SOAP (subjective, objective, assessment, and plan) format. All episodic care 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. Only one of the five youth was referred for further off-site care at a dentist. A review of ten staff training records revealed all were trained in the use of an epinephrine auto injector. An emergency drill was conducted monthly on each shift. At least one drill in the last six months included CPR/AED demonstration and the use of an epinephrine auto injector. Five staff were interviewed and indicated they could call 9-1-1 if there was a medical emergency. Five youth were interviewed and questioned if they could see a dentist for tooth pain or see a doctor if they requested, and all youth indicated they could.

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

A review of five youth medical records found three have needed referrals for off-site treatment. None of the youth required off-site emergency care or first-aid. Two of the three applicable youth were over the age of eighteen and none of the youth were in the custody of the Department of Children and Families. One youth required off-site dental care. Each record contained the Department's Summary of Off-Site Care Consultation Report forms, which were reviewed and signed by the designated health authority (DHA) upon the youth's return from off-site care. All records contained documentation of physician orders completed by the DHA upon their review of the discharge paperwork from the off-site visit. Follow-ups, referrals, and additional appointments were tracked and completed, as documented in the youth's medical record when applicable. Parental notification was made in the one applicable case and documented as required. An interview with the health services administrator reported the off-site care documentation is flagged in the youth's medical record and given to the DHA's to review at their weekly visit. Follow-up appointments are tracked through the clinic's internal calendar/tracker.

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

The program has a policy and procedures to provide guidance in the areas of chronic illness monitoring and periodic evaluation timeframe requirements. A review of five youth medical records and Facility Entry Physical Health Screening forms indicated four were identified with a chronic condition. All four youth were classified with a medical grade of two through five and all four were taking prescribed medication on an ongoing basis. None of the youth had a communicable disease. Two of the four youth were undergoing treatment for a physical health condition which included a body mass index greater than thirty. Each of the records documented updating of the Department's Problem List as changes occurred. A review of the four applicable records supported each youth each received periodic evaluations within the required ninety-days and there was no indication of lapses in care or evaluations for any of the youth. In an interview, the health services administrator indicated the designated health authority (DHA) is notified upon each youth's admission, regardless of having a chronic condition. Additionally, all youth with chronic conditions are tracked through the program's internal medical tracker and the chronic conditions tracking log. The assistant facility administrator (AFA) was asked what the programs procedures were regarding health care staff reviewing the important medical issues pertaining to the youth at the program and how often do they meet. The AFA indicated the staff from each department meet daily for their morning management meeting. During these meetings the staff discuss youth medical issues and document the information in the morning meeting database. Additionally, treatment team members, to include medical staff, meet weekly with the psychiatrist for medication management of youth on psychotropic medication.

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

The program maintains a policy and procedures to address medication verification and management. A review of five youth medical records revealed three were admitted into the program on prescribed medications. Upon admission, all three youth were transferred from a detention facility and each of the applicable records contained documentation showing medications were verified in detention. In each record, the nursing admission chronological notes and Facility Entry Physical Health Screenings (FEPHS) form documented the medications for each youth. Each of the records documented the designated health authority (DHA) and psychiatrist, when applicable, were verbally notified by telephone on the day of admission and orders to continue medication were received. Each youth's order was current, valid and documented on a physician's order form. Documentation in all records showed the DHA or psychiatrist resumed the prescribed medication for each youth. There were no instances when a youth's medication had to be returned to the youth's parent/guardian because the youth's medication could not be verified. When applicable, notifications were 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 medications when the youth are admitted to the facility and licensed health care staff are not on-duty. The program may obtain emergency prescriptions from a local pharmacy, when necessary. Reviewed Medication Administration Records (MARs) validated the continuation of each youth's medication.

All five youth medical records were applicable for the youth having a new medication ordered, a change to medications, or a medication discontinued. A review of five medical records found each youth had a MAR outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. All five youth had OTC medications administered which were not listed on the AET. In each instance the medications were administered in accordance with the approved protocols and physician's order.

A review of each of the MARs revealed the program uses the standard MAR provided by the program's pharmacy. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, and medical grade. A current picture of the youth is maintained in a binder with the current MAR so nursing staff can use them daily during med pass and sick call. The MARs clearly indicated medication start and stop dates and nursing staff documented side effect monitoring on each MAR daily. Licensed staff initialed the MAR for each administered medication entry. The medications are maintained in blister packs documenting the number of pills in each prescription order. The youth's MAR and/or individual controlled medication inventory record is updated after each administration and includes the number of pills/doses remaining under the nurse's initials. A review of MARs verified there were no lapses in youth's medication regimen.

The program has a list of staff who are currently authorized and trained to access and assist in the delivery of medications when licensed staff are not on-site. Training documentation provided to the review team revealed all staff were trained by a registered nurse and competency was assessed. None of the reviewed MARs indicated medication had been administered by a non-licensed health care staff. In an interview, the regional health services administrator admitted they have nursing staff on-site for sixteen hours and have not had the need to use trained, non-licensed health care staff to administer medication. All five youth records were applicable for medication/treatment refusals. All refusals were clearly documented on the MAR and on a refusal of treatment/medication form.

Observations of two medication administration by nursing staff during the annual compliance review validated the nursing staff followed procedures and the six rights of medication delivery/administration. One of the two medication administration observations were completed during observation of a sick call encounter. The youth was escorted to the medical clinic by a direct care staff member on both occasions. The youth was required to pull up their sleeves and allow staff to check their mouth after administration of medication. During an interview, the regional health services administrator confirmed the program does not have standing or pro re nata orders for psychotropic medications nor do they have emergency treatment orders for psychotropic medication. Five staff were interviewed regarding the administration of medication at the program and all reported the nurse administer the medications. Two of the five staff also stated a trained staff member could provide medications to youth. Five youth were interviewed and asked who gives them their medication. One youth indicated they do not take medication and four youth stated a nurse administers the medication.

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

The program has a policy and procedures for the inventory and storage of all medications and sharps. The procedures include reporting criteria and procedures for inventory discrepancies. All medications are secured either in a locked medication cart and/or locked cabinets within the locked medical clinic, which is inaccessible to youth. The program contracts with a pharmacy for all medication services. The program maintains a perpetual shift-to-shift inventory for all controlled medications which is outlined in the program's policy and procedures for medication management. All controlled medications are maintained in a locked box within the locked medication cart locked in the medical clinic. All medications are obtained through the pharmacy and are in blister packs documenting the number of pills in each prescription order. Each youth's individual controlled medication inventory record is updated after each administration and inventory is conducted on each shift by either two medical staff or one medical staff and one shift supervisor, or designee.

During an interview with the regional health services administrator, the administrator explained the process for disposal of expired or discontinued medications. Discontinued medications are returned to the pharmacy for credit. Medications returned to the pharmacy are through the contracted pharmacy consultant. Expired medication would be destroyed with the pharmacy consultant during their next scheduled visit to the program. The program uses Rx Destroyer to destroy medication on-site. The program maintains a medication disposal binder for all medications destroyed on-site. No medications have been disposed of during the annual compliance review cycle. The procedures indicate the destruction of all medications on-site will be witnessed and signed off on by two staff. All medications, sharps, and over-the-counter (OTC) medications are counted and/or verified weekly using a perpetually inventory. Syringes and sharps are stored in a locked cabinet within the medical clinic. Observations found all medications were securely stored within a locked cabinet, or medication cart, within the medical clinic. Oral medications are not stored with injectable or topical medications. Syringes and sharps are secured in a locked box within a locked cabinet. The medical department has a secured refrigerator only for the storage of medication. An inventory of three sharps, three OTC medications, one non-controlled substance medication, and one controlled substance medication were conducted with the nursing staff and all counts matched the inventory. A review of the program's perpetual inventories of medications and sharps from the past six months were reviewed. There were no discrepancies noted.

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

The program has an infection control and exposure plan combined into one comprehensive plan. The plan was updated in April 2019. The current assistant facility administrator signed the plan on October 21, 2019 after beginning their assignment at the program. The previous facility

administrator signed the policy on June 18, 2019 and the new facility administrator signed it on March 11, 2020. The designated health authority (DHA) reviewed and signed the plan on June 18, 2019. A review of the plan validated all required elements were included. The plan has procedures in place which includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as required by Occupational Safety and Health Administration (OHSA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan describes the process for needle stick post-exposure evaluation and indicates the employer will establish a separate file for all documents who have experienced an exposure process for needle stick post-exposure evaluation. There were no incidents of needle stick post-exposure within the annual review cycle. Staff have access to Hepatitis B immunizations and protective equipment. A review of ten staff training records verified all staff were trained in exposure control/infection control procedures. A review of five youth medical records confirmed all youth were provided infection and exposure control training to include handwashing, prevention of blood borne pathogens, and prevention of communicable disease within seven days of admission to the program. Training to youth is documented in the youth's medical record and on each youth's Health Education Record form. There were no instances where the local health department, CDC, and/or the central communications center should have been notified for an infectious disease.

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

The program has a policy and procedures written April 1, 2019, to ensure all youth are provided gender-sensitive and trauma-informed primary services, gynecological care and obstetrical services. Five youth medical records were reviewed and none of the youth were applicable for pre-natal care. Additional records were requested from the program; however, at the time of the annual compliance review, the program did not have any pregnant youth residing at the program. Since July 1, 2019, the program had two pregnant youth who have been discharged and one youth who was transferred to another residential program. Upon discharge or transfer from the program, a youth's medical record follows the youth or is sent back to the juvenile probation officer. The only documentation the program could provide were the health education records for two youth and other training agenda/sign-in sheets for a third youth. The reviewed documentation reveals one youth was offered and received a human immunodeficiency virus (HIV) test in addition to pre/post-test counseling. The reviewed documentation also indicates each youth received education on the following topics: alcohol and drug usage, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, and basic baby care. Two of the youth records contained documentation to show they also received education in child/infant development, and parenting skills. Due to each youth's release or transfer from the program none of the remaining requirements of the indicator could be verified. Five youth were asked if they have received prenatal, obstetrical, or gynecological services while in the program and they all indicated they have not needed the services. A review of ten staff training records reveal all staff were trained in female specific health services, which included pregnancy training.

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 policy for supervision is one staff to six youth during the daytime, and one staff to eight youth at nighttime. The program has one living unit and the daily schedule and activity schedules were posted in the living unit. Observations conducted throughout the four day annual compliance review confirmed staff consistently maintained active supervision of youth during daily activities such as school, large muscle activity/recreation activities, groups, line movements, and meals. Staff searched youth before and after all movements. The shift supervisor was observed calling formal head counts throughout the annual compliance review. Program staff were observed adhering to the daily activity schedule and providing active supervision. Youth were also observed engaging in recreational and leisure activities on the recreation yard and in the living unit and staff were observed providing active supervision. Staff were observed within the required ratio of one to six during daytime activities; video observations confirmed the ratio of one to eight during evening sleeping hours. Staff always positioned themselves to closely observe and respond to youth. An interview was conducted with five staff regarding procedures when the youth count cannot be reconciled, and all staff could articulate the program's process for count reconciliation and recounts appropriately.

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

The program has a policy and procedures regarding the behavior management system (BMS) which the program calls the positive performance system (PPS). The recreation therapist maintains the point trackers for all youth. A review of ten staff training records (five pre-service and five in-service staff) reflected all staff were trained on the programs BMS. There have been no changes in the BMS since the last annual compliance review, as there have been no prior reviews of the program since it transitioned from a boys' program to a girls' program July 1, 2019. The program recognizes positive behavior and the consequences of negative behavior with a ratio of four positives to one negative, which was validated by staff interviews along with an interview of the assistant facility administrator (AFA).

Five youth case management records were reviewed, and all records had documentation to support youth received an orientation to the BMS, received a copy of the youth handbook, and discussed the positive and negative consequences for behaviors. The BMS included all required information including how to maintain order and security, promotion and protection of youth

rights, positive and negative consequences, constructive disciplinary actions, positive reinforcement, recognition of accomplishments, socially acceptable means, a process for explaining sanctions, an opportunity for the youth to explain themselves, an opportunity for discussion, reasonable reparations, alternative behaviors, and promotion of positive resolution. The program accomplishes these tasks by having special treatment teams with documentation to reflect the required information above and provided expectations on the PPS. An individual behavior plan is developed, as needed, and the plans are developed around positive behavior in daily activities to minimize separation from the population. Through observations of the physical plant during the annual compliance review, it was evident staff are promoting a positive environment. Staff were observed having active conversations, greeting youth warmly, asking them questions, and verbally deescalating youth when necessary. Five youth were interviewed, and all the youth stated they are offered a variety of incentives and rewards used as positive reinforcement. All interviewed youth stated they received training in the BMS during orientation. Five staff were interviewed about the BMS and all staff were able to discuss the point system, incentives to include outings, special food nights, spa nights, and consequences of the BMS. Four out of five staff confirmed they cannot take things away from youth as a consequence. The fifth staff stated youth could lose privileges or their ability to participate in incentive activities as a consequence.

5.03 Behavior Management System Infractions and System Monitoring	**Failed 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 on the comprehensive and consistent implementation of the behavior management system (BMS) and training for staff on the understanding and implementation of the BMS. The policy covers protocols where staff provide feedback regarding implementation of the BMS. Position descriptions specified the required qualifications of staff whose job functions include implementation of the BMS. All required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The program does not use room restriction as part of the BMS. The BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. An interview with the assistant facility administrator (AFA) indicated the program utilizes a positive performance system (PPS) as the program's BMS. The annual compliance review team reviewed point cards for five youth and found staff consistently failed to complete weekly goals, triggers, or coping skills. AFA and recreation therapist/designee signatures were also left blank on all point cards and frequently staff and youth initials/signatures were missing. Point cards also reflected point boxes and/or totals not being filled out consistently. The AFA stated staff model a four-to-one rewards to consequences and peer support helps to ensure the practice is on-going. Youth can earn points daily and can move up to the next level by earning multiple positive days. Consequences can include a loss of points or a special treatment team. All five

interviewed youth reported they understand the program's BMS. Three youth were informally interviewed and stated they are not notified when they lose points and do not know if they made enough points to "make their day" until the afternoon community circle meeting. Five pre-service and five in-service staff training records were reviewed, and all documented training in the BMS. The program could not provide documentation showing education staff were jointly trained on the utilization of the BMS during school hours, which is required by Florida Administrative Rule 63E-7.103 (2)(9)(d). An interview with an education staff member confirmed education staff have not been trained in the program's BMS.

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

The program has a policy and procedures addressing the supervision of youth. The program currently has forty-seven cameras, and all were operational during the annual compliance review. The video footage is stored for thirty days. Ten-minute check sheets were reviewed for the living unit, as well as video footage for four randomly selected days to ensure compliance with ten-minute checks. All dates and dorms had ten-minute checks completed within the required timeframe, documented in real time, and all staff, except one, took the time to walk room-to-room and look into each room for safety and security. The one staff was observed skipping down the hall and was observed not looking into the youth rooms as they went by. This was addressed with the program, who ensured this issue would be addressed with the staff and additional training would be provided. All video observations coincided with the program's ten-minute accountability sheets. Five staff were interviewed, and all stated checks are conducted every six minutes when a youth is placed in their room while sleeping or for non-punishment reasons.

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

The program has a policy and procedures addressing census, counts, and tracking. Procedures outline at least six formal counts are completed, as well as ongoing informal counts within each

twenty-four-hour period to include emergency counts and running counts. The policy further states all results of counts will be documented in the shift logbook to include time the count was called, location and number of all youth, and time the count was cleared. Counts shall include the reason for the count and running counts to also include noting admissions, discharges and releases, transfers, emergency counts, and youth temporarily away from the program such as court, appointments, hospitalizations, and escape status. A review of six months of logbooks documented counts at the beginning of each shift, after outdoor activities, during movements, and during emergency situations. A review of the logbook confirmed an escape which occurred on October 10, 2019, was entered, as required, and documentation of an emergency count and notification to the Central Communications Center (CCC) was completed. Observations of youth counts confirmed the program follows the policy and procedures by counting the youth at various intervals throughout the twenty-four-hour period and by documenting the counts in the logbooks with the required information.

Five staff were interviewed and asked how and when youth counts are conducted and what happens when there is a discrepancy, including emergency counts. All staff indicated counts are done every hour and as needed, both formal and informal counts. Staff further indicated the supervisor will call the count and if the count has a discrepancy, and the count cannot be cleared, another count is completed. If the discrepancy is not clear, then all movement is stopped, and an emergency count is completed.

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

The program has a policy and procedures addressing logbook entries and reviews. A review of logbooks for the last six months validated all were bound with numbered pages, all entries were made in ink with no erasures or white-out areas, any errors were struck through with a single line, dated and initialed, all entries included the staff name, youth involved, and a brief description of the event which included the name and signature of the staff making the entry. No entries were obliterated or removed. The program's logbooks, which are kept with the shift supervisor, document contraband searches, perimeter checks, security checks, head counts, parking lot checks, youth restrictions, youth security alerts, Prison Rape Elimination Act (PREA) checks, fire drills, transition of youth from one location to another, heat index, medication pass, hygiene, education, emergencies, transports, admissions and releases, anytime law enforcement (LE) needs access to the youth, and escapes. The program had one escape during the annual compliance review period and the incident and subsequent information regarding the escape was noted in the logbook, to include contacting the Central Communications Center, emergency count, and LE contact. The program does not utilize a living unit logbook or shift reports, instead staff review the logbook before every shift and sign when it has been reviewed. A review of the last six months of logbooks validated each oncoming staff member signed the logbook prior to their shift indicating they reviewed the events, incidents, and activities from the last shift. In addition, the supervisor conducts a shift briefing on each shift to discuss the previous shift.

5.07 Key Control	Limited 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 for their key control process which was validated during the annual compliance review. Their policy and procedures included the control, the use of keys, and contained the required elements. Distribution and collection of keys were observed, and all procedures were followed. A review of the inventory revealed inconsistencies between the inventory and the actual key rings in use. Three staff were asked to provide their keys for review and comparison to the key inventory. One of the staff had a permanently assigned key ring. One of the three key rings reviewed contained the correct number of keys and each key matched the inventory. The second set of keys had the correct number of keys; however, one key did not match the key listed on the inventory and program was unable to ascertain what the key opened as it was not listed in the master inventory. The third set of keys contained an extra key on the key set which was determined to open the grievance box. Annual compliance review team members also pulled three random key sets from the key lockbox, of these three sets of keys, two key sets matched the key inventory and contained the correct number of keys. The other key set contained the correct number of keys; however, one key was incorrect in comparison to the inventory. The information was brought to the attention of the assistant facility administrator (AFA) and the program stated the issues would be corrected. The keys are maintained in locked cabinets labeled active keys and restricted keys in the administration office, both cabinets always remain locked. The key slots in the cabinet are color coded to notate who is assigned permanent keys, and which are assigned temporary keys. The cabinet is secure, and staff are not able to obtain any keys while the cabinet is locked. The recreation therapist's key set was lost during the annual compliance review period. The incident was documented in the logbook when the Central Communications Center (CCC) was contacted. The staff member was not disciplined because of the keys being lost; however, the program was re-keyed and replacement keys were issued. The program has a policy and procedures regarding the reporting and replacement of damaged keys and the practice was validated through review of broken key reports.

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

5.08 Contraband Procedure	Satisfactory Compliance
The program's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

The program has a policy and procedures addressing control of contraband, unauthorized items, and illegal contraband which are conducted through searches of the physical plant, facility grounds, and youth. The procedures clearly define items and materials considered contraband when found in the possession of youth and includes the consequences if youth are found to be in possession of contraband; the information is also listed in the youth handbook. The contraband list includes sharps which includes any item used to facilitate an escape, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. Policy and procedures also addressed consequences for any staff who is found in possession of contraband in the program and are subject to disciplinary action up to and including dismissal. Also included in the policy is law enforcement involvement if illegal items or unlawful activity are discovered.

The program practices search procedures to control contraband entering the facility by searching youth at the time of admission, after weekend visitation, return from home passes/visits, and upon reasonable suspicion a youth may be concealing contraband. The program documents confiscation and disposition of any contraband and contacts law enforcement if any item found would be considered illegal or evidence of unlawful activity. The assistant facility administrator shall determine the method of disposition of contraband and unauthorized items which are not illegal. Such contraband or unauthorized items may be discarded, returned to the original owner, mailed to the youth's home or stored and returned to the youth upon their release. A review of five youth case management records validated searches were conducted as outlined in the program's policy. The facility logbooks, incident reports, and search reports were reviewed and confirmed searches are being conducted at least weekly, if not more often, and the findings are recorded in the logbook and the room search binder.

The assistant facility administrator was interviewed and validated how the discovery of contraband and illegal contraband is handled and disposed of by confirming the contraband which is not illegal is confiscated by staff, documented, and disposed of in an appropriate manner. Illegal contraband is turned over to local law enforcement authorities and a criminal

report filed. All contraband is stored in the evidence box in the assistant facility administrator's office until it is turned over to law enforcement or properly disposed of.

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

The program has a policy and procedures regarding searches and full body searches. During the annual compliance review, the annual compliance review team was unable to observe any transports or admissions as there were none scheduled during the week of the review. The annual compliance review team observed classroom transitions and transitions to and from recreation, meals, classrooms, the living unit, and group treatment meetings and all youth were searched as required by the Protective Action Response (PAR) training manual, and the required ratio of staff-to-youth was observed. The searches were observed to be a normal practice for the youth and were conducted by a staff member of the same gender. The youth were treated with dignity and respect when being searched. Five staff and five youth were interviewed, and all confirmed youth are searched every time there is a movement.

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

The program has a policy and procedures on vehicles and maintenance. The program has one van currently operational. The van had an annual inspection completed on March 2, 2020. The program van was able to be observed during the annual compliance review. The van has a safety screen separating the front seat and driver's compartment from the rear passenger's compartment. A review of the van used to transport all youth found the van had operational seat belts, a fire extinguisher, a removable first aid kit, and a seatbelt cutter/window punch. Informal interviews of two staff who provide transports for youth revealed youth are not to be attached to any part of the vehicle by any means other than the seatbelt. The van was observed to be locked when not in use. The inside van door is unable to be opened from the inside. A random check of personal vehicles found all vehicles were kept locked when not in use.

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

The program has a policy and procedures addressing the transportation of youth. The policy requires a cell phone or radio to be issued to the transporter, the staff ratio of one staff to five youth must be in place for all transports (two staff are required for five or less youth), and at least one of the staff on the transport must be the same gender as the youth. During the annual compliance review, the annual compliance review team was unable to observe any transports; however, interviews of two staff who provide transportation validated the process. The policy

also includes secure transportation provided for non-secure youth determined to be at greater risk. The policy also states drivers must have a valid driver's license, staff shall not leave youth unsupervised in the vehicle, and all the procedures together reflect youth are not permitted to drive vehicles. A background check is completed on all new staff to include driver's license checks through the Good Hire report. Driver's licenses are checked monthly by the program's human resources staff through the Florida Department of Motor Vehicles website for all program staff who operate a program vehicle. The program maintains a monthly approved driver list to ensure no one without a valid license transports youth. One staff on the approved driver's list was shown to have an expired driver's license from November 29, 2019 until February 5, 2020. The program was able to provide documentation, as well as a review of the vehicle logbook, reflected the staff member did not transport youth during the period their license was expired. A random check of personal vehicles found all vehicles were kept locked when not in use. Five staff were interviewed, and all stated a cell phone is provided during transports and no staff can transport youth in their personal vehicles.

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

The program has a policy and procedures which addresses who is responsible for conducting weekly security audits and safety inspections, the corrective action process and the internal system for verifying deficiencies are corrected, which meets the Department's Rule. A review of the weekly security audits and safety inspections for the last six months validated one was completed each week, with only two completed one day late. The annual compliance review team was able to verify the corrective actions through a review of work orders and weekly maintenance reports addressing any deficiencies. An interview with the assistant facility administrator (AFA) validated they are involved in the program's process to identify, track, and address any deficiencies captured during the weekly security audits and safety inspections. The AFA further indicated the physical plan manager conducts weekly safety inspections to identify safety and security risks, and the shift supervisor's complete daily perimeters checks to ensure all areas are safe and secure.

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

The program's policy and procedures address the issuance, inventory, and control of equipment and tools. Through observations, it was validated all tools, both class A and B, are secured in the locked maintenance shed and each class A tool is hanging and marked on a shadow board. All tools, both class A and B are inventoried daily, following all work activities, and prior to being issued for work. All previously mentioned inventories were reviewed for the last six months and documented compliance with their procedures. The program has a policy and procedures to address missing or lost tools; however, no tools were missing or lost since the last annual compliance review. The policy indicates, if a tool becomes damaged or dysfunctional, the program follows their procedures to replace the tool. Ten staff records (five pre-service and five in-service), and five youth records were reviewed, and each documented staff and youth were trained on the intended and safe use of tools. Five staff were interviewed, and all indicated youth are permitted to use mops, brooms and scrub brushes.

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

The program's policy and procedures indicate staff-to-youth supervision during the use of tools is one staff to five youth. It further states the program has a process for issuance of tools, assessment of youth, tool distribution, and the search criteria during work projects. A review of five youth records validated all youth received an assessment to determine the youth's risk to self and others prior to the use of tools. Through an interview with the assistant facility administrator, it confirmed the program's process for youth handling and confirmed their knowledge of youth tool handling. Five youth were interviewed and asked what tools they are permitted to use, and they all indicated mops and brooms. Two of the five youth further indicated they are permitted to handle scrub brushes.

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

The program has a policy and procedures addressing the process for outside contractors. The program's form, Written Notification and Guidelines for Outside Contractors, is used to document when contractors arrive on-site with tools, when they leave with the same tools, and any follow up if tools are missing. The policy further documents tool restrictions and indicates youth are not permitted in the work areas. A review of three invoices and the Written Notification and Guidelines for Outside Contractors form for each invoice validated the program followed their procedures during each time an outside contractor was on-site. Each Written Notification and Guidelines for Outside Contractors form was signed by the contractor upon entry into the facility and signed by the contractor again when they exited, as well as by the physical plant manager. Each form documented a review by a program administrator within twenty-four hours. The program's procedures indicate prior written approval from the assistant facility administrator is required for the approval/permission for a contractor to enter the facility with a personal cell phone or electronic devise capable of capturing pictures and/or audio/video recordings.

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

A review of the program's Continuity of Operations Plan (COOP) indicated fire drills and COOP drills are to be conducted each month. The program's drills were reviewed for the last six months. A fire drill was conducted for each shift for the last six months, except for two months on the night shift. In addition, COOP drills, to include: a major disturbance drill, chemical spills, an escape drill, a bomb drill, and a weather drill were conducted on each shift, except for one month during the night shift, during the six-month review period. Each drill documentation captured the type of drill, date and time of the drill, participants, scenario, findings, and recommendations. During the program tour, observations of fire evacuation routes and egress plans were posted throughout the program. In October 2019, an inspection was completed, by a fire and security company, of all program fire extinguishers and each were tested and passed inspection. The assistant facility administrator was interviewed and indicated fire and COOP drills are completed monthly and on each shift. Five staff were interviewed and indicated they

participated in the following drills: weather, major disturbance, terrorist situation, chemical spills, flooding, escape, fire, medical, and suicide. Five youth were interviewed, and all indicated they have been instructed on what to do in case of a fire. Each of the five youth indicated they do participate in fire drills.

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

The program maintains a Continuity of Operations Plan (COOP), which was reviewed and updated on October 21, 2019. The program's COOP is posted in the assistant facility administrator's office. The plan addresses alternative housing which was sent to and approved by the Department's residential regional director. The COOP is combined with the program's disaster plan. The required COOP equipment is distributed by a contracted provider if needed, as well as by an alternative program-site, Tampa Residential Facility. The COOP contains all the required elements, in addition to updated and approved annexes. The program maintains a youth emergency shadow record for each active youth in a binder which documents all the required elements for each youth, and the binder is maintained by case management. When the assistant facility administrator was asked where the COOP is posted, they indicated it was kept in their office and readily available to staff and signs are posted throughout the facility notifying staff where the COOP is located.

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

A review of the program's policy and procedures validated the program follows their policy regarding storage and inventory of flammable, poisonous, and toxic items and materials. All flammable, poisonous, and toxic items are maintained in a locked storage building or in a locked closet in a locked cabinet in the administration area of the program, which is always secure and inaccessible to youth. A review of the inventory of such items and the actual items on-site validated the inventory matched. On the door of the storage building cabinet the program maintains a list of authorized staff, along with their positions and titles, who have access and can handle such items. Each of the reviewed items had a safety data sheet.

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

A review of the program's policy and procedures indicated the program maintains strict control of all flammable, poisonous, and toxic items and further indicates youth do not handle or dispose of any such items. All flammable, poisonous, and toxic items are maintained in a locked storage building or in a locked closet in a locked cabinet in the administration area of the program, which is always secure and inaccessible to youth. On one occasion during the annual compliance review, youth were observed cleaning in the cafeteria, and were never observed handling any flammable, poisonous, and/or toxic items. The program conducts preventative maintenance and documents their findings on the program's preventive maintenance checklist. The assistant facility administrator ensures these items are scheduled and repaired, to meet the Department's Rule. Five youth were interviewed and three indicated they do not handle any type of cleaning products or chemicals; one indicated they can put laundry soap in the washing machine with staff supervision; and one indicated they are allowed to use paint for arts and crafts.

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

The program has a policy and procedures in place for the control of hazardous materials. The policy states the physical plant manager is responsible for disposal of hazardous materials. The procedures also indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed of on-site, according to safety data sheet (SDS) requirements, and the disposal is to be documented on the applicable disposal form. A review of the physical plant manager's training plan shows they were trained in flammable, poisonous, toxic control. Items are stored in a room inaccessible to youth. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA) standards. During the annual compliance review, there were no materials disposed of and the program has not had any materials to dispose of during the annual compliance review. The program does not keep any hazardous materials at the facility. An interview with assistant facility administrator confirmed the program would follow Occupational Safety and Health Administration (OSHA) guidelines for all disposal of waste, log any waste disposal, and would bring waste to the proper waste disposal provider agency.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a policy and procedures addressing visitation and communication for youth and their families. The information is also provided to the youth and parent/guardian at orientation and is in the youth handbook. The policy further states the program will make alternative arrangements for visitation during not traditional hours, if necessary. The program's visitation schedule is posted throughout the facility, which is listed on the program's facility schedule. The program conducts visitation every Saturday and Sunday.

The visitation log was reviewed and revealed no visitation occurred from July to September 2019. The issue was identified during the start-up monitoring and was corrected. Since September 2019, visitation has occurred weekly. Visitation documentation supported a family day took place during the annual compliance review period. A review of five youth records

validated each youth had an approved phone, mail and visitation list. All phone calls, incoming and outgoing mail are documented on each youth's list. A review of each of these forms for each youth validated all were able to communicate with their families by phone, mail and visitation. A member of the annual compliance review team was unable to observe the program's case manager review incoming mail with a youth as no mail arrived at the facility during the annual compliance review. An informal interview was conducted with the lead case manager about the practice of the handling of incoming and outgoing mail. The lead case manager validated the program is following policy and procedures concerning incoming mail and the whole process is monitored by case management staff. Five youth were interviewed, and all indicated they have been given the opportunity to communicate with family members by mail, telephone, and at visitation.

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

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

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

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

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

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

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

The program has created a safety plan to utilize for youth which includes warning signs, youth's baseline behavior, crisis recognition, jointly developed coping strategies, interventions strategies, and debriefing preferences. Five youth records were reviewed to validate the program's safety planning process. All five reviewed safety plans were completed within fourteen days of admission. All five initial safety plans documented the joint preparation with the youth, youth's therapist, case manager, a living unit representative, and program administrator; however, plans did not document participation or collateral information from the parent/guardian for the two applicable youth under the age of eighteen. The assistant facility administrator indicated the parents/guardians were contacted by phone by the case manager on the day of

admission and the information verbally given to the therapist creating the safety plan; however, there was no documentation to verify the practice or contact was made.

During the debriefing process, the program acknowledged they were unaware they were supposed to be completing reviews of safety plans every thirty days prior to an internal audit completed in December 2019, and the annual compliance review team was able to verify all five youth in the sample had reviews completed every thirty days since December 2019. Each plan documented the review and incorporation of previous screenings and assessments, as well as, incorporated trauma responsive practices. Safety plans, after the initial plan was completed, were completed in conjunction with the treatment team meetings. Safety plans are kept in the staff duty station for staff to review. Five staff were interviewed but none were unable to articulate the process of reviewing safety plans. Four out of five staff stated safety plans are in the staff duty station and one staff indicated safety plans were kept in the assistant facility administrator's office. Five youth were interviewed, and each indicated they participated in the development of their safety plan.