STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Marion Youth Academy

Sequel TSI of Florida, LLC
(Contract Provider)
10420 NW Gainesville Road
Ocala, Florida 34482

Review Date(s): February 25 -28, 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:

Jennifer Schad, Office of Program Accountability, Lead Reviewer (Standard 1)
Renette Crosby, Office of Program Accountability, Regional Monitor (Standard 1)
Shirley Edmond, DJJ Detention Services, Assistant Detention Superintendent (Standard 5)
LeAnn Gruentzel, DJJ Probation, Juvenile Probation Officer Supervisor (Standard 2, 5, and Interviews)
Amy Hutto, Office of Program Accountability, Regional Monitor (Standard 3)
Cindy Jones, Office of Education, Regional Education Coordinator (Standard 2)
Jim Lightbody, DJJ Probation, Juvenile Probation Officer Supervisor (Standard 2)
Donna Stanton, TrueCore Behavioral, Health Services Administrator (Standard 4)

Program Name: Marion Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Marion County / Circuit 5
Review Date(s): February 25-28, 2020

MQI Program Code: 1205
Contract Number: 10321
Number of Beds: 48
Lead Reviewer Code: 143

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Marion Youth Academy is a forty-eight bed program, for fourteen to eighteen-year-old males, located in Ocala, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides mental health overlay services and substance abuse treatment overlay services. In addition, the program fosters each youth by providing Thinking for Change, Impact of Crime, Living in Balance, Life Skills Training, Young Men's Work, Anger Management, Passport, and Skillstreaming, and EQUIP. Additional treatment services provided includes family and individual therapy. Program administration is comprised of an executive director, assistant facility administrator, maintenance supervisor, clinical director, registered nurse manager, business manager, kitchen manager, and administrative assistant. Case management services are provided by a case management supervisor, three case managers, and two transition specialists. Mental health staff at the program includes the program's designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC), four master's-level therapists, and a recreational therapist. Medical services are offered from 7:00 a.m. to 6:00 p.m., seven days a week. Medical services are provided by a licensed medical doctor who serves as the program's designated health authority, two full-time registered nurses, one of which is the director of nursing. A copy of all licenses for clinical staff were reviewed and verified to be clear and active in the State of Florida. Expiration dates of both nurses are April 30, 2021 and April 30, 2022, respectively. Educational services are provided by the Marion County School System. The layout of the program includes: one building which houses administration in the front and divides into two wings of youth dormitories which are identified as phase one and phase two. Medical, case management, education, and mental health are also housed in the building. The program has forty-eight operating security cameras providing coverage. At the time of the annual compliance review, the program had three vacant positions, all youth care workers.

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 regarding initial background screening. Nineteen staff were hired since the last annual compliance review, requiring a clearance from the Department's Background Screening Unit (BSU) prior to hiring. All nineteen staff received an eligible background screening prior to their hire date. Each staff's criminal history report was reviewed. There is no documentation which indicates the Department's Staff Verification System (SVS) is consistently reviewed prior to hiring staff. Fifteen staff were direct care applicants and applicable for pre-employment assessment testing. Ten staff did not have a passing score per the assessment tool. The program's facility operating policy (FOP) states the staff should have a passing score. The program's administration stated because the scores were close to passing, it is an administrative decision to go forward with hiring the staff. The FOP was changed to reflect the program's current practice during the annual compliance review and include staff hired below the seventy percent threshold will receive additional training during pre-service training. All program staff had been added to the clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards for the program was completed December 6, 2019. The Annual Affidavit of Compliance with Level 2 Screening Standards for the local school system providing education was completed January 10, 2020.

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

The program has a policy and procedures for completing five-year rescreenings. No staff were eligible for a five-year background rescreening during the annual compliance review period.

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 regarding the provision of an abuse-free environment. The policy states all youth have unimpeded access to the Florida Abuse Hotline or the Central Communications Center (CCC) to self-report alleged abuse. When a youth states his desire to call, the supervisor is notified, takes the youth to a phone, and dials the number for the youth. If the call is accepted, the supervisor will obtain the case number and operator name. A review of personnel records confirmed staff sign for an employee handbook which includes the code of conduct for the program. The Florida Abuse Hotline and CCC numbers are posted throughout the facility. The program has completed a Trauma Responsive and Caring Environment (TRACE) self-assessment. There were four incidents related to physical, psychological, or emotional abuse since the last annual compliance review. One of the incidents was substantiated for improper use of force. The staff received retraining. The other allegations were not substantiated. Seven youth were interviewed. All seven youth reported feeling safe at the program and they have never been stopped from call the Florida Abuse Hotline. Four youth stated staff are respectful when talking with youth, one youth stated some of them, and two youth stated the staff are not respectful. Three youth stated they have never heard staff use curse words when speaking to youth, three youth stated occasionally, and one stated once. Seven staff were interviewed. Six staff stated when a youth requests to call the Florida Abuse Hotline or the CCC, they notify the supervisor and allow youth to make the call. All seven were able to explain the process when a youth wants to call the Florida Abuse Hotline. All seven staff stated they had never observed a coworker tell a youth they could not call the Florida Abuse Hotline. Six staff stated they have never observed staff using profanity when speaking to youth. An interview with the executive director confirmed the program's procedures and practices for ensuring an abuse free environment.

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 regarding the provision of an abuse-free environment. There were four incidents related to physical, psychological, or emotional abuse since the last annual compliance review. One of the incidents was substantiated for improper use of force. The staff received retraining. The other allegations were not substantiated. For any reported incident, the program immediately removes staff from youth contact, as required. There were no incidents found to not have been reported. An interview with the executive director confirmed the program's procedures for responding to allegations.

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

The program has a policy and procedures regarding incident reporting and the Central Communications Center (CCC). The program had twenty-one incidents reported to the CCC during the last six months, an increase from the previous annual compliance review period. Five incidents were reviewed. All five incidents were reported to the CCC within two hours of the incident or the program becoming aware of the incident. All five incidents were documented in the master log book. During the annual compliance review, there was no evidence of incidents not being reported to the CCC. An interview with the executive director indicated all incidents reported to the CCC are discussed during the daily management team meeting.

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

The program has a policy and procedures regarding Protective Action Response (PAR). The program has had six PAR incidents within the last six months. Five PAR reports were reviewed. All five reports were completed by the end of the staff member's workday. All five reports included the statements of all staff involved, included a review by a PAR certified instructor/supervisory staff, and had a post-PAR interview with the youth conducted within thirty minutes after the incident. One incident had statements which were not documented on the correct form. The incident had three statements on the other pertinent information form and one of the statements was on the witness statement form. None of the incidents included the use of mechanical restraints. One of the incidents had a PAR Medical Review conducted based on the post-PAR interview with the youth. The youth was sent off-site for medical attention. All five reports had a review of the PAR incident by the executive director or designee within seventy-two hours of the incident. A summary of PAR incidents were submitted to the Department monthly. The program has a PAR plan approved by the Department on February 17, 2020. The

program's PAR rate during the annual compliance review period was .86, which is below the statewide Residential PAR rate of 2.41. An interview with the executive director indicated PAR reports are reviewed at the daily management team meeting to ensure all procedures were followed and to track trends identified.

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 regarding pre-service training and certification. Seven staff training records were reviewed for pre-service training. All seven records indicated staff had been certified within the first 180 days of hire. All seven staff had completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training prior to any contact with youth. There was no documentation the staff completed active shooter training. Other required job-specific trainings completed included youth supervision and safety and security. Pre-service training hours ranged from 149 hours to 225 hours, exceeding the required 120 hours of training. All seven records had the training documented in the Department's Learning Management System (SkillPro). All instructors are qualified to deliver the training provided. The program submitted a written pre-service training plan to the Department's Staff Development, signed by the Department on January 13, 2020.

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 for annual in-service training. Seven staff training records were reviewed for in-service training. All seven staff had completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) update, ethics, six hours of suicide prevention, and active shooter training. Other required job-specific trainings completed included tool management, safety and security, and supervision of youth. All seven records had the training documented in the Department's Learning Management System (SkillPro). In-service training hours ranged from ninety-nine hours to 174 hours, exceeding the required twenty-four hours of training. Three supervisory training records were reviewed. Each of the three supervisory staff had seventeen hours of supervisory training. Supervisory training topics included management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All instructors are qualified to deliver the training provided. The program submitted a written in-service training plan to the Department's Office of Staff Development and Training, signed by the Department on January 13, 2020. The center has an annual training calendar which is adjusted, as needed.

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 regarding the grievance process. Seven pre-service and seven in-service staff training records were reviewed and reflected each staff received training on the grievance process. The program's grievance process includes times frames and informal, formal, and appeal phases. The program maintains a grievance binder which contains copies of grievances files for the past twelve months. Six grievances were reviewed. Three were related to not receiving canteen, one was about not obtaining points, one was about not being promoted to the next level, and one was asking about going on a home visit. Three of the grievances were resolved at the informal phase. The remaining three were resolved at the formal phase, one on the same day, and the other two grievances three days later, within the required timeframe. Seven youth were interviewed. All seven youth described an understanding of the grievance process and stated they can ask for assistance, if needed, when filling out a grievance form. Seven staff were interviewed. All seven stated the forms are located throughout the program, one staff stated youth can request assistance in completing form, six stated supervisors review the forms, and one stated the executive director reviews the forms. None of the staff described the three phases or the timeframes; however, all stated the grievances are reviewed by either supervisor or the assistant facility administrator who then speaks with the youth. An interview with the executive director confirmed the youth have access to the grievance forms and an understanding of the three phases.

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

The program utilizes Thinking for Change, Impact of Crime, Living in Balance, Life Skills Training, Young Men's Work, Anger Management, Passport, Skillstreaming, and EQUIP for intervention services. There are eight staff trained to facilitate the interventions. All the therapists have a master's-level education. The staff facilitating groups have at least the required number of years of experience working with adult or juvenile offenders. The staff's education and work experience are considered by the program when determining staff delivery of delinquency intervention services. The program is providing the required services based on their contract. The program's interventions are evidence-based, promising practices, or a practices with demonstrated effectiveness according to the Delinquency Intervention Sourcebook. The program's activity schedule provides structured, planned programming or activities at least sixty percent of the youth's awake hours. A review of the sign-in sheets show the groups were delivered, as designed. All staff are facilitating the evidence-based interventions are trained in the service to be provided. Three youth case management records were reviewed. There was documentation all seven youth are receiving a delinquency intervention which is evidence-based, a promising practice, or a practice with demonstrated effectiveness. An interview with the executive director confirmed the staff member's education

and work experience are considered when determining which staff will deliver life skills training or groups. Seven youth were interviewed and all seven stated they are participating in groups. All seven youth were able to list the different groups they participate in such as mental health and substance abuse groups as well as skills they have learned in the groups. All seven youth stated they are able to practice the skills they are learning in the groups.

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 utilizes Skillstreaming, Lifeskills, and Living in Balance as their life skills interventions. The youth receive life and social skills interventions which specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. The program provides life skills training by master's-level therapists. The program's policy and procedures were reviewed to determine how the services are provided. The activity schedule shows life skills training is provided to the youth. A review of the group sign-in sheets shows the youth received life skills training as outlined.

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

The program utilizes Impact of Crime (IOC) for their restorative justice service. The program's restorative justice activities are designed to assist youth to accept responsibility for harm they caused by their past criminal actions, teach youth about the impact of crime on victims and their families and their communities, expose youth to victims' perspectives through the victim speakers, and provide opportunities for the youth to plan and participate in reparation activities. There are two staff members trained to provide the IOC curriculum. The program's activity schedule indicates the service is provided. Three youth case management records were reviewed. All three youth had documentation of attending IOC groups.

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

The program provides Young Men's Work as their gender-specific service. This program addresses the needs of the targeted gender group. The service is designed for male youth who meet the common characteristics of the primary population. The program's activity schedule shows Young Men's Work is provided to the youth. The program utilizes the Young Men's Work facilitator's guide as the manual. A review of group sign-in sheets confirmed the groups are being delivered per the activity schedule. Interviews with the clinical director and executive director confirmed the gender specific programming.

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 regarding internal alerts and for alerts entered into the Department's Juvenile Justice Information System (JJIS). Alerts are entered and removed by case managers, medical staff, or clinical staff, as specified by the type of alert. Seven youth records were reviewed. A review of the program's internal alert list and the JJIS alerts found the alerts were consistent, with no exceptions. An interview with the executive director confirmed the program's policy and procedures for entering and removing alerts. Seven staff were interviewed. All seven staff were able to describe several ways alerts are shared with staff to include shift meetings, staff notification, alert boards, and the youth's safety plans.

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 separates the youth record into three individual records. There is one record for case management, one for healthcare, and one for mental health and substance abuse services. Seven youth records were reviewed. Each of the seven records included an individual case management record, an individual healthcare record, and a mental health record. Each record was marked as "confidential." Each individual case management record had the required file tab to include the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each individual case management record contained the sections to include legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Each of the seven individual records are labeled confidential and secured in a locked filing cabinet or locked room. Each filing cabinet is clearly labeled as "confidential."

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

The program has a policy and procedures to promote constructive input by youth. The policy indicates, and the executive director conformed, the program utilizes a youth advisory council which meets at least once a month. The council is selected through the monthly town hall meetings conducted in both phases (dorms). The youth are also able to express their thoughts and feelings through the "Let's Talk" form which they have access throughout the program.

Documentation reflected monthly town hall meetings and youth advisory council meetings were held. Let's Talk forms are located throughout the program and they are kept for up to one year. Seven youth were interviewed regarding the process for youth to provide input about what happened at the program. One youth said he did not know, one youth said to tell someone, but it would not go very far, and one youth just said yes. Two youth said to tell someone, and they will handle it. One youth spoke about the monthly meeting and one youth explained about the forms and then speaking to staff.

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 at least every ninety to 120 days. The program has an established advisory board which solicits active involvement from representatives from law enforcement, the judiciary community, other community partners, business community, school system, and faith community. The program also recruits a representative of the victim services community and a parent/guardian of a previous youth. Documentation indicated the advisory board has met for the past two quarters and the current quarter. Last quarter, there was no documentation of invitation letters sent to the representatives from law enforcement, judiciary community, business community, school system, or a representative of the victim services community; however, representatives were in attendance during the meeting. For the current quarter meeting, there was documentation of invitation letters sent to all members of the advisory board. An interview with the executive director confirmed the advisory board is meeting quarterly and they continue to recruit additional community members.

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

The program has a policy and procedures regarding program planning. The program utilizes youth and parent/guardian surveys. Survey results and results of Department reports are incorporated into the program planning process. The executive director ensures provisions for staffing, including a system of communication to keep staff informed and staff retention planning. The program's practice includes hiring direct care staff as pro re nata (PRN) and placing them in fulltime positions as the positions become vacant. A review of program meetings conducted include daily shift briefings, daily management team meetings, weekly team meetings, and monthly all staff meetings. Seven staff were interviewed. Six staff stated the program has monthly staff meetings, two staff stated there were daily shift meetings, one staff stated weekly meetings, and two staff stated bi-weekly meetings. The interviewed staff stated the meetings were helpful, informative, and discussed relevant program related issues. Five staff stated they are briefed on program information to include compliance reports, youth surveys, and parent/guardian surveys. Three staff stated communication amongst the staff at the program is very good, three staff stated it is good, and one staff stated it is poor. Six staff were able to describe a variety of way to provide input or feedback to the program. One staff stated they did not feel it mattered.

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 for evaluating staff performance. The program's policy is to evaluate staff after ninety-days of employment and then annually thereafter. A review of position descriptions determined they matched performance standards found on the evaluations. Seven staff records were reviewed. Staff are evaluated annually on established performance standards. Seven staff were interviewed regarding how often they receive a formal evaluation on their performance. Two staff stated there are yearly evaluations, two staff stated every six months, one stated monthly, one stated in the first ninety-days, and one stated they had not received an evaluation. An interview with the executive director confirmed the annual performance evaluation process.

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

The program has an activity schedule which reflects a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook confirmed activities occur as scheduled. The program provides activities based on the needs of the youth. Activities include a choice of leisure and recreation options and youth are encouraged to explore their interests. Youth were observed engaged in constructive use of leisure time. Activities for the youth promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program has a recreational therapist who meets the required qualifications according to the program's contract. A review of three youth records confirmed recreational activities are incorporated into the youth's individualized performance plan. The program also has a formal process to promote constructive input by youth through a youth advisory council and Let's Talk forms. Seven youth were interviewed, and all stated physical and leisure activities are provided for at least one hour each day. Youth were able to describe a variety of activities to include sports, card games, video games, television, and inside recreation. Six youth stated they are provided with varying degrees of mental and physical exertion throughout the day; one youth stated no. Seven staff were interviewed and were able to describe a variety of activities available to the youth.

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.	

Seven youth case management records were reviewed. Each record contained documentation to support telephone notifications were made to the youth's parents/guardians within twenty-four hours of the youth's admission. All seven records contained written notification to the youth's parent/guardian within forty-eight hours notifying them of the youth's arrival to the program. Each of the records contained supporting documentation the program provided written notification to the committing court and the juvenile probation officer (JPO) the same day of the youth's admission.

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

Seven youth case management records were reviewed. All seven records contained documentation indicating each youth was provided an orientation to the program which began on the day of admission. The program utilizes an orientation checklist which includes all services available, youth responsibilities, daily schedule, contraband information, hygiene and dress code, emergency procedures, access to the Florida Abuse Hotline and the Central Communications Center (CCC), grievance procedures, availability of and access to medical and mental health services, program's zero tolerance policy regarding sexual misconduct, as well as the information regarding the program's behavior management system. During this meeting, the youth also receives information regarding their room assignment, performance planning process, visitation, correspondence, anticipated length of stay, community access, and the physical design of the program. Each record contained the orientation checklist completed upon the youth's admission and was signed by both the youth and staff. Seven youth were interviewed. All seven youth stated orientation began within twenty-four hours of admission and included program rules, procedures, and schedules. There were no new admissions during the annual compliance review week; therefore, observations of an admission was unable to be made.

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

Seven youth case management records were reviewed. Two youth records were applicable for youth who were over the age of eighteen; therefore, an additional record was requested for review. All three records contained a consent form signed by the youth to release physical or mental health screening, assessment, or treatment information to their parent/guardian.

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

The program has written policy and procedures regarding the initial classification factors, procedures, and reassessments for activities. Seven youth case management records were reviewed. All seven records included an initial classification form which was completed on the date of each youth's admission to the program. The classification form includes the youth's physical characteristics, age and maturity, identified whether the youth has any special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, as well as identifying suspected risk for suicide, escape, security and medical. A new Screening for Vulnerability to Victimization of Sexually Aggressive Behavior (VSAB) Form was completed during the initial classification prior to the youth's room assignment. All seven records contained documentation indicating the youth were classified for purposes of assignment to a living area, sleeping room, group, and case manager. The program has a written policy and procedures requiring risk assessments to be completed prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments possibly used as potential weapons or means of escape and participation in off-campus activity. A review of the seven youth records confirmed a reassessment is completed for increase in privileges or participation in off-campus activities. The program utilizes a color-coded pin and photo board to keep staff updated on the alerts applicable to all youth. An interview with the executive director confirmed the program considers factors such as mental health status, physical health status, cognitive performance, age, and prior victimization when assigning a youth to his 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.	

Seven youth case management records were reviewed. One of the records was applicable for youth with gang affiliation; therefore, two additional records were reviewed. For each youth, a gang alert was entered into the Department's Juvenile Justice Information System (JJIS). The program keeps a separate binder for any youth with a gang designation. This binder contains a copy of the notification to law enforcement, education, and the youth's juvenile probation officer (JPO) for each youth.

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.	

Seven youth case management records were reviewed. One of the records was applicable for youth with gang affiliation; therefore, two additional records were reviewed. Each identified youth participated in intervention strategies through "Gangs 50 plus stories of Fractured Lives" and one of the three records included relevant goals relating to gang intervention strategies on their performance plans. The program also utilizes Impact of Crime as a gang prevention group. The program has a staff member designated as the gang intervention specialist.

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.	

Seven youth case management records were reviewed. Six of the records contained a Residential Assessment for Youth (RAY) completed within thirty days of the youth's admission to the program. One RAY assessment was completed thirty days late. Each of the RAY assessments were appropriately maintained in the Department's Juvenile Justice Information System (JJIS). The seven records were reviewed for a RAY reassessment. Six of the seven records indicated a RAY reassessment completed within ninety days of the initial RAY assessment. One RAY reassessment was ten days late. All reassessments were contained in each youth's 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.	

Seven youth case management records were reviewed. Six of the records contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of the youth's admission to the program. One YNAS assessment was completed thirty-one days late. Each YNAS was maintained in the youth's record and in 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.*	

Seven youth case management records were reviewed. Six of the seven records documented the youth performance plan was developed within thirty days of youth admission to the program. One performance plan was thirty-one days late. All performance plans were completed after the initial assessment with the treatment team leader, youth, administration representative, living unit representative, treatment staff, and education. All seven plans documented signatures by the youth, treatment team leader, and all parties who have significant responsibilities in goal completion. Each of the records documented mailed attempts to have the parent/guardian sign the plan and return it to the program. Each record contained performance plans which included specific delinquency interventions and individualized goals. The performance plan goals contained target dates for completion, youth's responsibility and program's responsibility to enable the youth to complete the goals. Each of the goals identified on the performance plans were individualized and based upon the applicable youth's prioritized needs and reflected the risk and protective factors identified during the initial assessment process, which included the top three criminogenic needs, court ordered sanctions, transition activities targeted for the last sixty days of the youth's anticipated stay and education. There was documentation in six of the seven records which supported the program sent the youth's performance plan to the committing judge, juvenile probation officer (JPO), and parent/guardian within ten working days of the plan being completed. For one record, there was no documentation of the performance plan being sent to the committing judge, JPO, and parent/guardian. All seven records contained documentation to support a copy of the plan was given to the youth. Seven youth were interviewed, and each was able to explain the program's treatment process of the performance plan, treatment team meetings, and goals they are working on. Five youth stated they have a copy of their performance plan. Six youth stated they received a copy of the performance summary sent to the court.

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.	

Seven youth case management records were reviewed for revisions to the performance plans. Performance plans were revised and updated on an as needed basis. All applicable performance plans were revised in response to the youth demonstrating progress towards a goal, based on any new information, transition expectations or if the Residential Assessment for Youth (RAY) reassessment warranted.

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.*	

Seven youth case management records were reviewed. Six of the records documented completion of performance summaries every ninety-days following the signing of the youth's performance plan. One performance summary was completed twelve days late. In each record, the performance summaries included the youth's status on each goal, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interactions with staff and peers, overall behavior adjustment to the program, and significant positive and negative events. Each of the seven records were reviewed for the transmittal of performance summaries. Documentation indicated the youth were permitted to read and add comments to their performance summaries prior to signing and the original summaries were filed in the case management records. Each performance summary was signed and dated by the treatment team leader, the executive director or designee, and the youth. Documentation revealed six of the seven performance summaries were sent within ten-working days of completion to the youth's assigned juvenile probation officer (JPO), parent/guardian, the committing court, and a copy was provided to the youth. For the seventh record, there was no documentation of it being sent.

Four of the seven reviewed youth records were applicable for a release summary sent with the Pre-Release Notification (PRN). All four applicable records contained documentation indicating the original summary had been sent with the PRN to the assigned JPO. Each release summary contained justification for the youth's release from the program and a signed copy was maintained in each youth record. There was documentation in all four records confirming the PRN had been sent at least forty-five days prior to each youth's anticipated release date. Three closed case management records were reviewed and documented, upon the court's approval of the PRN, the program provided written notification to the youth's parent/guardian advising of the youth's anticipated release. Each of the three records had a completed Residential Assessment for Youth (RAY) exit assessment. Seven youth were interviewed. Six of the youth stated they had received copies of their performance summaries.

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.	

Seven youth case management records were reviewed. Each of the seven records contained documentation showing the program's efforts to include each youth's parent/guardian in the case management process, including the initial assessment, development of the performance plan, progress reviews, and formal treatment teams. If unable to attend, the program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting. A treatment team meeting was observed during the annual compliance review where

the parent/guardian participated by telephone. The program encourages family participation by phone calls, written communication, treatment teams, counseling sessions, and quarterly family days. An interview with the executive director confirmed the program's practice of inviting parental participation through phone calls, written communication, and quarterly family days. During family days, case management staff and mental health staff are present and available for parent/guardian interaction. Seven youth were interviewed and all seven stated their parents/guardians participate in their treatment teams.

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.	

Seven youth case management records were reviewed. Each of the seven records included documentation indicating treatment teams were composed of the treatment team leader, youth, administrative representative, treatment staff, educational staff, the youth's parent/guardian, juvenile probation officer (JPO), and a representative from the youth's living unit. There were no youth with Department of Children and Families or Agency for Persons with Disabilities involvement in the program during the annual compliance review period.

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.	

Seven youth case management records were reviewed. A review of each youth's performance plan found the youth's academic plan was referenced, as well as the youth's mental health/substance abuse treatment plan goals, if applicable. None of the seven records reviewed warranted a support plan through the Agency for Persons with Disabilities (APD) or Department of Children and Families (DCF).

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.	

Seven youth case management records were reviewed. All seven records were applicable for formal treatment team reviews and each were held at least every thirty days. The formal treatment team review documentation included the youth's name, date of review, meeting attendees, treatment team member's comments, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance goals, positive and negative behaviors, behaviors which resulted in physical intervention, treatment process, and any applicable Residential Assessment for Youth (RAY) reassessment results. There was documentation in each record to support the youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged through advance notification to participate. Each youth was provided an opportunity during treatment team meetings to demonstrate skills they have learned.

The program conducts informal treatment team meetings on a bi-weekly basis for each youth. All seven records contained documentation to support informal treatment team meetings were conducted as required. The informal treatment team review documentation included the youth's name, date of review, meeting attendees, treatment team member comments, a brief synopsis of the youth's progress in the program, performance plan revisions, positive and negative behaviors, behaviors which resulted in physical interventions, treatment process, and the RAY reassessment results, if applicable.

A formal treatment team was observed during the annual compliance review and found all required treatment team members were present and participated, including the JPO and parent/guardian by telephone. Seven youth were interviewed. All seven youth stated staff review the youth's performance plan goals, positive and negative behavior, and treatment progress. Six youth stated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program.

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

The program has a policy and procedures to provide career education which is appropriate based on age, length of stay, and abilities of the youth. The program provides a Type 2 vocational competency development program, which includes the required vocational training, communication, and inter-personal and decision-making skills. The program provides an option for some youth to participate in the Home Builders Institute (HBI) program offering building construction, as well as a culinary program. An interview with the executive director also indicated cardiopulmonary resuscitation (CPR) and Occupational Safety and Health Administration (OSHA) certifications are offered, as well as the HBI program. Three closed youth case management records were reviewed and included sample applications, resumes, and documentation indicating the juvenile probation officer (JPO) and parents/guardians were aware of the vocational plans.

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

The program has a policy and procedures to provide for educational access. The school schedule was reviewed, and education is integrated into the daily schedule in such a way to ensure the integrity of the required minimum twenty-five hours of instruction weekly. The Marion County School System calendar was also reviewed showing the distribution of 250 days over a twelve-month period. All youth are enrolled in an academic schedule and receive credit, as appropriate. An interview with the lead educator indicated the school schedule is adhered to with little to no interferences. A review of the logbook also showed no interruptions to the daily school schedule. Seven youth were interviewed. Six youth stated there are not a lot of interruptions during educational instruction. One youth indicated the interruptions were due to youth talking during class.

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

The program has a policy and procedures to provide for an educational transition plan. Three closed youth case management records were reviewed and confirmed the program's instructional staff and youth completed an education transition plan for each youth, upon admission, which included services and interventions based on each youth's assessed educational needs and post-release education plans. All records included the provisions necessary for employment, including documentation of the juvenile probation officer (JPO) and parent/guardian being aware of the plans. One youth did not have a state identification card, but it was noted the required documents were not provided by the parents/guardians. The transition specialist stated the local Career Source locations and appointment schedules are discussed during the youth's Community Re-entry Team meetings and are followed-up with upon release by either the JPO or the youth's after care specialist.

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.*	

Seven youth case management records were reviewed for transition planning. Four open youth records were applicable along with three closed youth case management records were reviewed for the transition conference. Each record indicated the transition conferences were completed within the required timeframes, at least sixty days prior to the youth's targeted release dates, and all appropriate parties were notified of the conference in advance. Required parties, to include the youth, parent/guardian, and treatment team leader, were present or provided their input prior to the conference in all records. The youth's parent/guardian and juvenile probation officer (JPO) were invited by letter and email, as well as educational staff and transitional staff. The transition plans included appropriate goals and end dates for the youth's release back into the community. The plan was transmitted to the JPO and an email acknowledgement receipt was filed. Three of the four records were not yet eligible for a Community Re-Entry Team (CRT) meeting. One open record and three closed records documented the youth and case manager participated in the CRT prior to youth's release. Three of records contained invitation of the CRT meetings, one record did not have evidence of an invitation to participate in the CRT.

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

Three closed youth case management records were reviewed for exit portfolios. Each record documented the exit portfolio was discussed and initiated for the youth at the transition conference. There was documentation each youth, upon release, was provided an exit portfolio which contained their education records, resume, sample job application, copies of all certifications earned while in the program, and calendar of upcoming community appointments. Two of the three records contained the youth's social security card and birth certificate, which would be used to to obtain Florida identification cards. In one record, it was documented the birth certificate and social security cards were not sent to the program although they were requested. The exit portfolio was forwarded to the juvenile probation officer (JPO), verified by email; however, it was not documented in the youth's case management record. Additionally, the youth's exit portfolio was verified at the exit conference in each record reviewed.

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

Three closed youth case management records were reviewed for the exit conference. Each record documented the youth, parent/guardian, treatment team leader, education director, juvenile probation officer (JPO), and other pertinent staff essential for the youth's transition back in to the community, participated in the exit conference. The exit conference was conducted after the program notified the JPO of the release and at least fourteen days prior to release. The exit conference included a review of the status of transition activities established at the transition conference and finalized plan for the youth's release. In each record, the date of admission and date of termination documented in the case record correlated with the date in the Department's Juvenile Justice Information System (JJIS). The exit conferences were separate from the 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 who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida which expires on March 31, 2021. The DMHCA is on-site five days a week for a minimum of forty hours each week and is on-call, as needed. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. A copy of the DMHCA's license and position description were reviewed. An interview with the DMHCA indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions. Additionally, she monitors service provision through a review of all clinical documentation related to mental health treatment in the form of progress notes, treatment plans and reviews, and comprehensive assessments to ensure each youth receives daily services. The DMHCA also audits three therapist charts each week.

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 a licensed mental health counselor (LMHC) who serves as the Designated Mental Health Clinician Authority (DMHCA). The LMHC has a clear and active license in the State of Florida. The program also has a contract with a psychiatrist who is on-site bi-weekly, as confirmed through sign in logs for the past six months. The psychiatrist has a clear and active license in the state of Florida, which expires January 31, 2022. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services; certified by the Department of Children and Families, expiring October 25, 2020.

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 designated mental health clinician authority (DMHCA) assures the non-licensed clinical staff working under her supervision are performing services they are qualified to provide based on education, training, and experience. The program has four non-licensed mental health clinical staff providing mental health and substance abuse services in accordance with the current contract. A review of documentation confirmed the DMHCA has provided one hour each week of on-site face-to-face direct supervision to the non-licensed mental health clinical staff for the past six months. The supervision was documented on a form which includes all the information of the Department's Direct Supervision form (MHSA 019). A review of documentation confirmed all four of the non-licensed mental health staff have the appropriate master's-level of education necessary and in accordance with the contract. The staff degrees are the following: Counselor ED Rehabilitation and Mental Health, Master of Science and Counseling and Psychology, Master of Arts in Clinical Mental Health Counseling, and Master of Social Work. Documentation provided reflected two of the non-licensed staff have fully completed the twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Both staff conducted at least five Assessments of Suicide Risk (ASR) supervised by a licensed mental health clinical staff. The remaining two non-licensed therapist were in the process of completing the training and had each completed three ASRs supervised by a licensed mental health clinical staff.

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 regarding mental health and substance abuse admission screening. Seven youth mental health records were reviewed and all seven had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the youth's day of admission. All seven of the MAYSI-2 screenings were completed by trained staff and entered in the Department's Juvenile Justice Information System (JJIS) on the same day. All seven youth records reflected available information was reviewed to include the commitment packet, reports, and records for existing documentation of mental health or substance abuse problems. Six of seven MAYSI-2 screenings were not completed in full; the section reflecting service response was blank. However, the program's policy is to refer all newly admitted youth for a comprehensive mental health and substance abuse evaluation, and the executive director is notified of the referral. All newly admitted youth also receive an Assessment of Suicide Risk (ASR) screening as part of the intake process. Documentation reflected all seven youth received an ASR on their date of admission by a qualified staff member and was placed on standard supervision as a result of the screening. During the intake process, additional screenings are completed which include the Substance Abuse Screening Inventory (SASSI-2) and Beck's Depression Inventory (BDI). The executive director indicated, at intake, each youth is seen by case management, mental health, medical, direct care, and education. The MAYSI-2 is completed by case management staff and is then forwarded to the mental health department.

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

The program has a policy and procedures regarding mental health and substance abuse assessments and evaluations which reflects all youth will be referred for a comprehensive mental health and substance abuse assessment when they are admitted. Seven youth mental health records were reviewed, and each reflected the youth was referred for a new mental health evaluation on the day they were admitted, and the evaluation was completed within thirty calendar days of admission. All seven were completed by a non-licensed mental health clinical staff and were signed by the licensed mental health professional within ten calendar days after the evaluation was conducted. The new evaluations included the following: demographics, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also addressed substance abuse to include: patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse. Each of the seven youth records contained signed consent for substance abuse services. Each record contained the completed forms “Youth Consent for Substance Abuse Treatment” (form MHSA 012), and “Youth Consent for Release of Substance Abuse Treatment Records” (form MHSA 013).

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 regarding mental health and substance abuse treatment. Seven youth mental health records were reviewed and reflected each of the seven youth were assigned to a treatment team upon arrival to the program. The multidisciplinary treatment teams are comprised of the following individuals: the youth, program administration, direct care staff, education, medical staff, mental health staff, and the youth youth’s parent/guardian. Treatment team documentation validated it is comprised of individuals from each of these areas. For the seven youth records reviewed, each youth received individual, group, and family counseling as prescribed by their treatment plan with no exceptions. All seven of the youth have properly executed Authority to Evaluate and Treat (AET), and all seven had a signed Substance Abuse Consent and Release forms. All treatment progress notes were documented on a form containing all the required information as the Department’s Counseling/Therapy Progress Note form (MHSA 018). Group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer youth for substance abuse groups. All staff providing groups are qualified to provide services. Seven staff were interviewed; five indicated direct care staff do not facilitate any mental health or substance abuse groups, one indicated “all do,” and one indicated alcoholics anonymous (AA) drug abuse group. Seven youth were interviewed; five reported they are participating in groups and receiving specialized therapies.

The designated mental health clinician authority indicated the program offers mental health overlay services.

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. Seven youth mental health records were reviewed and all seven had an initial treatment plan developed on their date of admission. The initial mental health and substance abuse treatment plan is documented on a form containing all the required elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). The initial treatment plan was signed by the mental health clinical staff completing the form and was signed by the licensed clinical supervisor within ten days of completion. The plan was also signed by all treatment members who participated in the development of the plan and the youth, and was mailed to the parent/guardian.

Documentation reflected all seven individualized treatment plans were developed for each youth within thirty days of their admission to the program. The individualized treatment plans were developed on a form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form (MHSA 016). Each plan was signed by the non-licensed mental health clinical staff completing the plan and signed by the licensed professional the same day. Each of the plans were signed by all treatment team members who participated in the development of the plan, including the youth. Documentation reflected all seven plans were mailed to the parent/guardian for their signatures. Three of the plans included psychiatric services and were signed by the psychiatrist. Progress notes reflected each of the seven youth received services as stipulated in their treatment plan. All seven youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The program uses a form which includes all the required elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form (MHSA 017) to document treatment plan reviews.

Three youth mental health records were reviewed for discharge plans. All three had a discharge plan documented on the Department's Mental health/Substance Abuse Treatment Discharge Summary form (MHSA 011). None of the youth were a suicide risk upon release. Each of the discharge plans included recommendations of follow-up services for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment. The discharge plans were discussed with the youth, parent/guardian, and juvenile probation officer at the transition and exit conferences. Documentation supported the discharge summary was provided to the youth, juvenile probation officer, and the parent/guardian.

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

The program provides mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS), in accordance with their contract. All youth receive mental health services which include individual and family counseling monthly, and group counseling seven days a week. Daily therapeutic activities are provided by mental health staff. Psychiatric services are provided bi-weekly. Substance abuse groups are provided twice a week and use the Living in Balance curriculum. The program has a licensed mental health professional on-site at least five days a week. There are four therapists who have a maximum caseload of twelve youth. The program provides urinalysis drug testing upon the youth's initial intake. Groups are provided using the following curriculums: Passport, Skillstreaming the Adolescent, Anger Management, and EQUIP. Therapists are on-site seven days a week, including rotating weekends. A review of seven youth mental health records reflected youth are receiving services in accordance with their treatment plans, to include mental health services seven days a week.

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

The program has a contract with a psychiatrist to be on-site bi-weekly to provide services. Seven youth mental health records were reviewed and confirmed each youth received an initial psychiatric evaluation within fourteen days of their admission; regardless of their medication status. The initial diagnostic psychiatric interview included the following: history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM-IV), treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and medication monitoring frequency. The initial diagnostic psychiatric interview was documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as the "initial diagnostic psychiatric interview." Three of the youth reviewed receive psychotropic medication and documentation supports the youth were seen for a medication review by the psychiatrist every thirty days.

The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist meets with the nursing staff bi-weekly to discuss the youth's treatment. A review of sign-in logs for the past six months confirms the psychiatrist was on-site bi-weekly, with no exceptions. A review of mental health records reflected the psychiatrist signs individual treatment plans, treatment team reviews, and amended treatment plans for youth who are prescribed psychotropic medication. An interview with the psychiatrist confirmed his role in the coordination and implementation of psychiatric service at the program is to evaluate and manage medication. An interview with the designated mental health clinician authority (DMHCA) confirmed ongoing consultation with the psychiatrist to review youth behavior and any concerns.

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

The program has a policy and procedures regarding suicide prevention services. The program has a written plan which includes the following elements: identification and assessment of youth at risk of suicide, staff training of six hours annually, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The suicide prevention plan is reviewed annually with the last review taking place February 18, 2020 by the designated mental health clinician authority and the executive director.

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 which reflect all youth receive an Assessment of Suicide Risk (ASR) at intake. Seven youth mental health records were reviewed and each youth received an ASR on their date of admission and as a result was placed on standard supervision. All of the ASRs were completed by a licensed mental health professional. None of the youth were applicable for an alert in the Department's Juvenile Justice Information System (JJIS). If necessary, the program has procedures in place to notify the juvenile probation officer and parent/guardian of a youth's potential suicide risk, as indicated by the ASR.

The program has a suicide response kit which was observed in master control. The executive director has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The multidisciplinary review includes the following: circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by staff involved, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical, or mental health services, and/or operational procedures.

Seven staff were interviewed regarding what direct care staff are responsible for if a youth expresses suicidal thoughts. Four stated staff should notify mental health, one reported search youth and room for sharp objects, four stated constant sight and sound, one reported call a code yellow, and five indicated they would let a supervisor know. Additionally, the seven staff were asked where the suicide response kit was located. Five reported it is located in master control, one reported medical, and one reported in the phase one supply room.

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 precautionary observation logs. The program has not had any youth placed on precautionary observation since the last annual compliance review. The designated mental health clinician authority maintains a log confirming there were no youth on precautionary observation each month.

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

Seven pre-service and seven in-service staff training records were reviewed. Each staff received the required six hours of suicide prevention and implementation of suicide precaution training. Additionally, mock suicide drills were reviewed which reflected drills were held quarterly on each shift for all staff who come in contact with youth. Drill documentation documented each of the reviewed staff participated in quarterly drills, as required. The drills are also reviewed during the all staff meeting for each month a drill is held. Staff utilized the suicide response kit, cardiopulmonary resuscitation (CPR), and the use of calling 9-1-1 in each of the twelve drills reviewed. The automated external defibrillator (AED) was utilized in three drills. Each drill included pictures as confirmation the drill took place.

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

The program has a written crisis intervention plan. This plan includes the following: notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review. The mental health crisis intervention plan is reviewed annually by the designated mental health clinician authority with the last review occurring on February 18, 2020.

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

The program has not had to complete a crisis assessment since the last annual compliance review. The program has a written crisis intervention plan which includes the process for implementation of a crisis assessment form. The program utilizes a form which contains all elements of the Department's Crisis Assessment form (MHSA 023) to document crisis assessments. The program's form includes the reason for the assessment, method of assessment, mental health status, degree of danger youth presents to self or others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notifications.

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 policy and procedures regarding emergency mental health and substance abuse services. This includes a written mental health and substance abuse plan. The plan includes the following elements: immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Baker Act, transport for emergency substance abuse assessment and treatment under Marchman Act, documentation, training, and review. The plan is reviewed annually by the designated mental health clinician authority, with the most recent review occurring February 18, 2020.

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

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

Standard 4: Health Services

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

The program contracts with a designated health authority (DHA) who is a licensed physician with a specialty in internal medicine. The DHA holds a clear and active license which meets the requirements for independent and unsupervised practice in the State of Florida and expires on January 31, 2022. There is no record of discipline or public complaint related to the DHA's license. The DHA is on-site weekly to provide medical care to youth and clinic oversight. Documentation of DHA sign-in logs from the past six months were reviewed and confirm this requirement. The DHA is on-call twenty-four hours a day, seven days a week. The DHA has an agreement with a medical physician to cover any scheduled absences or vacation. The alternate physician has a clear and active license in the State of Florida which expires on January 31, 2022. The DHA is responsible for communication with staff related to the medical needs of youth, on-call availability twenty-four hours a day, seven days a week for all acute medical concerns, emergency care, and coordination of off-site care. The DHA is responsible to review of all medical records, physical assessments, chronic evaluations, follow-up care, and referrals. Interviews with the DHA and nurses along with a review of these practices, confirmed this practice during the review.

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

The designated health authority (DHA) and executive director documented an annual review of all written facility operating procedures (FOP) and treatment protocols, as indicated by a dated signature on January 1, 2020. Approval of treatment protocols were developed and authorized by the DHA. The full-time and pro re nata (PRN) nursing staff reviewed, signed, and dated a cover page for the treatment protocols on January 1, 2020. All FOPs and protocols related to psychiatric services were reviewed and approved by the program's contracted psychiatrist, signed on January 1, 2020. All health-related policies were program specific. All policies, procedures, and protocols appropriately reflected the program's health care services.

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.	

Seven youth individual healthcare records were reviewed. Five of the seven records contained a valid Authority for Evaluation and Treatment (AET) form. Two of the records were for youth over the age of eighteen. There were legible copies of AET forms stamped "copy" and were signed by the parent/guardian and a Department representative in all five applicable records. Parental notifications were filed behind the AET in all youth records.

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.	

Seven youth individual healthcare records were reviewed. Documentation of parental notification for over-the-counter (OTC) medications beyond those on the Authority for Evaluation and Treatment (AET) were present in five of the records. The remaining two records were for youth over the age of eighteen. There were no examples of consent to immunize after admission since the last annual compliance review. In two applicable records, parental notifications were made for an off-site invasive procedure and non-routine dental procedures. In three records, new medication was prescribed and verbal notification was obtained along with written parental notifications. Written notifications are sent regardless of telephone notifications. All telephone notifications were witnessed and documented in the youth's individual healthcare record. Additionally, six of the seven records had written notifications to the parent/guardian when initially seen by the designated health authority (DHA) and the results of each visit. The remaining youth was eighteen years old at admission.

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.	

Seven youth individual healthcare records were reviewed. All seven records contained the Department's Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN) on the day of admission. None of the records were applicable for a healthcare admission rescreening. Three additional youth records were requested and reviewed for admission rescreening after a change in physical custody. Two youth had a change in physical custody three times and one youth had a change in physical custody twice. A healthcare admission rescreening form was completed upon return to the facility in each case. The FEPHS form was completed by a registered nurse for all rescreenings.

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.	

Seven youth individual healthcare records were reviewed. Each record documented a general health care orientation completed on the day of admission. The healthcare orientation topics included how to access sick call, what constitutes an emergency, how medications are administered, when to notify staff of medication side effects, allergies, medical issues, chest pain, extreme shortness of breath, faintness while exercising, the right to refuse care, what to do in the case of a sexual assault, the non-disciplinary role of the health care provider, and situations in which the healthcare staff shall notify security and/or the program director. Additionally, youth with chronic conditions were provided healthcare education on their specific conditions.

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.	

Seven youth individual healthcare records were reviewed. In six applicable records, the designated health authority (DHA) was notified for youth with a known or suspected chronic condition. None of the seven youth required emergency treatment upon admission. The DHA was notified through fax/phone at the time of the youth's admission, which was documented on each intake admission progress note along with a copy of the fax confirmation sheet.

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.	

Seven youth individual healthcare records were reviewed. The Department's Health Related History (HRH) form was used in all seven records. Each record contained a new HRH form completed on the youth's day of admission. The HRH forms were reviewed by the designated health authority (DHA) at the same time or before the comprehensive physical assessment (CPA) was conducted.

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.	

Seven youth individual healthcare records were reviewed. All seven youth records had a current comprehensive physical assessment (CPA) completed on the Department's form by the designated health authority (DHA). It is the program's practice to complete a new CPA on all newly admitted youth. Six youth records had tuberculin skin test (TST) screening at the time of admission, which was documented on the CPA. One youth had a positive TST with chest x-ray results documented on the CPA. All fields on the CPA were completed, as required, with the exception of the Tanner Stage in all seven records. The DHA noted "refused by youth" with the youth's signature for the Tanner Stage in all seven records. Four youth had a documented medical grade of three or higher and were appropriately placed on the program's internal alert list. The Department's Problem List was updated in all seven records.

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.	

Seven youth individual healthcare records were reviewed. All seven records documented a sexually transmitted infection (STI) screening. The designated health authority (DHA) ordered testing for all seven youth. All seven youth were tested on the date of admission. The test results were documented on the Infectious and Communicable Disease (ICD) form and filed in the lab section of the youth record in all seven records. None of the youth were out of Department's physical custody for over thirty days. There was evidence in each record confirming each youth was offered counseling, testing, and treatment for human immunodeficiency virus (HIV). Two youth records documented consent for HIV testing. An

additional youth record was requested and reviewed HIV testing. All HIV testing is conducted at the Marion County Health Department where a 501 certified HIV counselor conducts the testing and provides the pre- and post-test counseling. The pre- and post-testing counseling was documented on the health education record for each youth receiving the HIV testing. HIV testing results were maintained in a sealed envelope in the lab section of the youth's individual healthcare record. Seven youth were interviewed and all seven stated they can ask for an HIV/AIDS 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.	

Sick call is conducted at the program twice a day, seven days a week, at 11:00 a.m. and at 3:00 p.m. The program only employs registered nurses (RN). All reviewed sick calls were completed by an RN. When a licensed nurse is not on-site, staff are to follow non-healthcare staff protocols. Sick call forms are available on each dorm and in the dining room. The youth place their completed sick call requests in a locked box or give them directly to the nurse. Seven youth individual healthcare records were reviewed. Six records were applicable and none of the youth presented with a similar sick call complaint three or more times within a two-week period. None of the youth complained of any severe pain with which staff was unfamiliar. All sick call request forms were filed in the progress notes section of each youth's individual healthcare record in reverse chronological order. Seven youth were interviewed. Six youth stated they can be seen for sick call within one day and one youth stated within three days of submitting a request. This facility has no restricted housing. Seven staff were interviewed and all seven stated the nurse responds to sick calls. Six staff stated the nurse conducts sick call while one staff stated the supervisor conducts sick call.

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

The program has a comprehensive process in place to provide episodic care, basic first aid procedures and interventions. Emergency medical and dental care are available twenty-four hours a day. Seven youth individual healthcare records were reviewed. All seven records documented instances of on-site first aid or episodic care. All instances of episodic care are tracked using the Department's episodic care tracking log. Thirteen episodic events were reviewed in the seven records for the past six months and all were documented on the episodic care log. The program has nine first aid kits located in master control, the medical clinic, the nurse's office, maintenance, the kitchen, each of the two dorm areas, and two in master control. The two first aid kits stored in master control are checked out and utilized during youth transports. All first aid kit contents are approved by the designated health authority (DHA) and the kits are monitored weekly by the director of nursing. All nursing staff have current training for first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and the use of epinephrine auto injector. The program has one AED on-site, located in master control. The procedures for the AED are attached to the AED and in a separate binder kept next to the AED. The director of nursing conducts and documents weekly checks of the AED. The battery expiration date was observed to be May 2023 and the pads expiration date was observed to be

June 2020. The AED batteries were last changed January 23, 2018 and the pads were last changed March 17, 2018. Emergency numbers are posted in master control and located in the non-healthcare protocol notebook in the exam room. A list of current telephone numbers and cell phone numbers, including the number of the statewide Poison Control Center are posted and accessible to all staff on all shifts. The list is in a location inaccessible to youth. Emergency drills were conducted monthly on all three shifts. Drills included the use of CPR and the AED at least quarterly on each shift. Seven youth were interviewed and all seven stated they could see a doctor if needed and a dentist if they had tooth pain. Seven staff were interviewed and six stated they are allowed to call 9-1-1 in the event of an emergency.

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

Seven youth individual healthcare records were reviewed. Two youth records were applicable for requiring off-site first aid or emergency care for a total of three instances. For all three instances, parental notification was documented. The summary of off-site care form was utilized and filed in the youth's record along with all applicable discharge documents. The designated health authority (DHA) reviewed and signed all off-site summary forms, instructions, and follow-up information. Each youth required follow-up care which was documented in all three records.

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.	

Seven youth individual healthcare records were reviewed. Three records were applicable for chronic conditions. All three youth were placed on the program's chronic condition list and received a specialized treatment plan. Each youth receives a periodic evaluation within the ninety-day requirement and prior to renewal of an expired prescription medication. The director of nursing tracks this process to ensure there are no lapses in care or missed periodic evaluations. The periodic evaluations were documented in the progress notes section by a nurse and in the practitioner's order section by the designated health authority (DHA). The Department's Problem List was updated for each applicable youth. An interview with the DHA confirmed youth with chronic conditions are evaluated every three months or less.

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.	

Seven youth individual healthcare records were reviewed. Four youth were applicable for being admitted with prescribed medication. All medication had a current valid order and given according to the current prescription or practitioner order. The designated health authority (DHA) was contacted, and an order was written to continue the specified medications. A progress note documented the verification. There was also documentation a notification is sent to the parent/guardian informing them the DHA approved continuation, hold, or discontinuation of a medication following admission. There is no restricted housing at this program. Over-the-

counter medication not listed on the Authority for Evaluation and Treatment (AET) form is administered according to the approved protocols or practitioner's order. The program uses the standard Department Medication Administration Record (MAR) form. The MAR clearly indicates start and stop dates and staff initial each administered medication. There were no lapses or errors in medication administration. Refusals were clearly documented. Side effects were documented on a daily and weekly basis. There are trained non-healthcare staff to assist in the self-administration of medication; however, non-licensed staff have not assisted in self-administration of medication within the last six months. There are no standing orders, no emergency treatment orders, or pro re nata (PRN) orders for psychotropic medication. Seven youth were interviewed. Four youth stated the nurse gives them medication and were able to describe the process. Three youth stated they do not take medication. Seven staff were interviewed and all seven stated the nurse provides medication to the youth.

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.	

All medications to include prescriptions, over-the-counter (OTC), and topicals, are stored in separate, secure, and locked areas inaccessible to youth. All non-controlled, prescribed, and OTC medications are stored inside a locked medication cart and the bulk supply of OTC medications are kept in a locked cabinet inside the locked medical clinic. The medication cart is clean, organized, and stock items are separate from youth specific medications. All controlled substances have a perpetual inventory, shift-to-shift counts, and are stored in a locked box located inside the locked medication cart. Oral medications were not stored with topical medications. There is a refrigerator used for medication storage only. Syringes and sharps are secured in a locked cabinet. Expired or discontinued medication, which are not controlled, are disposed of in the presence of two nurses. Controlled medications are logged and held for the pharmacy consultant to destroy on-site with two witnesses. The program has a policy and procedures in place related to the disposal of medication. Three different sharps and three OTC medication counts were observed with the counts matching ending inventory numbers completed by the nurse. There was one youth on controlled medication during the annual compliance review period. The perpetual count was completed by the nurse and was verified by the supervisor with both signing the shift-to-shift count sheet. An interview with the director of nursing confirmed the program's policy and practice concerning medication inventory.

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 infection control policy and procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious disease. The program's infection control procedures address all Department required topics. A review of documentation indicated universal precautions were included in the comprehensive program education. All youth receive hand washing and infection control training at admission. Hepatitis B

immunizations are available for staff. Staff also have access to protective equipment. There were no instances in which the local county health department, the Centers for Disease Control and Prevention (CDC), or the Central Communications Center (CCC) should have been notified of an infectious disease. Seven staff training records were reviewed for in-service training. There is documentation in the training records for prevention of blood borne pathogens and prevention of communicable diseases. The program has comprehensive process in place for needle sick post-exposure evaluation.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures regarding active supervision. Staff-to-youth ratios are one-to-eight during day time activities and one-to-twelve during sleeping periods. During the annual compliance review, observations of supervision were made each day. Staff were observed supervising youth during school, transitions, and after school activities, and in compliance with ratio requirements. The program has a full schedule of activities planned and youth were observed engaged in the activities. The daily schedule was posted in each dorm. Staff account for youth under their supervision at all times. Staff were observed escorting youth from one location to another; not letting youth roam free. When asked, staff members were able to explain the procedures for when the count is not reconciled. All youth are placed in the day room area and are counted body to body.

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 detailed written behavioral management system (BMS). The written description is provided in the youth handbook and includes rules governing conduct positive and negative consequences, including the classroom. Seven staff training records were reviewed and indicated each staff received BMS training. A review of the program's contract included all appropriate parties were involved, including education, in the development, implementation, and on-going maintenance of the applicable BMS. Documentation in the case management records included youth orientation and training on BMS. No postings of the BMS were observed. The program uses a variety of rewards and incentives to encourage youth participation and completion of the program. Seven youth were interviewed and indicated negative consequences included not receiving points for positive rewards, restrictions such as going to bed early or confinement and positive rewards included canteen, outings, home visit, and Saturday upgrade food days. Seven staff were interviewed. Each of the staff indicated they knew about the point and level systems and the positive and negative consequences. An interview with the executive director confirmed how the rewards and punishments were monitored and the incentives.

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

The program's behavioral 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. Position descriptions specify the required qualifications of staff whose job functions includes implementation of the program's BMS. All seven interviewed youth were able to explain the differences between each level and how to move to through the levels, youths are not allowed to punish other youth, and staff are consistent with the use of rewards. Two youth rated the BMS as very good, three rated it as good, one rated it as fair, and one rated it as poor. Seven staff were interviewed and stated the youth are informed of the consequences and are able to explain their behaviors and supervisors monitor staff use of BMS and provide feedback. An interview with the executive director confirmed how the implementation of the BMS was monitored to ensure it is administered fairly. The program does not use room restriction as a consequence; however, controlled observation is utilized.

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

The program has forty-eight cameras, all of which are operational. Video recordings are stored for sixty days. The program utilizes the electronic wand system for ten-minute checks. Each room has up to two youth. Various dates and times were reviewed for ten-minute checks on the second and third shifts. All checks were completed, as required, with one exception. Staff conducted the last check at 5:02 a.m. and did not do another check before youth were woken at 6:00 a.m. During the time, staff were observed cleaning the module and completing laundry. Seven staff were interviewed, and all seven stated room checks are completed every ten minutes.

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

The program has a policy and procedures regarding how the youth census, counts, and tracking are conducted. During the annual compliance review, counts were observed being conducted throughout the shifts. Documentation in the logbooks indicated counts were logged at the beginning of each shift, after each outdoor activity, during a power outage, and at other times as needed. When a youth is temporarily away from the program, it is noted in the logbook during the count. Seven staff were interviewed and asked how and when youth counts conducted and what happens when there is a discrepancy. All seven staff stated counts are conducted each hour. When there is a discrepancy, staff keep counting until the count is accurate.

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's logbooks were observed to be bound with numbered pages. The program utilizes one master control logbook; there are no living unit logbooks. All entries were made in ink with no erasures or white out areas. No logbook entries were obliterated or removed. All errors were struck through with a single line, dated, and initialed by the person correcting the error. All entries included the date and time of the event, with the name of the staff and youth involved, a brief description of the event, and the name of the staff making the entry. The program utilizes a shift report to summarize events, incidents, and activities documented in the master control logbook. The shift supervisor briefs the incoming staff about the contents of the shift report and the incoming staff can review the shift report. Incoming staff sign and date the shift report for the previous shift to document their review. A copy of the shift report is maintained for at least forty-eight hours. The program documents emergency situations, special instructions for supervision and monitoring youth, population counts at the beginning and end of each shift, and any other population counts conducted, perimeter security checks conducted by direct care staff, transports away from the facility, admissions, and incidents reported to the Florida Abuse Hotline of the Central Communications Center (CCC).

5.07 Key Control	Satisfactory Compliance

The program has a system in place to govern the control and use of keys including the following:

- *Key assignment and usage including restrictions on usage*
- *Inventory and tracking of keys*
- *Secure storage of keys not in use*
- *Procedures addressing missing or lost keys*
- *Reporting and replacement of damaged keys*

The program has a policy and procedures regarding key control which includes 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, and reporting and replacement of damaged keys. The keys are stored in master control. Master control maintains a daily tracking and reconciliation of the keys with a sign-in and sign-out log. The key inventory was reviewed and matched the actual key rings in use. The key storage area was observed to include the secure storage of keys when not in use, key assignments for temporary and permanent keys, provisions for restricted keys, and inventory and tracking of keys. The keys are not easily accessible while locked and unable to be reached your hand even when locked. There were no incidents regarding keys reported to the Central Communications Center (CCC) during the annual compliance review period. An interview with the master control operator confirmed the program's policy, procedures, and practice concerning key control. Three staff key ring inventory was compared with the keys the staff were carrying with no discrepancies found. Seven staff were interviewed regarding the key control process and were able to explain the process for turning in personal keys, obtaining facility keys, and tracking of keys.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a system in place to prevent contraband from entering the facility. The program's policy and procedures include a definition of items and materials considered contraband, as well as exemptions. The prohibited list includes illegal items, 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, and non-facility issued keys. The policy includes searches of the physical plant, facility grounds, and youth are conducted to prevent the introduction of contraband. Youth are provided with a list of what is considered contraband and informed of the consequences if found with contraband. The program's policy addresses staff who are found in possession of contraband and resulting disciplinary action. The program documents the confiscation of contraband and the disposition. There were no instances of illegal contraband being discovered where law enforcement had to be contacted. An interview with the executive director confirmed the process for contraband searches and resulting consequences.

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.	

During the annual compliance review, searches were observed occurring at various times to include before and after groups, after transports, transitioning class to class, and after meals. During the searches, the youth were treated with dignity and respect to minimize the youth's stress and embarrassment. The searches were conducted by the appropriate number of staff who were the same gender as the youth. Seven youth were interviewed regarding when searches occur. Seven youth stated after meals, five youth when returning from off campus, five youth stated after class, four youth stated after outdoor activities, and one youth stated after visitation. Seven staff were interviewed and indicated searches occur every time there is movement, after meals, leaving class, and when youth return from off campus trips.

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

The program has two vans which are used to transport youth. Both vehicles received annual safety inspections. Both vans had documented maintenance records, a fire extinguisher, approved first aid kits which were maintained in master control unless being used, seat belt cutters, window punches, and appropriate number of seat belts. The vans are secured at all times and the door to the youth passenger area cannot be opened from the inside.

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 which meets all requirements outlined by the Department relating to transportation of youth and driver eligibility. A cellular phone and program radio are issued to the transporter. A one-to-five staff-to-youth ratio is maintained during all transports. A transport of one youth to a medical appointment was observed. At least one staff of the same gender as

the youth was on the transport. Youth and staff were observed wearing seatbelts and the youth was not attached to any part of the vehicle by any means other than the proper use of the seatbelt. A random check of personal vehicles found one vehicle left unsecured. The program maintains a list of approved drivers which ensures those operating the program vehicles have current driver's licenses. Staff do not leave youth unsupervised in vehicles and youth are not permitted to drive program or staff vehicles. Seven staff were interviewed and all seven indicated they are issued a cell phone and radio for transports. All seven staff also stated staff are not allowed to use personal vehicles to transport youth.

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

The program has a policy and procedures outlining the audit/inspection process. The policy includes who is responsible for conducting the weekly security audits and safety inspections, the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, or inspection, and an internal system to verify the deficiencies are corrected and existing systems are improved, or new systems are instituted as needed to maintain compliance. A sample of weekly safety and security audit documents ensured the reports were submitted weekly. An interview with the executive director confirmed the process for compliance of the weekly audits.

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

The program has a policy and procedures which addresses the issuance, inventory, and control of equipment and tools. Tools were observed securely stored when not in use. All tools were marked for easy identification. All tools are inventoried prior to being issued for work and following work activities. Sharp-edge or pointed tools were inventoried daily, except on days not used. A monthly inventory of tools which do not have sharp edges or points is also maintained. There were no machetes, bowie knives, or other long blade knives. Missing or lost tool procedures are followed. Dysfunctional tools are disposed of and replaced as needed. Training documentation documented staff and youth are trained on the intended and safe use of tools.

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

The program has a policy and procedures for the supervision requirements when youth use tools. The procedures indicate, prior to a youth being issued tools, a risk assessment must be completed to determine the youth's risk to self and others. Staff-to-youth ratios during activities involving tools is one-to-five. Seven youth records were reviewed, and each contained a risk assessment identifying youth who may use tools. Seven youth were interviewed regarding which tools they are permitted to use and all seven mops and brooms. Seven staff were interviewed regarding which tools youth are permitted to use. All seven staff stated youth are allowed to use mops and brooms. Four staff also stated youth are allowed to use dust pans.

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 which addresses outside contractors. The sign-in/instruction sheets for outside contractors were reviewed. The guidelines include tools will be checked upon arrival and departure, tool restriction while in the facility, youth are restricted from the work area, and missing tool follow-up, if needed. Project invoices submitted to the program by the vendor were reviewed and compared to the sign-in sheets. Documentation supported the program inventoried the tools or equipment when the vendor arrived and left. The program's policy and procedures determine who is responsible for giving an outside contractor permission to bring in equipment needed for repair which would normally be considered contraband.

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

The program conducts practice drills and is prepared for immediate implementation or mobilization of the plans whenever an emergency or disaster situation necessitates. The program's documentation confirmed fire drills are conducted monthly on each shift. The executive director also confirmed fire drills are conducted on each shift monthly. Seven youth were interviewed and all seven reported they had participated in a fire drill. One youth stated he participated in two drills each month, four youth stated every month, one youth stated every other month, and one youth stated he had only participated in two drills. Seven staff were interviewed regarding the drills they have participated in within the last twelve months. Six staff stated they had participated 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 Continuity of Operations Plan (COOP) is available in the office of the executive director and assistant facility administrator, as well as master control. In these locations, the plan is readily available to staff. The COOP was reviewed April 17, 2019 and approved by the Department's Regional Director on April 23, 2019. The plan addresses alternative housing plans approved by the Department's Regional Director. The program maintains equipment and supplies required for continuous operation and services during emergency or disaster situations. An interview with the executive director confirmed the location of the COOP and availability to all staff. The program's COOP includes the following: fire and fire prevention and evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed,

information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program's COOP also includes delegation of authority, cooperative agreements, vendor contact list, emergency and staff contact numbers, and county cooperation checklist. The program maintains an administrative hard-copy record of critical identifying information for each youth in the program.

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

The program has a policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials. Observations indicated flammable, poisonous, and toxic items were secured at all times. These items are stored in areas inaccessible to youth. Inventories for all flammable, poisonous, and toxic items were reviewed and were accurate. There were no items missing from the inventory. The inventory matched the actual items within the program. The program maintains a list of facility positions authorized to handle flammable, poisonous, and toxic materials. The program also has a Safety Data Sheet (SDS) maintained onsite for all materials.

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

The program has a policy and procedure which addresses youth handling and supervision of flammable, poisonous, toxic items and materials. The program maintains strict control of flammable, poisonous, and toxic items and materials. Youth do not use, handle, clean-up dangerous or hazardous chemicals. Youth also do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. There is restricted youth access to areas where items are being stored. Youth were observed during daily cleaning activities to be in compliance with the program's policy and procedures. Seven youth were interviewed, and five stated they do not handle any chemicals or cleaning products. Two youth stated cleaning products are used with staff supervision.

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

The program has a policy and procedures for the disposal of flammable, toxic, caustic, and poisonous items. The policy determines who is authorized to dispose of these items. The authorized staff have received training for disposing of hazardous and toxic materials. For any materials requiring disposal, the item is transported to the county's landfill for disposal. The program has not had any materials transported for disposal during the annual compliance review period. The program also maintains a contract with a local waste management company for disposal of items. Hazardous liquid waste is disposed of in accordance with the Safety Data Sheet. Hazardous liquid waste is stored in a hazardous materials storage area. Liquid waste from work details is disposed of in the plumbing drains. Kitchen liquid waste, except grease, is disposed of in the kitchen. Grease is placed in a separate container for disposal. The program maintains a policy and procedures for cleaning up chemical spills. An interview with the executive director confirmed the disposal procedures for flammable, toxic, caustic, and poisonous items.

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 utilize water activities; therefore, this indicator rates as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedure related to visitation, youth correspondence by mail, and use of the telephone use. The program has a posted visitation schedule. The visitation log, telephone log, and mail log were reviewed. Alternative visitation arrangements are available for parents/guardians, if needed. Youth are given the opportunity to communicate with family members by mail and by telephone. Incoming and outgoing mail is searched. Seven youth were interviewed, and all indicated they have had the opportunity to communicate with family members by mail, telephone, or at visitation.

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

The program has a written policy and procedures regarding controlled observation. The rooms identified for controlled observation meet the Department's requirements of a minimum of thirty-five unencumbered square feet, metal door with shatter-resistant window, vents not easily accessible, suicide-resistant bed, recessed light fixtures covered with shatter-resistant material, no outside windows, no electrical outlets, and electrical switches not inside the room. There has been a total of three usages of controlled observation within the previous six months. All three incidents of the use of controlled observation were reviewed. All three controlled observation reports documented staff conducted an inspection of the room prior to placing the youth in the controlled observation room and staff of the same gender searched the youth prior to placement. Each report documented the date and time of placement as well as the date and time of release.

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

The program has a written policy and procedures regarding controlled observation. There has been a total of three usages of controlled observation within the previous six months. All three incidents of the use of controlled observation were reviewed. None of the reviewed reports indicated the youth placed in controlled observation were exhibiting signs or behaviors indicative of a mental health crisis or suicide. Authorization for placement in controlled observation for all three reports was made by a supervisory staff or higher. Each report indicated youth who were placed in controlled observation met the required criteria. Documentation in all three reports indicated youth were made aware of the reason for their placement in controlled observation and expected behavior for removal. Each report documented indicated the health status checklist was completed by a healthcare staff or staff member of the same gender. Each report indicated the youth were released from controlled observation within two hours. Time in controlled observation ranged from one hour and nineteen minutes to one hour and thirty-seven minutes. No extension of time was required. Each youth placed in controlled observation was approved by the executive director or designee. Seven youth were interviewed. Five youth stated they had been sent to their room for punishment with the door shut and locked.

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

The program has a written policy and procedures regarding controlled observation. There has been a total of three usages of controlled observation within the previous six months. All three incidents of the use of controlled observation were reviewed. Each report documented the staff making placement completed the first page of the controlled observation report and submitted it to a supervisor. Each report indicated staff conducted and documented safety checks at least every fifteen minutes and observed the youth's behavior. All safety checks and observations were documented on the Controlled Observation Safety Check form. Each report documented

the executive director or designee approval of release from controlled observation and determinations are made by staff if an internal alert is warranted. The Controlled Observation Report, Health Status Checklist, and Controlled Observation Safety Checks forms are maintained in an administrative file and in the youth's individual management case record. Documentation in each report indicated the executive director or designee reviewed the controlled observation report within fourteen days and indicated whether placement was appropriate.

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

The program has a policy and procedures regarding safety plans for youth. The program maintains a safety plan for each youth in a centralized location for all staff. The safety plans for each youth addresses warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth and debriefing preferences. Seven youth records were reviewed, and each indicated, on the date of each youth's admission a safety plan was completed. Each plan indicated it is was jointly developed and incorporated recommendations from previous or current clinical assessments or screening instruments and incorporates trauma responsive practices. During monthly treatment team meetings, the youth's safety plan is reviewed and any updates are addressed at this time. Furthermore, direct care staff sign the plan, indicating they have reviewed the youth's safety plan. Seven youth were interviewed. Six youth stated they were involved in the development of their safety plan. One youth did not remember if he was involved. Seven staff were interviewed regarding the location of the youth's safety plans. All seven staff stated the safety plans are located in master control. All seven staff were able to describe a variety of methods to review the youth's safety plans to include when the youth first arrives, during shift briefing, and in master control.