STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Marion Youth Academy

Sequel TSI of Florida, LLC

(Contract Provider)
10420 NW Gainesville Road
Ocala, Florida 34482

Review Date(s): March 26-29, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Amy Hutto, Office of Program Accountability, Lead Reviewer (Standard 1)
Renette Crosby, Office of Education, NE Region Education Coordinator, (Standard 2, 5, and Interviews)
Roberta Ellis, DJJ Probation, Senior Juvenile Probation Officer (Standard 2)
Katina Horner, Office of Program Accountability, Regional Monitor (Standard 4)
Ben Marrufo, Office of Program Accountability, Technical Assistance Specialist (SPEP)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Standard 3)
Theresa Susino, DJJ Detention Services, Detention Officer Supervisor (Standard 5)

Program Name: Marion Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Marion County / Circuit 5
Review Date(s): March 26-29, 2019

MQI Program Code: 1205
Contract Number: 10321
Number of Beds: 48
Lead Reviewer Code: 157

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
_____ # Case Managers

1 # Clinical Staff
_____ # Food Service Personnel
1 # Healthcare Staff
1 # Maintenance Personnel
_____ # Program Supervisors

7 # Staff
7 # Youth
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☒ Egress Plans
☒ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☒ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
7 # Health Records
7 # MH/SA Records
21 # Personnel Records
14 # Training Records/CORE
3 # Youth Records (Closed)
7 # Youth Records (Open)
_____ # Other: _____

Observations During Review

☐ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☒ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☐ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	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	Limited
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	Limited
1.17	Advisory Board	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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 the following services: Mental Health Overlay Services and Substance Abuse 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, EQUIP, Passport, and Skills Streaming. Additional treatment services provided includes family and individual therapy. Program administration is comprised of a program director and assistant facility administrator. Case management services are provided by a director of case management, two case managers, and two transition case managers. Mental health staff at the program includes the program's designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC). The program has four non-licensed mental health clinical staff who serve as therapists. Medical services are offered 7:00 a.m. – 6:00 p.m. Monday through Friday and 7:30 a.m. to 5:30 p.m. on Saturday and Sunday. 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, and two as needed (PRN) nurses. Educational services are provided by the Marion County School Board. The layout of the program includes: one building which houses administration in the front and divides into two wings 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 fifty-two operating security cameras providing coverage. At the time of the annual compliance review, the program had four vacant positions; one administrative assistant and three 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. A contract provider may hire an employee to a position that requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures regarding initial background screening. Twenty-one new employees were hired since the last annual compliance review. Twenty of the background screenings were completed prior to the employees' hire dates. The one exception reflects the screening is in process; the employee is in training but has no contact with youth. In each case the criminal history report was reviewed. Seventeen of the employees were considered direct care and a pre-employment assessment tool was administered. Of these, all received a passing score except four. The program responded they can hire individuals who do not pass the pre-employment assessment due to the subsequent training the staff will receive. Eight volunteers started since the last annual compliance review. All received a background screening prior to their start dates except one. In this case the program indicated the volunteer listed was part of an organization volunteering at the program; however, he had not come to volunteer prior to the completion of the screening. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and sent to the background screening unit on December 26, 2018.

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 regarding five-year background rescreening. There were no employees or volunteers eligible for a five-year rescreening since the last annual compliance review.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a policy and procedures for reporting abuse. The program director confirmed the abuse reporting procedure. Any incident requiring notification to the Department's Central Communications Center (CCC) are made within the allocated two-hour reporting window. Any allegation of abuse by a program resident, or if any employee ever suspects some sort of abuse may have taken place, a call is made to the Florida Abuse Hotline if the youth is under eighteen. If the youth is over eighteen, a call is placed to the CCC registry. An interview with the program director further confirmed employees are held to professional expectations and are provided a list of things considered to be violations of the code of conduct. The program utilizes progressive disciplinary process, which specifies what measures would be taken towards an individual who violates the code of conduct by committing physical abuse, threats, or profanity towards youth. Actions can include, but are not limited to, oral warnings, coaching notes, written disciplinary write-ups, suspension, and termination A review of twenty-one personnel records revealed each contained signed documentation indicating the staff's acknowledgement of the program's code of conduct. The Florida Abuse Hotline and Central Communications Center (CCC) numbers were posted throughout the facility. There were two incidents which were reported to the CCC for use of excessive force by staff which were substantiated.
Seven youth were interviewed six indicated they feel safe at the program. The one youth who stated they did not feel safe at the program indicated they felt they could get jumped at any moment and feel staff do not intervene when necessary. All seven youth stated they had never been stopped from reporting abuse to the Florida Abuse Hotline or CCC since they have been at the program. Four of seven youth stated staff are respectful when speaking with them and other youth. One youth stated they have never heard staff use profanity when speaking with them or other youth, four stated occasionally, and two stated often. Seven staff were interviewed and all seven were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC. All of the staff indicated they would notify their supervisor, so the youth could be taken to make the call. Of seven staff, six stated they have never observed a co-worker telling a youth they could not call the abuse hotline. The one other staff stated they have seen staff act like they do not hear the youth asking to make the call. The program administration was informed of this during the annual compliance review. Five of seven staff stated they have not observed a co-worker using profanity when speaking to youth.

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.	

An interview with the program director revealed all staff are trained during pre-service training and during annual in-service training on the process of contacting the Florida Abuse Hotline and the Central Communications Center (CCC). The calls are tracked and discussed during daily morning meetings, weekly management team meetings, and during monthly reports. These calls are also tracked through weekly management reports which are submitted to the corporate office. Documentation was reviewed regarding two incidents reported to the CCC for use of excessive force. In each case there was evidence management took immediate action. Both staff received retraining and one staff received a written reprimand. There were no internal incidents found of physical, psychological, or emotional abuse which should have been reported, but were not.

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

There were seventeen incidents reported to the Department's Central Communications Center (CCC) in the past six months. Five of these were reviewed. Four of five were reported within two hours. The other incident was reported three hours after the medical incident occurred in which the youth was transported to the hospital. The type of incidents included medical, improper supervision, contraband, and arrest of staff. Each of the incidents were documented in the logbook. The program has not experienced an increase in the number of CCC calls.

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

The program's monthly summary of all Protective Action Response (PAR) incidents submitted to the Department by the fifteenth of each month were reviewed for the last six months. The program's PAR plan has been approved by the Department. The program has not experienced an increase in the number of PARs since the last annual compliance report. The program's PAR rate for the quarter was 1.38 which was below the statewide PAR rate of 1.47. In the past six months, the program has had fourteen uses of PAR. Five were reviewed. Four of five reports were completed with statements from all staff involved by the end of the staff member's work day. The last PAR incident occurred on December 4, 2018 and the staff member completed their statement on December 8, 2018. All five included statements from all staff involved. All five reports also included a review by a PAR certified instructor/supervisory staff. In four of the reports, a PAR medical review was conducted and deemed necessary by the post-PAR interview. Four reports reflected the post-PAR interview was conducted with the youth by the

administrator, or designee, no longer than thirty minutes after the incident. The last post-PAR interview occurred after the thirty minutes. All five PAR incident reports were reviewed by the administrator, or designee, within seventy-two hours of the incident and were placed in a central file after being signed by the program director.
An interview with the program director indicated PAR incidents are discussed during daily morning meetings, weekly management team meetings, and by way of monthly reports submitted to the Department and Sequel's corporate office. Additionally, the program director indicated PAR incidents are tracked on a weekly basis by way of management reports which are submitted to Sequel's corporate office. A monthly trend analysis is also conducted of all PAR related incidents.

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

Seven staff training records were reviewed for pre-service training. Three staff were hired less than 180 days prior and were still completing trainings to become certified. The other four staff completed their 120 hours of pre-service training within 180 days of hire. The employees completed the following trainings: cardiopulmonary resuscitation, first aid, Protective Action Response, professionalism and ethics, suicide prevention, emergency procedures, grievance process, prison rape elimination act (PREA), and child abuse reporting. All instructors are qualified to deliver the trainings provided. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led training on January 30, 2019.

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

Seven staff, including three supervisors, training records were reviewed for in-service training. Each had completed over twenty-four hours of in-service training. Five of the staff reviewed required recertification in cardiopulmonary resuscitation (CPR), first-aid, and automated external defibrillator which was completed. Six of the staff completed the Protective Action Response (PAR) update. The staff which did not complete the updated has been out due to a work-related injury since September 2018. The program plans to have him complete the full PAR training when he returns to work. Five staff completed professionalism and ethics training. All seven staff completed six hours of instructor led suicide prevention training. The three supervisory staff reviewed each received at least eight hours of training in the following topics: management, leadership, personal accountability, employee relations, and communication skills. The program had not entered all in-service training in the Department's Learning Management System (SkillPro) but corrected this on-site. All instructors are qualified to deliver the training provided. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training including names, descriptions, objectives, and training hours for any

instructor-led training on January 30, 2019. The program's training plan for 2018 was also approved.

1.09 Grievance Process	Limited 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 staff pre-service training records and seven staff in-service training records were reviewed and reflected each staff received training. The program's grievance process includes the following phases: informal, formal, and appeal phase. The program maintains a grievance binder which contains copies of grievances filed for the past twelve months. There were three filed in twelve months and each related to the youth not receiving canteen. The grievances were resolved at the formal phase on the same day, one day later, or two days later. Seven youth were interviewed. One youth indicated he has never written a grievance, and one stated he is not sure how the grievance process works. Two youth were able to explain the grievance process. Two indicated they understood the grievance process. Three youth indicated the grievance process does not work making comments such as "every time I write one they tell me it will not get to the front (administration). I have never spoken to anyone and I have filled out three or four," "you put it on paper and nothing is done about it," and "it barely works, you put them in and they only use them [when there's an annual compliance review]." The program did not give an explanation for why the youth would say the process does not work. All seven stated they can ask for assistance in completing a grievance form. Seven staff were interviewed. Five stated forms are placed throughout the program, one stated youth can request assistance in completing the form, four stated the supervisor reviews grievances, and four stated the program director reviews the grievance. One staff also stated, "the write ups don't make it up front or nothing happens with them."

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

An interview with the program director revealed staff member's education and experience are taken into consideration for many reasons to include who delivers or facilitates specific group curriculums. There are ten staff who provide delinquency interventions which include: Thinking for a Change, Impact of Crime, Anger Management and EQUIP. The staff each have between two and seventeen years of experience working with adult or juvenile offenders. The program utilizes evidence-based interventions. A review of the program's activity schedule reflected the program is providing structured, planed programming or activities at least sixty percent of the youth's awake hours. Group sign-in sheets were reviewed and reflected the groups are being delivered as designed. Staff training records were reviewed for the staff providing delinquency interventions and confirmed each was trained on the evidence-based strategy or model. Seven youth records were reviewed. All seven were involved in a delinquency intervention which is

evidence-based, or a practice with demonstrated effectiveness. All seven youth were involved in a delinquency intervention which addressed an identified prioritized need and the youth's performance plans addressed an identified prioritized need.

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

The program provides life skills training to the youth which addresses: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, including problem-solving and decision-making. The program provides Life Skills Training (LST) and Living in Balance (LIB) on Saturdays and Sundays which are provided by trained therapists and case managers. A review of group sign-in sheets reflected the youth are receiving life skills training as outlined. Seven youth were interviewed and each as able to list new skills or behaviors they were taught through participation in group and how they practice the new skills in group. Seven youth records were reviewed and all seven were either in LST or LIB.

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 provides restorative justice awareness for youth through Impact of Crime (IOC). The instruction assists youth to accept responsibility for harm they have caused by their past criminal actions, teach youth about the impact of crime on victims, their families, and their communities, expose youth to victims' perspectives, and provide opportunities for youth to participate in reparation activities intended to restore victims and communities. Training records were reviewed for staff who conduct IOC groups which confirmed they had the required training. IOC is held Monday and Wednesday mornings from 9:00 a.m. – 10:00 a.m. Youth were observed participating in IOC and a review of sign-in sheets reflected the curriculum is being delivered as designed. The youth have several opportunities for community service through Habitat for Humanity and volunteering at the local strawberry festival. Seven youth records were reviewed which reflected none of the youth were participating in IOC. IOC is a closed group and the seven youth reviewed are scheduled to start the next IOC group which will begin in two weeks.

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

The program provides gender-specific programming to address the needs of youth at the program. Young Men's Work is provided to youth on Saturdays from 3:00 p.m. – 5:00 p.m. The program director confirmed all youth are assigned to participate in the Young Men's Work curriculum. This curriculum is evidence-based and is structured to reduce violence in the community. A review of staff training records for staff facilitating the group confirmed they received training to provide the group.

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 indicating how alerts are identified, documented, updated, and communicated to employees. The program's internal alerts were compared to the alerts entered into the Department's Juvenile Justice Information System (JJIS) and there were no discrepancies. When youth were removed or downgraded from alert status it was done by the appropriate staff; nursing staff addressed medical alerts and mental health staff addressed suicide alerts. The program director described the internal alert system as reflecting all safety and security alerts in addition to all medical, dietary, and mental health alerts. The alert roster is updated daily by the medical department, is circulated to all necessary parties, and is reviewed during shift briefings. Alerts are posted in the conference room on an alert board and within master control. Seven youth records were reviewed. Each youth's alerts were verified prior to being entered into JJIS.

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 separated the youth records into separate records: an individual management record which addresses all case management activities, and an individual healthcare record which is further divided into two separate records for health and mental health/substance abuse. The cover of the individual management record contains the following information: youth's name, Department of Juvenile Justice Identification number, date of birth, county of residence, and committing offense. The records contain the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All youth records are labeled "confidential." All official youth case records are secured in a locked file cabinet or a locked room.

1.16 Youth Input	Limited 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 program director confirmed, the program will conduct monthly town hall meetings, monthly meetings for the youth advisory council, and the youth will complete quarterly surveys. Documentation of the youth advisory council reflected only one meeting was held which occurred in September. Additionally, documentation confirmed quarterly surveys of the population had not been conducted. Reviewed documentation did reflect monthly town hall meetings were conducted as required for the past six months. Seven youth were interviewed regarding the process for youth to provide input regarding what happens at the program. Three stated there is a speak out form. One stated there is a process, but they have never done it, and three stated there is not a process to provide input.

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

The program has documentation reflecting they solicit active involvement on the community advisory board from the following: law enforcement, community partners, business community, school board, and faith community. There was not documentation to indicate participation was solicited from judiciary staff, victim services, or a parent/guardian whose child was previously involved in the juvenile justice system. Documentation reflected a meeting was held in October. The next meeting was scheduled for January but was not conducted due to no participation by the advisory board 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 the program's system of staff communication. The program director ensures provisions for staffing, including a system of communication to keep staff informed and give them opportunities to provide input and feedback pertaining to operation of the program; and staff retention planning including steps to minimize turnover and improve employee morale. The program director stated, and documentation provided supports, the program has several meetings to include: morning meetings which are held daily with program administration and department heads, monthly all staff meeting which all staff are required to attend. All staff meetings are held to keep staff informed of important developments or changes at the program, and additionally to receive coaching that enables supervisors to share information with their staff. Six months of youth and parent/guardian surveys were reviewed of youth who had completed the program. The survey gives the youth and parent/guardian an opportunity to rate the services and care received while in the program. The program also uses a survey for staff that assesses many areas and provides insight as to the level of staff morale. The program also had documentation of staff events which were held to encourage staff morale. Seven staff were interviewed, and all reported meetings are held monthly. Six of the seven find the information provided at the meetings valuable. Three staff indicated they feel communication is very good amongst the staff, two reported good, and two reported very poor.

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 regarding the program's system for evaluating staff performance. Staff are evaluated annually on their anniversary of hire. A review of seven staff records reflected their position descriptions clearly identified their performance standards. Additionally, each of the seven received an annual performance evaluation. The performance standards the employees were evaluated on matched the job descriptions for each staff reviewed. Seven staff were interviewed and three reported they receive formal evaluations yearly, three stated every six months, one stated thy should receive three a year, and three stated they have not received an evaluation.

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 case management records were reviewed. All seven had notations of phone calls to parents/guardians the day of admission. All seven also contained letters sent out the day of admission to the parent/guardian, the committing court, and the supervising juvenile probation officer, in advance of the five-day timeframe statutorily mandated.

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 case management records were reviewed. All seven records contained notation of orientation completed the day of admission. The orientation includes youth expectations, services, behavior management system, consequences for infractions, dress code, visitation and communication, access to Florida Abuse Hotline or Central Communications Center, grievance procedures, and other essential information as prescribed by facility policy. Each orientation includes a tour and assignment to living unit and treatment team. One orientation was conducted while the review team was touring the program. A viewing of the log book showed the facility logs orientation activities. Seven of the seven youth interviewed advised they received an orientation upon their admission to the program.

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

There was only one record of the initial seven reviewed which concerned a youth who attained the age of eighteen while in the program. Two additional records were requested and reviewed. All three records contained documentation, signed by the youth, giving the program permission to speak with the youth's parents/guardians after the youth turned eighteen.

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

The program utilizes a standard classification sheet for each admitted youth. Seven of seven reviewed records contained this sheet, filled out completely. The standard sheet lists the youth's demographic information including their physical characteristics. It also includes maturity level, any special needs, violence history, gang designation if appropriate, and sexual aggression or vulnerability. All youth enter the program with medical and security alerts until seen by appropriate professionals. Youth are assigned to a living area and sleeping room based on the balance of factors including physical characteristics and various risk levels according to the interview with the program director. All seven reviewed records contained a follow up assessment which increased the youth's participation in outside activities and increase in privileges based on the removal of the security alert. The program utilizes a color-coded pin and photo board to keep staff updated on the alerts applicable to all youth. Staff was seen to check this board during the annual compliance review week. The board is hidden from inadvertent view by a poster board cover.

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.	

Of the seven records provided, none contained suspected or verified gang members. The program's gang liaison provided the reviewer with an overview of the procedures surrounding any gang information obtained by the program. The program keeps a separate binder for any youth with a gang designation. This binder contains a copy of the notification to local law enforcement and education, as well as the supervising juvenile probation officer. One binder was reviewed and contained all applicable information. Three additional records were reviewed of youth who were labeled suspected or verified gang members. In each case law enforcement was notified. Additionally, the youth's gang status was shared with education, and the youth's juvenile probation officer. These youth were identified after admission to the program and an alert was entered into the Department's Juvenile Justice Information System.

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.	

At the time of the annual compliance review, three youth in the program were identified as gang members or suspected gang members. The reviewed performance plans included gang goals

relevant to intervention. All youth participate in various gang intervention activities including outside speakers being brought to the program. A letter is provided to parents/guardians with gang awareness information. 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 R-PACT Assessment and Re-Assessments	Satisfactory Compliance
The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS. The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record.	

Each youth admitted to the program is required to have a Residential Positive Achievement Change Tool (R-PACT) completed within thirty days. Seven of seven records reviewed had R-PACTs completed at the appropriate time. R-PACTs are required to be completed again at ninety-day intervals. Six of the seven reviewed records were eligible for a ninety-day reassessment. All six were completed in the appropriate timeframe.

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

Youth Needs Assessments Summary (YNAS) are required to be completed within the first thirty days after admission and after the initial Residential Positive Achievement Change Tool (R-PACT) is completed. Seven of seven reviewed records had the YNAS completed. All seven were completed within thirty days and documented 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.*	

The youth's initial performance plan is due to be completed within thirty days of admission. The plan includes input from the initial assessment, the treatment team leader, the youth, administration, education, living unit representative, and treatment staff. Seven of seven records had appropriately completed performance plans with all signatures except the parent/guardian.

Each record contained a notation the plan was sent to the parent/guardian with a request to return the signature page. Within ten days of completion, the plan and letter were sent to the committing court, the supervising juvenile probation officer (JPO), and the parent/guardian. All plans contained both youth and staff responsibilities, addressed the top three criminogenic needs, and set target dates for completion. The plans also addressed goals for transition. According to the youth interviews, seven of seven youth interviewed had a copy of their plan, but none stated they knew their goals.

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.	

Performance reviews were conducted on six of seven reviewed records. One of seven was not yet eligible for a ninety-day review. All six eligible plans showed a new Residential Positive Achievement Change Tool (R-PACT) completed and plans adjusted based on any new information, goal completion, or transition expectations.

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.*	

Ninety-day performance plan summaries were completed for six of seven records reviewed. One of seven was not yet eligible for a summary. In three of three closed records, transition summaries were prepared prior to request for release and discharge. One of six records had a prepared plan a day late due to internet outage in the program. Each plan contained the youth's status on the goals, overall progress in treatment, academic status, behavior, level of motivation to change, interaction with peers and staff, overall behavior and any significant positive or negative events. The youth was given opportunity to make comments on the summary prior to signing, provided a copy, and the original was filed in the case record. Each plan was signed by the youth, treatment team leader, staff member who prepared the summary, and the program director or designee. The records showed copies of the summary were sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten days. One of seven open records were reviewed as the youth was in transition, two closed records were reviewed after exit. All three records showed a summary with justification for release sent with a Pre-Release Notification to the supervising JPO. No records contained an objection by the court. The program provided letters to all three parents/guardians of the anticipated release dates. Only three of the seven youth interviewed reported they had copies of their 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.	

The program sends letters and packets to parents/guardians, as evidenced by notations in all seven of seven reviewed records, encouraging parents/guardians to participate in their youth's progress and monthly treatment teams. Parents/guardians are also called during the treatment team and transition meetings, according to notations in the youth's record. The contact expectations are met according to the provider's contract. Seven of seven youth interviewed stated their parents/guardians participate in their treatment teams. Treatment team meetings were unable to be observed during the annual compliance review as they occurred the week prior to the review.

2.13 Members of Treatment Team	Satisfactory Compliance
The team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.	

The program provides a list of expected treatment team members including the youth, treatment team leader, educational and treatment staff, juvenile probation officer (JPO), parent/guardian, gang specialist if needed, and representatives from administration and living unit. All seven youth records reviewed confirmed active participation from all required treatment team members.

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.	

All seven of the youth records reviewed included the youth's academic plan as part of the performance plan. Additionally, youth performance plans reflected incorporation of separate treatment plans for mental health or substance abuse for youth based on their needs. None of the youth reviewed were in the care of the Department of Children and Families.

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

Formal treatment teams were held every thirty days in all seven reviewed records. The youth's juvenile probation officer (JPO), parent/guardian, and other parties needed were invited to

participate by letter or e-mail. The program utilizes a review sheet for each formal treatment team which shows youth's name, date of review, a list of all meeting attendees, comments from all members, an overview of youth's progress, any revisions to the performance plan and goals progress, positive and/or negative behaviors, any behavior which resulted in a physical intervention by staff, treatment progress, and if the youth was given a new Residential Positive Achievement Change Tool (R-PACT). Each youth is allotted a fifteen-minute window for their meeting. All seven interviewed youth stated they do not demonstrate their learned skills in treatment team. However, the youth helps conduct their meeting, demonstrating their skills by default. Bi-weekly informal reviews are also held, including all the information presented at the formal review. Bi-weekly reviews do not include the parent/guardian or JPO. The week of the program review was an off week for reviews so there was no opportunity to observe a formal review. The anticipated release dates were reviewed in the Department's Juvenile Justice Information System confirming it is updated at least ever ninety days and at the sixty day transition conference.

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

The program provides appropriate career education based on age, length of stay, and is appropriate for the educational abilities of the youth in the program. The program is a Type 2 programming level, an interview with the lead teacher indicated the program offers a career course to all the youth. The youth earn the Safe Serve certification, and selected youth are afforded the opportunity to work with Home Builders Institute. In three closed records reviewed, documentation included a completed employment application, sample resume, appropriate documents essential to obtaining employment, and an appointment with Career Source. In all three records reviewed, documentation was available of the youth's parents/guardians and juvenile probation officer (JPO) were aware of the vocational plan for the youth.

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.	

Marion County Public Schools provide the education on a 250-day calendar distributed over twelve months which includes twenty-five hours of instruction weekly. The youth receive credits for the education and training received while at the program. Interview with the lead teacher and review of the log books indicate minimal disruption of class. Seven youth were interviewed and four indicated there are not a lot of interruptions during educational instruction. Three youth indicated there are interruptions and they are related to youth talking or arguing, staff coming in and out of the classrooms, and staff distracting them outside of the classroom because there are large windows.

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

Three closed records were reviewed for an educational transition plan. Each record had an individual education transition plan developed based on youth's post release goals beginning at

admission to include all key personnel related to transition activities, and included responsibility requirements, and post-release needs. Three closed records were reviewed for employability as a transition goal and included provisions for continuation of education and or employment, appropriate documents essential to obtaining employment and documentation of the youth's case manager and parent being are aware of the plan.

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.*	

Five youth records were reviewed for transition planning. Five of five had appropriate transition dates set sixty days prior to the targeted release date. Four of five had already held transition meetings, with all pertinent parties in attendance to include the youth, treatment team leader, program director, and other team members. Written input was also provided. The youth's parent/guardian and juvenile probation officer (JPO) were invited by letter and e-mail as well as educational staff and transitional staff. According to the transition paperwork, four of five eligible records reviewed included transitional activities, performance plan, additional activities needed, and identified persons responsible and target dates. Signatures were obtained with transition plan copies going to anyone not in personal attendance. The plan was also transmitted to the JPO and an e-mail acknowledging the receipt was filed. In two of the five records a Community Reentry team (CRT) was held. Three of the five were not yet eligible for a CRT. The case manager noted participation in the CRT with the youth. However, two of two eligible records did not contain a copy of the invitation for the CRT printed in the record.

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 records were reviewed for the exit portfolio. On each the exit portfolio was discussed and initiated for the youth at the transition conference. The exit portfolio for all three contained a copy of the youth's transition plan, vocational certificates earned in the program, all educational records, resume, sample job application, and the education staff forwarded the exit portfolio information to the receiving school district. Additionally, the youth's exit portfolio was verified at the exit conference and given to the youth upon release.

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

Three records were reviewed regarding the exit conference in each the date of admission and date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS). Documentation reflected the following parties participated in the exit conference: intervention and treatment team leader, parent/guardian, and education representative. The conference was conducted after the program notified the juvenile probation officer of the release and was conducted at least fourteen days prior to release. The documentation in the case record included the dates, signatures, and a summary of pending transition goals. The exit conferences were separate from the 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 Designated Mental Health Clinician Authority (DMHCA) is a Licensed Mental Health Counselor (LMHC). The DMHCA has a clear and active license in the state of Florida which expires March 31, 2021. The DMHCA is also a qualified supervisor mental health counselor. At a minimum, the DMHCA is on-site weekly for a sufficient amount of time to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. The DMHCA is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the program. A copy of the license and position description was reviewed. An interview with the DMHCA indicated she oversees the delivery of clinical services consisting of individual, family, and group therapy sessions and is responsible for assisting and supervising case management and clinical staff. The DMHCA monitors all service provisions through a review of all clinical documentation related to mental health and substance abuse 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 youth records weekly.

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 professional who is a Licensed Mental Health Counselor (LMHC) in the position of Designated Mental Health Clinician Authority (DMHCA). The LMHC has a clear and active license in the state of Florida. The DMHCA is also a qualified supervisor mental health counselor. The DMHCA is a full-time employee and available for contact twenty-four hours a day, seven days a week. The program has a contract with a psychiatrist who is on-site biweekly. The psychiatrist has a clear and active license in the state of Florida, which expires January 31, 2020, with a specialty in child and adult psychiatry. A review of documentation for the past six months confirms the psychiatrist is on-site bi-weekly, with no exceptions. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. 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 in October 2019.

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 their 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. Three of the non-licensed staff have been employed at the program since the last annual compliance review. One non-licensed staff was hired September 2018. Two of the non-licensed clinical staff are registered mental health counselor interns. All four of the non-licensed clinical staff work forty hours a week and rotate weekend coverage. The DMHCA, a Licensed Mental Health Counselor (LMHC), provides one hour a week of on-site face-to-face supervision with the four non-licensed mental health clinical staff. A review of documentation for the past six months indicates supervision has been held each week, with no exceptions. There were two instances of staff being out on vacation or sick leave which was clearly marked in the supervision log by date and reason. The weekly supervision is documented on a form similar to the Department's Direct Supervision form (MHSA 019). The form includes all the required information of competency areas, discussion/focus areas, details of supervision, and youth discussed. Each of the four non-licensed mental health clinical staff hold the appropriate master's-level of education necessary and in accordance with the current contract. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services. All four mental health clinical staff have received twenty hours training in Assessment of Suicide Risk (ASR). Seven youth mental health records were reviewed. Each mental health substance abuse evaluation, initial treatment plan, and individual treatment plan completed by a non-licensed clinical staff was reviewed and signed by the DMHCA within ten calendar days. Each ASR completed by a non-licensed clinical staff was reviewed and signed by the DMHCA the next scheduled time she was on-site.

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. All seven youth had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered on the day of admission. Each MAYSI-2 screening was completed by trained staff and completed in the Department's Juvenile Justice Information System (JJIS) on the same day. All seven records had documentation existing mental health and substance abuse information was reviewed from each commitment packet. Four of the seven MAYSI-2 assessments indicated a further assessment was required. Three MAYSI-2 assessments did not indicate a further assessment was required. It is the program's policy for all newly admitted youth to be referred for a comprehensive mental health substance abuse evaluation. All newly admitted youth are administered an Assessment of Suicide Risk (ASR) as part of the intake process. Documentation confirmed each youth had an ASR during intake. Each youth was placed on

standard supervision as a result of the ASR. Additional screenings completed by the program at intake include the Substance Abuse Subtle Screening Inventory (SASSI-2) and Beck's Depression Inventory (BDI). An interview with the Facility Administrator confirmed each youth is seen by case management, mental health, medical, direct care, and education at intake. Case management completes and reviews the MAYSI-2 which and forwards the information to mental health.

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. Seven youth mental health records were reviewed, and each youth was referred for a new mental health evaluation on the day of admission. All seven youth had a mental health evaluation completed within thirty calendar days of admission. All seven evaluations were completed by a non-licensed mental health clinical staff were signed by a licensed mental health professional within ten calendar days after the evaluation was conducted; six of the seven signed by the Designated Mental Health Clinician Authority on the same day. The new evaluation included the following: identifying information, 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 included a substance abuse assessment with 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.

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. All seven youth are assigned to a treatment team upon arrival to the program. The multidisciplinary team is comprised of the youth, program administration, direct care staff, education, medical staff, mental health staff, and parent/guardian when possible. Treatment team documentation validates it is comprised of representatives from mental health and substance abuse, case manager, direct care staff, medical, education, and psychiatrist, if applicable. The treatment team review forms do not have a signature line for administration and there is no indication a representative from administration was involved in the treatment plan review. For the seven records reviewed, all youth received individual, group, and family counseling as prescribed by their treatment plan with no exceptions. All seven of the youth receiving mental health treatment have an Authority for Treatment and Evaluation (AET). All seven youth had a signed substance abuse consent and release forms. Treatment progress notes are documented on a form containing all the required information similar to Department 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, and all seven confirmed direct care staff do not conduct mental health or substance abuse groups.

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 the date of admission. The initial mental health and substance abuse plan is documented on a form containing all the required information similar to 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. Five of the initial treatment plans were completed by a non-licensed clinical staff and signed by the licensed mental health professional on the same date. The initial treatment plan was signed by all treatment team members who participated in the development of the plan. All seven initial treatment plans were mailed to the parent/guardian for signature. Four were signed by the parent/guardian, one was returned by the parent/guardian but unsigned, and two were not returned by the parent/guardian.

All seven individualized treatment plans were developed for each youth within thirty days of admission. The individualized treatment plan is developed on a form containing all the requirements similar to Department's Individualized Mental Health/Substance Abuse Treatment Plan form (MHSA 016). Two of the plans did not have the date they were developed on the cover page of the plan. Each individualized treatment plan was signed by the non-licensed mental health clinical staff completing the plan and signed by the licensed mental health professional the same date or within one day of completion. Each plan was signed by all treatment team members who participated in the development of the plan. There was documentation each plan was signed by all treatment team members who participated in the development of the plan. There was documentation all seven plans were mailed to the parent/guardian for signature although none were returned with signature. Three individualized plans included psychiatric services and were signed by the psychiatrist. Each youth had treatment plan reviews every thirty days following the development of the individualized treatment plan. The treatment plan review is developed on a form containing all the requirements similar to the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form (MHSA 017).

Three closed 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 at suicide risk upon release.

Each discharge plan included a recommendation of follow-up services for daily maintenance. Each discharge plan had documentation the plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) at the transition and exit conferences. There was documentation a copy of the discharge plan was provided to the youth, parent/guardian, and JPO.

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 is contracted to provide both mental health overlay services (MHOS) and substance abuse overlay services (SAOS), as required by the contract. Each youth receives mental health services which includes individual, group, and or family counseling, seven days a week. Daily therapeutic activities are provided by mental health clinical staff. Psychiatric services are provided on the second and fourth Wednesdays each month. Substance abuse groups using the Living in Balance curriculum are provided two days a week, on the weekends. The program has a licensed mental health professional on-site at least five days a week. Each therapist has a maximum caseload of twelve youth. The program provides urinalysis drug testing upon the youth's initial intake into the program. Individual and family sessions are provided monthly and additionally, as needed. Additional on-going curriculum includes Passport, Skillstreaming the Adolescent, Anger Management, and EQUIP. Clinical staff are on-site seven days a week, including rotating weekends. A review of seven youth mental health records confirmed, mental health services are being provided 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.	

The program has a contract with a psychiatrist to provide services on-site biweekly. The psychiatrist is on-site the second and fourth Wednesday each month. Each youth admitted into the program receives an initial psychiatric evaluation within fourteen days of admission. Seven youth mental health records were reviewed for psychiatric services. All seven youth received an initial psychiatric evaluation within fourteen days of admission, regardless of their medication status. One youth arrived at the program on psychotropic medication. Two youth were prescribed psychotropic medication subsequent to their admission. The initial diagnostic psychiatric interview included medical history, mental health history, substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. The evaluation was clearly identified as an "initial diagnostic psychiatric interview" Page 3 of the Clinical Psychotropic Progress Note (CPPN) was completed for each youth. For the three youth on psychotropic medication, there was documentation the youth had been seen for a medication review by the psychiatrist at a minimum, 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 every fourteen days to discuss the youth's

treatment. A review of documentation for the past six months confirms the psychiatrist is on-site biweekly, with no exceptions. An interview with the psychiatrist confirmed his role in the coordination and implementation of psychiatric services in the program is to evaluate and manage medication. An interview with the Designated Mental Health Clinician Authority (DMHCA) confirmed ongoing consultation with the psychiatrist bi-weekly to review each youth's behavior and any concerns. The DMHCA is present with the psychiatrist when he meets with youth. A review of mental health records indicated the psychiatrist signs all individual treatment plans, treatment team reviews, and amended treatment plans for youth who are prescribed psychotropic medication. The facility operating procedures related to psychiatric services and psychotropic medication are reviewed annually, with the last review being March 2019. There are no standing orders for psychotropic medications or emergency treatment orders for psychotropic medications.

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 policy and procedures regarding suicide prevention services to include a written plan detailing suicide prevention procedure. The plan includes identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process which includes suicide attempts and a mortality review. The plan also includes staff training of six hours annually. The plan is reviewed annually and was last reviewed March 5, 2019 by the Designated Mental Health Clinician Authority and the Facility Administrator.

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.*	

Seven youth mental health records were reviewed. It is the policy and practice of the program to conduct an Assessment of Suicide Risk (ASR) for each youth being admitted to the program. All seven youth had an ASR at intake and, as a result, were placed on standard supervision. Two of those youth each had an additional ASR completed, one after returning to the program from a transport and one due to staff observations. Both ASRs resulted in the youth being placed on standard supervision. None of the youth were placed on precautionary observation. 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 an ASR. Eight of the nine ASRs were completed by a licensed mental health professional. One completed by a non-licensed clinical staff was reviewed and signed by a licensed mental health professional. None of the youth were applicable for an alert in the Department's Juvenile Justice Information System (JJIS).

The Facility Administrator has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide as part of the program's suicide prevention plan. The review includes circumstances surrounding the event, procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for any changes, if needed. The program has a suicide response kit located in master control which was observed. Seven staff were interviewed. All seven staff were able to indicate the suicide response kit is kept in master control. Three staff stated an additional kit is kept in medical and one staff stated there is one kept on dorms. For the interviewed staff regarding what to do when a youth expresses suicidal thoughts, seven staff stated to search youth and room for objects, seven staff stated to keep youth in sight and sound, five staff stated to notify mental health and document supervision, and two staff stated to place youth in locked room. One staff responded with other remarks which indicated to document ten-minute checks.

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

The program has a policy and procedures in place regarding suicide precaution observation (PO) logs. The program has not had any youth placed on PO logs since the last annual compliance review. The Designated Mental Health Clinician Authority keeps a log confirming there were no youth on PO 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 staff pre-service training records and seven in-service training records were reviewed. The past three quarters were reviewed for mock suicide drills. A drill was conducted each quarter, for each shift. In addition, an all staff meeting was held the same month, to review the mock suicide drills which were conducted. Seven of the nine mock suicide drills included the use of cardiopulmonary resuscitation (CPR), eight of the nine drills included the use of automated external defibrillator (AED), all nine drills included the use of calling 9-1-1, and six of the nine drills included the use of the suicide response kit. Each drill included pictures of staff and the mock subject, a large stuffed bear, during the drill as confirmation of the drills being conducted. The pictures were unique to each drill and included the use of the subject in each situation receiving mock first aid and CPR. All applicable staff, with the exception of three staff, participated in at least one quarterly mock suicide drill. The three staff who did not participate are PRN staff, two nurses and one youth care worker.

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 policy and procedures regarding mental health crisis intervention services which includes written crisis intervention procedures. The crisis intervention plan includes notification and alert system, means of referral, communication, supervision, documentation, and review. The plan is reviewed annually by the Designated Mental Health Clinician Authority, last reviewed March 5, 2019.

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

The program has a written crisis intervention plan which includes a process for implementation of a crisis assessment form. The program documents a crisis assessment on a form which contains all of the information in the Department's Crisis Assessment form (MHSA 023). The program's form includes the reason for crisis assessment, method of assessment, current mental health status, degree of dangerousness youth presents to self or others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notifications. The program has not had to complete a crisis assessment during the annual review period.

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 which includes a written mental health and substance abuse plan. The emergency mental health and substance abuse services plan includes 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 designates a

local receiving facility for emergency transports. The plan is reviewed annually by the Designated Mental Health Clinician Authority, last reviewed March 9, 2019.

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

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

Standard 4: Health Services

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

The program continues to contract with the same Designated Health Authority (DHA). The DHA 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 Florida and expires on January 31, 2020. 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 an alternate medical physician to cover any scheduled absences or vacation. The alternate physician has a clear and active license with one record of documented discipline, which expires on January 31, 2020. 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 for review of all medical records, physical assessments, chronic evaluations, follow-up care, and referrals. These practices were confirmed during record review, and interviews with the nurses and DHA.

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 March 1, 2019. Approval of treatment protocols were developed and authorized by the DHA. The full-time nursing staff reviewed, signed, and dated a cover page for the treatment protocols in various dates in March 2019. All FOPs and protocols related to psychiatric services were reviewed and approved by the program's contracted psychiatrist, signed on March 1, 2019. 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.	

All seven individual healthcare records reviewed contained a valid Authority for Evaluation and Treatment (AET). There were legible copies of AET forms stamped "copy" and were signed by the parent/guardian and a Department of Juvenile Justice representative in all seven cases. Parental notifications were filed behind the AET in all seven youth records

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

Documentation of parental notification for over-the-counter (OTC) medications beyond those on the Authority for Evaluation and Treatment (AET) form were present in all youth records reviewed. In one applicable record, parental notification for consent to immunizations was present. There were no other examples of consent to immunize after admission since the last review. One applicable notification was made for changes in condition/medication for youth with chronic conditions. In two applicable records, parental notifications were made for off-site emergency care and 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 by another staff and documented in the youth's individual healthcare record. Additionally, all seven records had written notifications to the parent/guardian when initially seen by the Designated Health Authority (DHA) and the results of each visit.

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

New psychotropic medication was prescribed for three applicable youth. In all three cases, a witnessed verbal consent was obtained prior to starting the youth on the new medication. A notification along with the third page of the Clinical Psychotropic Progress Note (CPPN) was mailed to the parent/guardian in both applicable cases and contained explanatory information. Parental notification was also mailed when medication was discontinued for one youth.

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

All seven youth records contained documentation of youth vaccinations which were verified within thirty days of admission by a nurse and reviewed by the Designated Health Authority (DHA). An interview with the program's director of nursing indicated immunization records are normally included in the initial health care admission packet or can be obtained from Florida Shots.

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

All seven youth records contained the Department's Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN) on the day of admission.

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

The program has an internal medical alert system in place. Seven youth records were reviewed. All seven youth had identified chronic conditions classified with a medical grade of two or higher. Seven youth were on alert for chronic conditions, four youth had medical alerts for seasonal allergies, one youth had an alert for a visual impairment, and three youth were on alert for medication side effects. All internal alerts were identified in each applicable youth's record and were included in the Department's Juvenile Justice Information System (JJIS). The internal medical alerts were accurate and up-to-date. Interviews with staff confirmed they are notified of the youth's alerts from different sources including alert boards, shift briefings, verbally, and from the internal alert list completed by medical staff.

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

All records reviewed documented a general health care orientation completed on the date of admission for all seven youth. The healthcare orientation topics include 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.

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

Seven youth records were reviewed and the Designated Health Authority (DHA) was notified for youth with a known or suspected chronic condition in all seven cases. The DHA was notified through fax 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.

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

Seven youth records were reviewed, and one record was applicable for healthcare admission rescreening. This youth had a change in physical custody twice due to court appearances and a Healthcare Admission Rescreening form was completed upon his return to the facility in both cases. An additional record was reviewed for this requirement, making the total sample three. A Healthcare Admission Rescreening form was completed upon this youth's return to the facility as well. A Facility Entry Physical Health Screening form was completed by a registered nurse for all three rescreenings.

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

All seven records contained a new Health Related History (HRH) form completed on the youth's date of admission before or at the same time the Comprehensive Physical Assessment (CPA) was conducted. Each HRH was reviewed by the Designated Health Authority (DHA) and a Department form was used in all seven cases.

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

While all seven youth had a current Comprehensive Physical Assessment (CPA), it is the program's practice to complete a new CPA on all youth, even if they are admitted with a current physical. This was evident in all seven records reviewed. Each youth record had a CPA using the Department's form completed by the DHA. All fields on the CPA were completed as required. Three youth had a documented medical grade of three or higher and were appropriately placed on the program's internal alert list. In each youth record, where the youth declined the genital exam, the DHA noted "refused by patient" with the youth's signature. In all seven cases the Tanner Stage was marked with a circle in each of the records since a genital exam was declined. The DJJ Problem List was updated in all seven records.

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

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

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

There was a verified Tuberculin Skin Test (TST) documented on the Comprehensive Physical Assessment (CPA) and the Infectious and Communicable Disease (ICD) forms in all seven records. All seven youth records contained a Tier I TB screening documented on the Facility Entry Physical Health Screening (FEPHS) screening form, completed by a registered nurse (RN) on the day of admission. None of the youth records indicated further evaluation was needed.

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

All seven healthcare records reviewed documented a sexually transmitted infection (STI) screening. The Designated Health Authority (DHA) ordered testing for all seven youth. Four youth were tested on the date of admission, the remaining three youth were tested the next day

after admission. The test results were documented on the Infectious and Communicable Disease (ICD) form in all seven cases and filed in the lab section of the youth record. There were no additional referrals needed and rescreening was not applicable, as none of the youth were out of Department of Juvenile Justice (DJJ) physical custody for over thirty days.

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

Seven youth records were reviewed. 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 and an additional record was reviewed for this requirement, making the sample size three in total. All HIV testing is conducted at the Marion County Health Department where a 501 certified HIV counselor, whose certification expires November 15, 2019, conducts testing and provides pre/post-test counseling. The counseling was documented on the Department's Health Education Record form in all three records. The HIV results were filed inside the youth's record in a sealed enveloped marked "CONFIDENTIAL." The HIV status was not included on the internal alert list for any of the youth or on the Infectious and Communicable Disease (ICD) form. Seven youth were interviewed and all seven youth said they could ask for an HIV test if they wanted one.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

Sick call is conducted at the program twice a day, seven days a week, at 11:00 a.m. to 12:00 p.m. and at 3:00 p.m. to 3:30 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. Four records were applicable and none of the youth presented 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 applicable youth's individual healthcare record in reverse chronological order. Seven youth were interviewed, and one youth said they can be seen immediately, three said within one day, two said more than three days of submitting a request, and one said they have never requested a sick call.

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

Seven youth records were reviewed and three were applicable for sick call. A total of seven sick call request forms were reviewed. All sick call forms documented vital signs, treatment, education, and follow-up, if needed. All sick calls reviewed were documented on each youth's corresponding sick call index and on the sick call referral log in all three records. All sick call request forms were filed in the progress notes section of the individual healthcare record in reverse chronological order. Each included the youth's signature or youth's initials on each sick

call form. The sick call process was observed twice with verbal consent from both youth. A direct care staff escorted the youth to the clinic. The Designated Health Authority (DHA) completed one youth's sick call request and a registered nurse completed the other. The sick call was completed inside the medical clinic in an area designated for exams while the youth's privacy was maintained. The area was private and contained an exam table. The youth's vitals were taken, and they were cooperative during the evaluation. The youth signed indicating they were seen after the exams were complete. Seven youth were interviewed and all seven said they could see the doctor if needed. Seven staff were interviewed and six said the nurses conduct sick call. The remaining staff said sick call is completed by a nurse or supervisor.

4.20 Room Restriction/Controlled Observation	**Satisfactory Compliance**
All youth in Room Restriction/Controlled Observation shall have timely access to medical care, as required by the Department.	

The program's written policy and procedures state nursing staff are to conduct daily checks on youth in controlled observation. The policy requires youth to continue taking any prescribed medication. Three occurrences were reviewed. A Health Status Checklist form was completed for all thee youth and two were taking prescription medication. All three youth have been released and the progress notes were not available. During an interview with the Director of Nursing, she stated the youth are seen daily for sick call services and medication pass while in controlled observation.

4.21 Episodic/First Aid 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. The program staff can call 9-1-1 for emergency medical services to transport to a local hospital. All seven youth records reviewed documented instances of on-site first aid or episodic care. Non-healthcare staff episodic care documentation includes the date/time of episodic care, nature of the complaint, findings of person rendering care, treatment rendered, referral to off-site care, if needed, education/instruction to youth, if needed, plans for follow-up/future care, placement on alert list, if needed, parental notification, and name, and credentials of staff providing care. In two cases youth were seen by non-healthcare staff. Youth seen by non-healthcare staff were seen by a nurse the following day in both cases. The nurses complete a problem oriented SOAP (subjective, objective, action, plan) note to document episodic care. All instances of episodic care are tracked using the Department's log. Twenty episodic events were reviewed in seven health care records for the past six months and all were documented on the episodic care log. The program has eight first aid kits located in master control, the exam room, the nurse's office, maintenance, the kitchen, and in the Phase II dorm area. The remaining two kits are stored in master control and are placed in both vehicles when they are used to transport youth. All first aid kit contents are approved by the Designated Health Authority (DHA) and the kits are monitored weekly by the Director of Nursing. The weekly monitoring log includes expiration dates of eye wash, saline, and triple antibiotic ointment in each of the first aid kits. Three first aid kits were opened, and all approved items were current with no expired contents. Seven youth were interviewed, and all said they could see a doctor if needed. Seven youth were interviewed and six said they could see a dentist if they had tooth pain and one youth said he could not.

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

The program has a policy and procedures in place outlining the process for emergency care of youth and responding to emergency situations. The program completes mock emergency medical and mental health drills monthly on each shift. The drills included a simulation of an emergency event calling for immediate first aid and/or administration of cardiopulmonary resuscitation (CPR) for a life-threatening event. All nurses and staff have current certifications for first aid and CPR along with automated external defibrillator (AED) training. The program has one AED machine on-site located in master control. The procedures for the AED are attached to the AED machine and in a separate binder kept next to the AED machine inside master control. The Director of Nursing (DON) conducts and documents weekly checks of the AED machine. The DON removed the battery and conducted a test of the AED in front of the monitor. The AED functioned properly when tested. The battery expiration date was observed to expire in May 2023 and the pads were observed to expire in 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. The nurses trained staff on use of an epinephrine auto injector on April 12, 2018. Seven staff were interviewed, five staff stated they are personally allowed to call 9-1-1 if a youth had a medical emergency. The remaining two staff stated they would notify the shift supervisor or master control to call 9-1-1.

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

Seven youth records were reviewed and two were applicable for requiring off-site first aid or emergency care. Two youth went off-site for care four times. In all cases, 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 reviewed and signed all off-site summary forms, instructions, and follow up information. The youth required follow up and it was completed in all four cases.

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

Seven youth records were reviewed, and all were applicable for chronic conditions and/or taking psychotropic medication. All 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 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.

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

Seven youth records were reviewed, and one youth was admitted with prescribed medication. Two additional records outside of the sample were reviewed and the medication was verified prior to being accepted into the program in all three cases. All youth were in a Department of Juvenile Justice facility prior to being admitted. A progress note documented the verification. The nurses contacted the Designated Health Authority (DHA) prior to administering to all three youth and this practice was documented in the progress notes. A notification is also sent to the parent/guardian informing them the DHA approved continuation, hold, or discontinuation of a medication following admission.

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

Seven youth records were reviewed, and one youth was admitted with medication. Two additional records were reviewed outside of the sample and all three had a current and valid order for their medication. Current medications prescribed prior to admission were renewed for the life of the prescription when it was continued as originally prescribed. The Designated Health Authority (DHA) documented continuations in the practitioner order section. None of the three youth received over-the-counter medications not listed on the Authority for Evaluation and Treatment form.

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

Medication storage at the program was reviewed during the week of the review. All medications are stored in a separate and secure area inaccessible to youth. All non-controlled, prescribed, and over-the counter (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 clinic. The medication cart is clean, organized, and stock items are separate from youth specific medications. Controlled medications are stored in 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 is not controlled, is 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 places related to the disposal of medication.

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

The stock supply of sharps is inventoried weekly and perpetually if any of the supply is used. All prescribed and over-the-counter (OTC) medications inside the medical cart are inventoried

daily. There is a procedure in place for inventory discrepancies. There is a procedure in place for disposal of narcotics and other controlled substances. Three controlled medications, OTC medications, and sharps were each inventoried by the monitor with the nurse and were found to be accurate. Inventories for the past six months were reviewed and there were no discrepancies indicated.

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

The program has a facility operating procedure (FOP) in place for inventory of controlled medication. There were two controlled medications on-site. Both controlled medications were observed and secured behind two locks. Shift-to-shift counts are conducted with a nurse or trained supervisor and documented on the youth's individualized Controlled Medication Inventory Record. The Director of Nursing was observed completing an inventory for both controlled medications, the medication on hand matched the ending inventory numbers on the controlled medication sheets. Inventories from the past six months were reviewed and found to be accurate.

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

Seven youth records were reviewed, and one was applicable for having a current Medication Administration Record (MAR). Two additional records outside of the sample were reviewed for a total of three. The program uses the Department's standard MAR form. Each youth's MAR contained all required elements including the youth name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth alongside the MAR. Three youth taking medication at admission matched the medication list and received their medications as ordered. Each youth's MAR clearly indicates start/stop dates. Documentation of weekly side effect monitoring was documented on the back of each youth's MAR. There were no indications of lapses or errors in medication administration. Refusals of medication were clearly marked on the MAR and included a separate additional form documenting the youth's refusal.

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

Medication is administered twice a day by a registered nurse. None of the youth in the program required parenteral medication. As observed, the working environment was clean and organized. The medication was not pre-poured, and a window separated the youth from the nurse and the medication cart. The medication pass process was structured for youth to approach the nurse. The nurse maintained continuous control of the medication and the cart when observed. A direct care staff was present during medication pass and it occurred as scheduled. The nurse verified the Five Rights of Medication Administration for each youth. The nurse and direct care staff observed the youth closely to ensure the medication was swallowed.

Seven youth were interviewed and four stated a nurse gives them their medication, three said they do not take medication.

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

Trained non-licensed staff assist youth with self-administration of prescribed oral, topical, inhaled and over-the-counter medication, in the absence of a licensed healthcare professional. The designated staff are identified by name and title. The program's policy states, while assisting youth with self-administration, the designated staff cannot conduct or supervise any facility activities during this time. There were no instances of this practice to evaluate. Seven youth were interviewed. Four youth stated a nurse administers medication and three youth stated they do not take medication. Seven staff were interviewed and six stated the nurse administers medication to youth. The remaining staff said the nurse or trained supervisor administers medication to youth.

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

Seven youth records were reviewed, and one was applicable for having a prescribed psychotropic medication upon admission. An additional file was reviewed and there have been no other examples since the last annual compliance review, therefore only two examples were reviewed for this requirement. The Designated Health Authority (DHA) and Designated Mental Health Clinician Authority (DMHCA) were notified, as required in both instances when youth were admitted with psychotropic medication. The psychotropic medication both youth were taking prior to admission was continued until the DMHCA completed an initial diagnostic psychiatric interview of each youth. Both youth's initial diagnostic psychiatric interviews were completed within fourteen days of their admission. Medication monitoring of prescribed psychotropic medication prescribed prior to admission was completed by the DMHCA. Both youth were referred to the DMHCA for further evaluation. The psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note form and included all three pages. There were no standing orders for psychotropic medications, emergency, or pro-re-nata (PRN) treatment orders for psychotropic medication.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program has infection control 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. There is documentation Universal Precautions were included in the comprehensive program education and prevention

administered at the program. 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 (CDC), and/or the Central Communications Center (CCC) should have been notified of an infectious disease. The program has five blood borne pathogen kits located in master control, the kitchen, the clinic, and in each van.

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

All staff were trained on the program's infection control plan. All seven youth records reviewed documented infection control practices. There is evidence the youth received infection control training on hand washing techniques, standard precautions, prevention/transmission of communicable disease, vaccinations, and Center for Disease Control (CDC) guidelines for infection control. Documentation of youth training was filed in each youth's record.

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

The program has an Exposure Control Plan in place written in accordance with Occupational Safety and Health Administration (OSHA) Standards available to all employees. The Exposure Control Plan was reviewed and signed by the Executive Director (ED) and Designated Health Authority on March 1, 2019. The ED maintains a separate confidential record for youth and staff who have experienced a facility/occupational exposure. There have not been any cases of exposure since the last annual review. The Exposure Control Plan includes risk assessment, methods of compliance, and a comprehensive process in place for needle stick post-exposure evaluation. An interview with the ED indicated the exposure control plan is maintained in the clinic.

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

This is an all-male program; therefore, this indicator is not applicable.

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

This is an all-male program; therefore, this indicator is not applicable.

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

This is an all-male program; therefore, this indicator is not 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 ratio is one staff to eight youth during awake hours and one staff to twelve youth during sleeping hours. Observations of staff and youth during daily activities such as school, recreation, meals, breaks, and line movements were completed each day of the annual compliance review and reflected the program was in ratio. Staff were interacting positively with youth. Staff were asked the number of youth they were supervising at various times during the review and staff immediately knew the count. The program has a full schedule of daily activities planned. The schedule was observed posted in each living area. Youth were observed participating in the full schedule of activities. Youth were accounted for and accompanied at all times. Staff explained when the count is not reconciled master control stops all movements and a supervisor walks down completing a physical count of all youth in the facility. After the count is confirmed clear movement can resume.

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

The program has a detailed written Behavior Management System (BMS). The written description is provided in the resident handbook and includes rules governing conduct positive and negative consequences including while in the classroom. All seven in-service staff and seven pre-service staff reviewed were trained in the BMS. 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 the BMS. Seven youth interviews were reviewed, and two youth rated the BMS as very poor, one youth rated it poor, three youth rated it as fair and one youth rated it as very good. The program uses a variety of rewards/incentives to encourage youth participation and completion of the program. During interviews, both the staff and youth indicated rewards such as outings, canteen, additional food items were used as part of the BMS.

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, provides opportunities for positive reinforcement and recognition for accomplishments and positive behaviors. In each use of room restriction, the program documented a description of the behavior resulting in room restriction, the date and time it was implemented, the name of the staff and the name of the approving supervisor, the name of the staff person removing the youth from room restriction, the date and time of removal to include the youth's behavior and attitude upon removal. No documentation was available to review regarding if the door was left open or evidence of staff and youth discussion every thirty minutes.

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 fifty-two cameras providing coverage inside and outside the facility. All fifty-two cameras are operational. Video recordings are stored for thirty days. Video was reviewed to ensure ten-minute checks were completed with fidelity. The program uses an electronic wand system to log the checks which ensure the checks are completed in real time. Video was reviewed of six days, three days video of second shift completing ten-minute checks, and three days of third shift completing ten-minute checks. All video reviewed showed checks were completed in intervals no greater than every ten minutes and there were no missed checks. Seven staff were interviewed, and all seven reported checks are completed every ten-minutes when a youth is placed in their room for sleeping.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program has a policy and procedures regarding census, counts, and tracking. During the four day annual compliance review counts were observed being conducted. Logbooks were also reviewed which reflected counts are completed at the beginning of each shift, and after each outdoor activity. Documentation of counts in the logbooks also reflected when a youth was temporarily away from the program, such as when a youth was off-site for medical attention. Seven staff were interviewed, and six reported youth counts are conducted every hour. One staff did not remember how often counts are conducted. Six staff were also able to explain the procedure if the count does not clear then movement stops and a physical count is conducted.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

Logbooks were reviewed which revealed they are bound with numbered pages, all entries were made in ink with no erasures or white-out areas, and no logbook entries were obliterated or removed. 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 and signature of the staff making the entry. The program uses shift reports to summarize the events, incidents, and activities documented in the program's logbook. The program supervisor verbally briefs incoming staff about the contents of the shift report. The program documents the following events, incidents, and activities in the logbook: emergency situations, population counts at the beginning and end of each shift, perimeter security checks and other security checks conducted by direct care staff, transports away from the facility, requests by law enforcement to access any youth, removal of any youth from the mainstream population, and admissions and releases. A review of the logbooks all showed internal incidents reported to the Florida Abuse Hotline and/or the Central Communication Center (CCC) were documented.

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. The system 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. During the annual compliance review, the distribution and collection of keys by master control was observed. The key inventory was reviewed and matched the actual key rings in use. The key storage area is a locked cabinet in master control. The program has a list of permanent issue keys for the program director, department heads, director of support services, facility nurse and clinicians. No other staff have access to medical, staff or youth records, or property lockers. The program tracks and reconciles keys daily through the key inventory sheet. In the past six months there were no instances of lost or missing keys. Three staff were randomly checked, and none were in possession of their personal keys. Seven staff were interviewed and able to explain the program's key control process.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a policy and practice regarding contraband. The program has a system to define items or materials considered contraband as well as exceptions. The youth are provided a list of contraband and informed of the consequences if found with contraband at intake. The contraband policy includes searches of the physical plant, facility grounds, youth, and outgoing mail. The policy and procedure address employees who is found in possession of contraband in a program will be subject to disciplinary action up to and including dismissal. The program had documentation of daily searches of the physical plant to include youth rooms. The program

documents the confiscation of contraband but does not document the disposition of the contraband. An interview with the Assistant Facility Administrator indicated contraband items like pens are distributed to staff but it is not documented on the form as to the disposition of those items. Two incidents where money was confiscated did not indicate on the contraband form as to whether the currency was secured. There was documentation both incidents were called into the Central Communications Center (CCC) which indicated the money was secured. An interview with the Facility Administrator concerning the money indicates once the investigation determines the source of the money, disposition occurs. In both of these cases, the source of the money was family during visitation. The money was returned to the family and their visitation was addressed with 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.	

The program has a policy and procedures regarding youth searches. Throughout the review period, youth were observed being searched before and after groups, for transports, after education, and after access to tools or equipment. No youth were observed being searched at admission; there was documentation in the logbook where youth are searched at admission. There were no visitation searches observed. During searches, youth were treated with dignity and respect to minimize the youth's stress and embarrassment. Youth were searched by the appropriate number of staff and gender. Youth searches were observed being conducted according to the Protective Action Response (PAR) training manual. Seven youth were interviewed. Seven youth stated they are searched after visitation, six youth stated after outside recreation, five youth stated after being off campus and when items are missing, and four youth stated after meals and work detail. Seven staff were interviewed. Six staff stated youth are searched after every movement and one staff stated before meals and after being outside.

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

The program utilizes two vans for transporting youth. Each received an annual safety inspection. Each vehicle was also observed which revealed they were equipped with seatbelts, seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. A transport was unable to be observed during the annual compliance review. Both vans were locked.

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

The program has a policy and procedures regarding the transportation of youth. Youth are transported with a ratio of 1:5 staff to youth. One staff of the same gender is on the transport with the youth. A random check of personal vehicles and facility vehicles was conducted, ensuring the vehicles are locked when not in use. Only staff with a valid license are allowed to drive program vehicles. An inspection of the vehicles ensured they are equipped with safety equipment and seatbelts for each youth and staff. Youth are not left unsupervised in the vehicles and no youth are permitted to drive program or staff vehicles. All staff operating a program vehicle has a current driver's license. Seven staff were interviewed and all seven stated they do not used their personal vehicles to transport youth. All seven staff stated they have use of a cellular phone during a youth transport.

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

The program does not have a policy but does have a procedure and practice of conducting weekly security audits and safety inspections. Three weekly facility security audit and safety inspection were reviewed. Deficiencies were noted for the digital video recording (DVR) system, which was corrected on a later form. An interview with the Facility Administrator confirmed the practice of completing the weekly audits along with a shift supervisor and maintenance staff. The completed form is submitted to the Department's Safety and Security Coordinator by noon on Wednesday of each week.

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 regarding the issuance, inventory, and control of equipment and tools. Tools are securely stored when not in use. All tools are marked for easy identification. All tools are inventoried prior to being issued for work. All tools are inventoried following work activities. Sharp-edged, or pointed tools, are inventoried daily. A monthly inventory of tools which do not have sharp edges or points is completed. Machetes, bowie knives, or other long blade knives are prohibited. Fourteen staff training records were reviewed, and all received training on the intended and safe use of tools. Seven youth records were reviewed, and all received training 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 youth tool handling and supervision. Before a youth is permitted to use tools, a risk assessment is completed on the youth. During activities involving tool use the ratio is maintained at one staff per five youth. Seven youth records were reviewed, and each had a completed risk assessment reflecting if the youth was permitted to

use tools. Seven youth were interviewed regarding tools they are allowed to use. Two stated screwdrivers, two stated hammers, one stated a saw, two stated rakes, three stated scrub brushes, six stated mops and brooms, and one stated youth are not allowed to use tools. The program has youth who participate in the Home Builders Institute (HBI) program in which they would use tools such as screwdrivers, hammers, and saws. Seven staff were interviewed. Two reported youth may use scrub brushes, three reported mops and brooms, four stated youth do not use tools. Three staff stated if youth are in HBI they may use tools in that program.

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 regarding outside contractors. Sign-in sheets for outside contractors were reviewed. Guidelines for external worker tools include the following: tools are checked upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. Project invoices submitted to the program by the vendor were reviewed. The date the project was being worked on matched the sign-in sheets of the outside workers. The program inventoried the tools when the vendor left.

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's Continuity of Operations Plan (COOP) was reviewed. The program conducts practice drills to be prepared for immediate implementation of mobilization of the plan whenever an emergency or disaster situation necessitates. The program conducted the following drills fire drills, safety drills, evacuation drills, and disaster drills. Unannounced fire drills were conducted monthly, under varied conditions, and across all shifts. The drills were documented in the Fire Safety Log. During the annual compliance review, the program conducted a fire drill and all staff and youth were observed evacuating the building. Seven youth were interviewed. Six stated they have been instructed on what to do in case of a fire, and five reported fire drills occur monthly. All seven staff reported they have participated in a fire drill.

5.17 Disaster and Continuity of Operations Planning	**Satisfactory Compliance**
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program's Continuity of Operations Plan (COOP) is available in master control, the Assistant Facility Administrator's office, and the Facility Administrator's office. The COOP is reviewed and updated annually. The most recent review occurred March 8, 2019. The plan addresses alternative housing plans approved by the Department's Regional Director. The program maintains provisions of equipment and supplies required for continuous operation and services during emergency or disaster situations. The COOP includes the following information: fire and fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorism, staff roles and responsibilities, 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.

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 procedure regarding the storage and inventory of flammable, poisonous, and toxic items and materials. Flammable, poisonous, and toxic items are secured at all times, and stored in secure areas inaccessible to youth. Inventories are maintained for all flammable, poisonous, and toxic items. A review of the inventories revealed they matched the actual items within the program and there were no items missing or additional items not on the inventory. The program maintains safety data sheets 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 maintains strict control of all flammable, poisonous, and toxic items and materials. Youth do not use, handle, or clean-up dangerous chemicals. Youth do not clean, handle, or dispose of any bio-hazardous material, bodily fluids, or human waste. There is restricted youth access to areas where items are being used or stored. Seven youth were interviewed. Two youth stated they use paint, one stated rubbing alcohol, two stated bleach, two stated laundry soap, and three stated window or toilet cleaner. Three youth stated they do no use any chemicals or cleaning products. Two youth indicated they are given gloves, one youth stated staff spay the cleaner. One youth stated staff leaves the cleaner out, and sometimes come back and collect it. One youth indicated he used paint while doing maintenance work with the maintenance worker.

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

The program has a policy and procedures regarding the disposal of flammable, toxic, caustic, and poisonous items. The program also designates maintenance staff to dispose of these items and he has received training. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA). The program's disposal log was reviewed. Liquid wastes from work details are disposed of in plumbing drains, kitchen liquid waste, except grease, is disposed of in the kitchen. Grease is placed in a separate container for disposal. There were no instances of chemical spills. The program director indicated the program has identified a local site where flammable, caustic, and toxic items can be taken for disposal. Furthermore, the

program has an agreement with a local waste management company who will come on-site and pick these items up if needed.

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

The program has a policy and procedures regarding recreation and leisure activities. The program has an activity schedule which has a range of structured indoor and outdoor recreation and leisure activities for the youth. The program has a recreational therapist which has been at the program since 2016. During the review period, youth were observed participating in outside recreation on the digital recording video system. Seven youth were interviewed. All seven youth stated they have an hour of recreation each day with a variety of sport activities. The activities are constructive, and interesting. The activities promote healthy competition, teamwork, fitness, and/or mental stimulation. Seven staff were interviewed. Six of the staff stated the youth get at least one hour of recreation each day with a variety of activities. One staff stated the youth get an hour of recreation each day with the same activities of watching television, sleeping, or playing video games.

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

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

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

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

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

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

The program does not participate in water activities; therefore, this indicator is rated non-applicable.

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedure regarding visitation and communication. The program has a posted visitation schedule for visitation on Sunday from 2:00 p.m. to 4:00 p.m. A review of documentation indicated the program conducts weekly visitation as scheduled. There was documentation a number of visitors stay for the whole two hours of visitation. The visitation policy allows for alternative visitation arrangements on a case-by-case basis. There was documentation youth are given an opportunity to communicate with family by telephone and by mail. Seven youth were interviewed and all seven youth confirmed they have an opportunity to communicate with family.

5.24 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 utilizes controlled observation. The controlled observation rooms meet the following requirements: at least thirty-five unencumbered square feet, metal door with shatter-resistant window, vents not easily accessible, fire retardant plastic mattress, recessed light fixture covered with shatter-resistant material, and no electrical outlets. Documentation was reviewed of four uses of controlled observation. In each case, the documentation reflected staff conducted an inspection of the room prior to placing the youth in the room, and staff of the same sex conducted a full body visual search of the youth before placing the youth in the room.

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

In the past six months, there were four uses of controlled observation. In each case, supervisory or high-level staff authorized placement. Documentation reflected the youth were showing active aggression toward others, violent behavior, and staff advised youth for the reason of placement in controlled observation and expected behavior for removal. Three youth were in controlled observation longer than two hours. Documentation did not reflect the program director or designee granting an extension in any of the three cases, nor continuing to approve placement every two hours.

5.26 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.	

In the four uses of controlled observation documentation reflected staff making the placement completed the first page of the controlled observation report and submitted it to a supervisor. Documentation further revealed in all for cases, staff conducted safety checks and observed youth’s behavior. The program director or supervisor who has delegated authority gave written approval before the youth was released from controlled observation in all four instances when it was determine, based on his behavior, the youth was no longer an imminent threat to himself or others. Documentation further reflected the program director or assistant reviews controlled observation reports within fourteen days of the youth’s release from controlled observation to determine if the placement was appropriate.

Program Name: Marion Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Marion County / Circuit 5
Review Date(s): March 26-29, 2019

MQI Program Code: 8304
Contract Number: 10321
Number of Beds: 48
Lead Reviewer Code: 157

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.09 Grievance Process	5.25 Controlled Observation
1.16 Youth Input	
1.17 Advisory Board	