STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Martin Girls Academy
TrueCore Behavioral Solutions, LLC
(Contract Provider)
800 South East Monterey Road
Stuart , Florida 34994

Review Date(s): August 21-24, 2018

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:

Shakela Minns, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, Technical Assistance Specialist (SPEP)
Christina Calvert, Office of Program Accountability, Regional Monitor (Standard 3)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Standard 2)
William Henderson, Eckerd Project Bridge Circuit 17, Program Manager (Standard 2)
Gary Mogan, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 4)

Program Name: Martin Girls Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Martin County / Circuit 19
Review Date(s): August 21-24, 2018

MQI Program Code: 1138
Contract Number: 10139
Number of Beds: 30
Lead Reviewer Code: 159

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

- ☒ Facility administrator
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- 2 # Case Managers
- 4 # Clinical Staff
- _____ # Food Service Personnel
- 4 # Healthcare Staff
- 1 # Maintenance Personnel
- 2 # Program Supervisors
- 5 # Staff
- 5 # 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
- 8 # Health Records
- 8 # MH/SA Records
- 5 # Personnel Records
- 10 # Training Records/CORE
- 5 # Youth Records (Closed)
- 3 # Youth Records (Open)
- _____ # Other: _____

Surveys

- 5 # Youth
- 5 # Direct Care Staff
- _____ # 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	Limited
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

* 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	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Satisfactory
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	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	Satisfactory
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Satisfactory
4.39	Prenatal and Neonatal Staff Education	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook entries and Shift Report Review	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	Satisfactory
5.26	Controlled Observation Safety Checks and Release Procedures	Satisfactory

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Strengths and Innovative Approaches

- Local news Channel 12 obtained clearance to do a story on the Power of Art at Martin Girls Academy, on August 24, 2018. Volunteer Lynne Barletta developed the curriculum called the Power of Art by piloting it at Martin Girls Academy for youth to express themselves through the art of painting.

Standard 1: Management Accountability

Overview

The Department of Juvenile Justice contracts with TrueCore Behavioral Solutions, LLC to operate Martin Girls Academy, located in Stuart, Florida. The facility is a is a thirty-bed hardware-secure high-risk and maximum-risk program for female youth ages thirteen to twenty. At the time of the annual compliance review, the program had twenty-one youth in the program. The program is licensed under Florida Statutes, Chapter 397, and certified through the Department of Children and Families (DCF) to provide outpatient substance abuse treatment and prevention services for adolescents. The program has a community advisory board consisting of representatives from the school board, community partners, the business community, faith-based organizations, a local victim's advocacy agency, and a parent/guardian which meets quarterly. The program administration team is comprised of a facility administrator, assistant facility administrator, human resources manager, and a staff development specialist. At the time of the annual compliance review, the program had eleven vacancies consisting of six youth specialists I, two youth specialists II, one health service administrator, one registered nurse, and one licensed therapist.

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. The background screening process is completed prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a written policy and procedures which follows the established statutory requirements for background screening along with the submission of the Affidavit of Compliance with Level 2 Screening Standards. Nineteen staff, twelve volunteers, and one contracted staff was applicable for pre-hire background screenings. A review of the background screening documentation for the newly hired staff, contracted staff, and volunteers found all have been determined to have an eligible rating prior to having contact with youth. Four staff were hired after July 1, 2018 and had a completed pre-employment assessment filed in each personnel record. All teachers are background screened by the School Board of Martin County. The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU)/Clearinghouse on January 3, 2018, meeting the annual requirement.

1.02 Five-Year Rescreening	Limited 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 written a policy and procedures to establish the rescreening process for staff every five years based upon their original hire date. Staff rescreening is submitted to the Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the staff's five-year anniversary date of hire. A review of the employee and volunteer roster indicated one staff member was eligible for the five-year background rescreening. Reviewed documentation found the staff was hired June 24, 2013. The program did not complete the five-year rescreening until August 2018.

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 maintains a written policy and procedures for reporting abuse, providing an abuse free environment and reporting all allegations of suspected child abuse to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) for youth who are eighteen years old. The policy indicates youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. Each staff signs a written acknowledgement of their understanding of the code of conduct, located within the employee handbook, at their time of hire. Documentation within five personnel records validated each had a signed employee handbook acknowledgement. A resident handbook provided to each youth upon admission details the rights of youth, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and the CCC. A tour of the program during the annual compliance review found the program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The tour of the program also indicated telephone contact numbers, both for the Florida Abuse Hotline and the Department's CCC contact information, were posted throughout the facility. A telephone was located in the girl's module. A review of incident reports found there were no substantiated allegations against staff pertaining to physical and/or emotional abuse since the last compliance review. Five interviewed youth reported feeling safe in the program. Each youth reported they have never been stopped from reporting abuse to the Florida Abuse Hotline or the CCC. Five interviewed staff were able to explain the program's abuse reporting process in its entirety. Each staff reported never observing a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. Four staff reported never observing a co-worker telling a youth they could not call the Florida Abuse Hotline or CCC. One staff reported observing a co-worker telling a youth they could not call the Florida Abuse Hotline. The youth was acting very

violent and aggressive towards the staff at the time. However, once the situation was de-escalated the youth was provided the opportunity to call the Florida Abuse Hotline. An informal interview with the facility administrator (FA) validated the FA was able to explain the program's abuse reporting process in its entirety. The FA further reported staff are expected to aspire to the highest standards of conduct and performance. The program has three classifications of violations of standard conduct which are minor, major, and critical. The code of conduct covers the program's expectations for acceptable workplace performance and workplace behavior. The FA discussed many violations which violates the code of conduct. All offenses are investigated, and disciplinary action is progressive, based on the level of the infraction and the history of the employee. Critical offenses may result in suspension or immediate termination.

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

The program maintains a written policy and procedures addressing allegations of physical, psychological, and emotional abuse. It is the program's practice to conduct an initial internal investigation on all staff complaints and to remove a staff from contact with youth when necessary. Reviewed documentation of internal incident reports reflected management staff took immediate corrective action, when applicable, to address incidents of physical, psychological, or emotional abuse. A review of internal incident reports reflected three staff were removed from youth contact pending the outcome of the investigation. An informal interview with the program's regional compliance manager confirmed the program has not had any incidents which were substantiated. The facility administrator (FA) reported youth are advised of the abuse reporting process during admission into the program. The FA further reported the program has a monthly tracker which looks for trends regarding abuse and has not had any DCF abuse findings since the last annual compliance review. Observations made during the annual compliance review found a telephone located in the youth's dormitory for direct access to contact the Florida Abuse Hotline. The FA reported staff are also made aware of incidents reported to the CCC from the previous day during their morning meetings. In addition, the program had presentations by the Department and the Department of Children and Families (DCF) regarding abuse reporting.

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

The program maintains a written policy and procedures regarding the incident reporting process. A review of the Central Communications Center (CCC) reports for the past six months revealed the program had a total of sixty-five reported incidents to the CCC and nine reports were randomly selected for review. The review of the nine reports found all had been reported within the required two-hour time frame of staff becoming aware of the incident. In addition, the program maintains a logbook where the reported information identifying the case number of each incident is documented. A review of the information contained in the program's logbook compared to the CCC total number of incident detail reports found one of nine CCC reports was not documented in the logbook. A review of ten staff training records indicated staff complete

pre-service and in-service training on the reporting process. A review of the program's internal incidents and grievances found there were no additional incidents which should have been reported to the CCC.

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

The program has written a policy and procedures concerning the use of Protective Action Response (PAR). The program's PAR plan was approved by the Department's Office of Staff Development and Training on May 14, 2018. The program had twenty-five PAR incidents within the last six months and five were reviewed. A review of five randomly selected PAR incidents found all appropriate staff completed statements prior to the end of their shift. All reports were reviewed and processed within the required time frame. Four PAR reports included a post PAR interview. One record did not include a post-PAR interview. One reviewed report indicated a need for medical review. Reviewed documentation validated a medical review was completed by the program's nurse. There were no reports requiring a report to the Florida Abuse Hotline or the Department's Central Communication Center (CCC). Reviewed documentation found the program submits a PAR summary to the Department monthly. All PAR reports are required to be reviewed by the facility administrator and assistant facility administrator. The program's PAR rate during the annual compliance review period was 5.81, which is above the statewide residential PAR rate of 1.49. The facility administrator (FA) reported each use of PAR is reviewed in various ways. The FA, assistant facility administrator, and assistant director of operations responds to the use of PAR when they are on-site. A debriefing is held within 72 hours with the staff to discuss what occurred and how the restraint was handled. The administration staff reviews video footage to review the incident if they are on/off site and secondary reviews of all PAR paperwork. The FA further stated the video footage is also used as a teaching tool for staff. Each month, the program submits to the Department a written clinical analysis of each PAR occurring during the previous month, providing examples of each incident, and behavioral examination. Youth identified with multiple restraints within a single month participates in a special treatment team (STT) with the therapist, to review the youth's safety plan and to discuss any clinical issues related to triggers leading to the response.

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

The program has a written policy and procedures regarding pre-service training. The program maintained a pre-service training plan for all newly hired staff which was approved and signed by the Department's Office of Staff Development and Training on July 3, 2017. The pre-service training is conducted through web-based and instructor-led courses. A review of five applicable pre-service staff training records indicated all five staff were certified within 180-days of hire as required. All staff were certified in cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Each staff was trained in Protective Action Response (PAR), suicide prevention, professionalism and ethics, emergency procedures, Prison Rape Elimination Act (PREA), and child abuse reporting. There were no additional trainings required by this contract.

All staff training was documented in the Department's Learning Management System (SkillPro) reflecting their completion of over 120 hours of pre-service training. Documentation indicated all trainings were delivered by qualified trainers.

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.*	

The program maintains a written in-service training plan, which was reviewed and accepted by the Department's Office of Staff Development and Training on July 3, 2017. Five staff training records, including two supervisor training records, were reviewed for completion of in-service training. Two applicable supervisory staff completed at a minimum eight hours of management training. All staff exceeded the twenty-four hours of mandatory annual in-service training. All staff completed cardiopulmonary resuscitation (CPR) annual in-service training, automated external defibrillator (AED), first aid, and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, as well as the required six hours of suicide prevention. Two supervisor training records were reviewed for completion of eight hours of management/supervisory training relating to leadership, personal accountability, management, employee relations, communications skills, and fiscal. There were no additional trainings required by this contract. Reviewed documentation confirmed each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). Reviewed documentation validated the program has an annual in-service calendar which is updated as changes occur.

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

The program maintains a written policy and procedures regarding the youth grievance process. The process is a three-tiered system with an informal phase, formal phase, and an appeal phase. The informal phase encourages the youth to resolve the question, dispute, and complaint through informal communication with program staff. The program's grievance process is explained to each youth at the time of admission and orientation, and further explained in the youth's handbook. Once a youth submits a grievance, the grievance officer has seventy-two hours to investigate and render a decision in writing to the youth. If the youth is still dissatisfied with the outcome of the grievance they may submit their grievance to the facility administrator (FA) as the final appeal. The FA has seventy-two hours to review the findings of the grievance officer and determine whether the grievance was handled appropriately or if there should have been a different outcome. The youth are also given an opportunity to file an alternative informal request by way of a Chatty Cathy, as a first opportunity to voice a grievance and informally resolve a complaint. Five grievances were reviewed during the annual compliance review period. Each reviewed grievance was handled in accordance to the program's policy.

Observations during the annual compliance review validated the program's practice of maintaining formal and informal grievances in separate binders for a period of at least one year. A review of five staff training records confirmed staff received the required training regarding the program's grievance process and procedures during orientation, and on-the-job training. Five interviewed youth indicated grievance forms are placed throughout the program. Three indicated there are three phases. Two indicated they never had to fill out a grievance form. Five interviewed staff indicated grievance forms are placed throughout the program. Staff had knowledge of the program's grievance process and were able to explain the process. An interview conducted with the FA confirmed the program's grievance process

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

The program provides delinquency interventions through evidence-based principles such as Thinking for a Change (T4C) and Impact of Crime (IOC). As part of the evaluation process for this intervention youth are provided a specific goal based upon their personal characteristics. Reviewed documentation of sign-in sheets confirmed the curriculum is being delivered at least sixty percent of the youth's awake time. Each of the listed interventions are on the daily activity schedule and are being delivered as designed. Reviewed documentation reflected the program maintains a binder with sign-in sheets for each group. A review of staff training records confirmed the appropriate training in specific interventions were completed by staff conducting the group. Reviewed documentation from five youth case management records reflected intervention service goals were included as part of their individualized performance plans. The facility administrator reported staff are required to have the appropriate education and experience to perform their job duties. Specialized training is provided for specialty groups. The facility administrator stated each youth's risks and needs are reviewed during management team meetings and treatment team meetings. Youth are matched with staff, counselors, case managers, and intervention groups based upon these individual factors.

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 interventions focusing on developing life and social competencies in youth. The program's mental health staff provide life skills groups and instruction to the youth at the program. Life skills training is used as targeted group intervention to address needs identified within each youth's individual performance plan (IPP). A review of five youth records found individualized needs outlined on the IPP by the Residential Positive Achievement Change Tool (R-PACT) assessment included active goals to address recognized risk factors. The daily activity schedule indicated youth are to participate in group interventions seven days a week. Each youth receives training in such areas as avoidance, high risk situations which could endanger self or others, communication, anger management, critical thinking, non-violent resolutions, interpersonal relationships and interactions. A review of two staff training records validated staff were trained to deliver the curriculum. The clinical staff conducts groups on

various topics including Teen Relationships, Voices (A Program of Self-Discovery and Empowerment for Girls), SAVVY Sisters, and Impulse Control. Reviewed sign-in sheets documented youth who participated in groups. Five interviewed youth reported they participate in various groups offered at the program. Four youth reported participating in Thinking for a Change (T4C). Each youth stated they participated in Voices (A Program of Self-Discovery and Empowerment for Girls). Two youth reported participating in the Impact of Crime (IOC) curriculum. All youth indicated they have learned new skills from the groups they participated in and can apply the new skills daily. An interview with the facility administrator confirmed the groups provided at the program.

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's restorative justice instruction and activities included utilizing the Impact of Crime (IOC) curriculum. IOC is considered a practice with demonstrated effectiveness, according to the Department's Sourcebook of Delinquency Interventions. The program's victims and restorative justice plan contains activities or instructions intended to increase youth awareness of, and empathy for, crime victims and survivors, expose youth to victim's perspectives through victim speakers, in person or on videotape, audiotape, victim impact statements and increase personal accountability for youth's criminal actions and harm to others. The program's transition therapist training record was reviewed during the annual compliance review. Reviewed documentation reflected staff delivering the curriculum were trained in IOC, as required. Five youth case management records were reviewed. Each youth participated in several restorative justice projects throughout the year geared towards increasing youth personal accountability for their criminal actions and harm to others. A review of sign-in sheets validated groups are being delivered as designed. The daily activity schedule validated restorative justice activities were provided, and sample activities were observed by the review team throughout the review week. The facility administrator (FA) reported as part of the program's restorative justice awareness activities, youth make blankets for a local nursing home and provide new adoption bags for the Humane Society. Youth also complete community service hours by working on different projects such as the cleaning crew, assisting with group preparation, youth advisory board, and other areas. The FA further reported guest speakers often come to the program to talk about various topics. The most recent guest speaker was a victim of abuse.

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

The program provides delinquency and treatment services which are gender-specific and targets the female population as required by the program's contract. Gender-specific treatment focuses on areas including health and hygiene, physical environment, address substance abuse, sexual abuse, trauma, crime specific topics, as well as relational and emotional topics. The program's activity schedule has specific times set aside for youth to participate in groups for Girls 4 Success, Voices (A Program of Self-Discovery), and Empowerment for Girls, which was provided in rotation with Teen Relationships. Voices was observed during the week of the annual compliance review. An observation in comparison with staff training records confirmed the group was conducted by one of the program's mental health clinicians who was trained to deliver the curriculum. A review of the material used to educate the youth reflected it was

geared towards gender specific issues. The facility administrator (FA) was interviewed and validated the program provides various gender-specific programming to address the needs of the youth. Reviewed documentation validated the program maintains a binder with sign-in sheets reflecting the names of youth attending the groups, the name of the facilitator, the lesson for the day, and the date/time of the groups.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a policy and procedures in place outlining the program's internal alert system. The program's internal alert list is accessible to all program staff and keeps them alerted about youth who are a security or safety risk, health related concerns, food allergies, and special diets. These alerts are also updated in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation and observations of a shift briefing, reflected the alert reports are reviewed daily during shift briefings by the program's supervisory staff. In addition, master control maintains an active internal alert board. The program maintained two dry erase communication boards in the employee break room and facility administrator's office which identified youth placed on alerts for medical, mental health, safety, and special dietary precautions. The communication board also included a posted picture of each youth and their assigned sleeping room number. Four youth were applicable for downgrading or discontinuing of a youth's alert status. A review of the program's logbooks reflected alerts were documented according to policy. A review of JJIS reflected no issues affecting classification. All applicable internal alerts were downgraded or discontinued by the appropriate staff. A review of medical, mental health, and security alerts found each was entered into the programs internal alert system and JJIS as required. A review of JJIS in comparison with the program's internal alert list found no inconsistencies. An interview with the facility administrator (FA) revealed alerts are discussed at each morning's management meeting. Alerts are closed by the appropriate staff, including medical and case management and updated as needed. The FA further stated youth alerts are communicated to master control as well as the alert board located in the staff lounge. Five interviewed staff indicated they are made aware of alerts by reviewing the alert board. Three stated they are also made aware of alerts during shift briefings.

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

The program maintains an official case record, labeled, "Confidential" for each youth's individual healthcare record and individual case management record. Five youth case management records were reviewed. All records were labeled confidential. All youth records contained the youth's name, Department of Juvenile Justice identification number (DJJID), date of birth, county of residence, and committing offense. All case management records were maintained with separate tabs dividing information into specific sections. All case management records contained legal information, correspondence, case management, and treatment team activities. An observation of the program found the records secured in the appropriate office area behind a locked office door within a locked cabinet inaccessible to youth. All individual healthcare records were labeled as "Confidential," and all official youth case records were secured in a locked file cabinet or a locked room. The program uses file cabinets to store official youth case records labeled as, "Confidential."

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

The program has a formal process to promote constructive input by youth. The program utilizes various avenues such as the youth advisory board and Chatty Cathy forms which gives youth an opportunity to address both positive and negative issues they may have. The youth advisory board meets monthly to discuss various topics. Additionally, the program has an open floor forum during daily circle meetings where youth express issues and concerns relating to all areas of the program. Each program department sends a representative to the daily circle meetings to directly and immediately respond to the youth's concerns. A review of the youth advisory board's notebook reflected an agenda, sign-in sheets, along with meeting minutes summarizing the subject areas which were discussed. Five interviewed youth reported the program has a process which allows each youth to provide input about what happens at the program. An interview with the facility administrator confirmed the program's practice.

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

The program has a community advisory board, which meets on a quarterly basis. The community advisory board consists of a school board representative, community partners, the business community, faith-based organizations, a local victim's advocacy agency, and a parent/guardian. The program maintained a notebook listing all the partnership agencies and businesses. Reviewed documentation validates the program sends emails to solicit active involvement of interested community partners. During the annual compliance review, contact was made with a board member to determine the level of involvement with program activities. The board member reported the meeting is held quarterly and the community advisory board discuss various topics to help improve the program. An interview with the facility administrator validated the advisory board meets on the third Monday once a quarter. A review of meeting

agendas and participant sign-in sheets support the program meets quarterly to discuss current program issues and status.

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 in place regarding program planning designed to establish a system of communication, facilitating staff involvement, discussing program issues and the development of policies, procedures, and programs. The program conducts morning management meetings daily, Monday through Friday, which includes mental health, medical, case management, and administration. The program also conducts monthly staff meetings to allow all staff an opportunity to provide input and feedback pertaining to operations. All areas of facility operations are discussed in the meetings addressing subjects such as alerts, safety and security, video review, youth progress, medical and mental health updates including alerts, and security updates. The Comprehensive Accountability Report (CAR) data is also shared with staff at the monthly all staff meetings. The program staff are provided lunch during the monthly meetings for all of their hard work. The facility administrator (FA) attempts to make all staff meetings fun as well as informative and use them as an opportunity to recognize successes such as employee of the month and employee of the year. A review of sign-in sheets and agendas validated the program's practice for conducting monthly meetings. A review of documentation to minimize staff turnovers and boost staff morale was also provided. The program conducts parent/guardian and youth surveys upon each youth's release. The surveys are designed to allow the youth and parents/guardians to provide feedback and input in case management, mental health, and the health services treatment process. This information is used to assist with improving operations. Four interviewed staff reported meetings are held monthly at the program. One staff reported meetings are held bi-monthly at the program. Each staff reported various topics are discussed during the staff meetings. Three staff reported the communication amongst the staff is very good. Two staff reported the communication is good. All staff indicated they are not briefed on CAR reports, annual compliance reports, and/or youth and parent/guardian survey results. An informal interview with the FA confirmed the program has daily meetings and also weekly meetings to keep staff informed of program changes. The FA also reported the CAR is not provided to the staff but is discussed during the meetings. Additionally, the program has only had one survey returned by a parent/ guardian since the last annual compliance review.

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

The program maintains a policy and procedures regarding employee position descriptions and performance reviews. Performance evaluation measures are completed annually for in-service staff while at the initial ninety-days probationary period for pre-service staff, covering areas inclusive of job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. Documentation supported the program maintained position descriptions for each position title with corresponding performance standards. A review of the position descriptions outlined the job functions and duties required of each position. Five staff personnel records were reviewed. Each was evaluated on their understanding and implementation of the program's positive performance system including consistency in providing rewards and/or consequences for

behavioral violations. Staff were also measured on their understanding of youth stages of change. Two interviewed staff reported receiving written evaluations of their performance at least annually. Two staff reported receiving some evaluation every six months. The facility administrator (FA) reported staff receive an annual evaluation done by their immediate supervisor and reviewed by the FA and assistant facility administrator (AFA). The contents of annual evaluations are shared with staff who have the opportunity to provide input which may impact the scoring of their evaluation.

Standard 2: Assessment and Performance Plan

Overview

The program has a director of case management, two case managers and one transition services manager who provides case management services to each youth while at the program. The director of case management is responsible for overseeing the case managers and the transition services manager. Transition services begin at the time of a youth's admission and follows the youth through the program to ensure a successful transition into the community upon completion of the program. The program case management services involve the completion of youths needs assessments, and youths risk classifications, the Residential Positive Achievement Change Tool (R-PACT) and R-PACT reassessments, development of youth's performance plans, and informal and formal treatment teams. The program has a lead educator who completes methods and curricula beyond the minimum required to allow the youth in the program to have learning opportunities more similar to youth in the community. The education department has a ten-station training lab called zSpace, which is a three-dimensional computer technology system. Youth are able to obtain skills using the zSpace system to help transition back into the community after being released from the program. Youth in the program are taught how to create and present Microsoft PowerPoint presentations, which additionally provides opportunities to practice and demonstrate public speaking skills, along with completing activities which consist of engineering, technology, mathematics, and science. The system also allows youth to engage in physics and build experiments. Youth learn skills using the zSpace system to help with their transition back into the community after being released from the program.

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

The program has a written policy and procedures in place regarding parental notification and court notification. A review of five youth case management records documented the parent/guardian was notified by telephone within twenty-four hours of admission. Each record included written documentation of the parent/guardian being notified within forty-eight hours of the youth's admission. Each youth's juvenile probation officer (JPO) and post residential services counselor was notified within five working days. Four of five records included documentation of a letter being mailed to the committing court within five working days of each youth's admission into the program. One letter was mailed to the committing court eight days late.

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

The program has a written policy and procedures in place regarding youth orientation. A review of five active case management records included documentation of each youth receiving orientation on the day of admission. Each record also included a signed acknowledgement of

receipt of an orientation. Orientation to the program included information regarding services available daily schedule, expectations and responsibilities of the youth, the behavioral management system including rules governing conduct and positive and negative consequences for behavior, information on availability and access to medical and mental health service, the Florida Abuse Hotline or if the youth is eighteen years or older, the Department's Central Communications Center (CCC), and items considered contraband. Orientation also included youth's performance plan process to include the development, dress code, hygiene, procedures on visitation, mail, use of the telephone, youth anticipated length of stay, community access, the program grievance procedures, emergency procedures, physical design of the facility, and assignment to a living unit and room treatment team. During the annual compliance review, there were no new admissions into the program. Five interviewed youth stated receiving an orientation to the program including program rules, procedures, schedules, within twenty-four hours of the admission.

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

The program has a written policy and procedures to obtain written consent of any youth eighteen years of age or older prior to discussing or providing the parent/guardian any information related to the youth's physical or mental health screening or assessment. Two of the five reviewed active youth case management records were eighteen years of age. One additional record was requested for review. Each record documented written consent was obtained prior to providing or discussing with the youth's parent/guardian information relating to the youth's physical or mental health screening, assessment, or treatment unless youth is incapacitated and has a court-appointed guardian. When applicable the program obtained written consent for providing youth information to the Department of Children and Families (DCF) for youth eighteen years of age or older. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures in place regarding the classification system. The program's classification system promotes safety and security, as well as effective delivery of treatment services. A review of five youth case management records reflected each youth had an initial classification completed upon admission. Each reviewed initial classification form documented the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to

victimization, and identified or suspected risk factors. Each reviewed record confirmed the program utilized a classification system in accordance with the Florida Administrative Code, promoting safety and security as well as the effective delivery of treatment services. Reviewed documentation confirmed reassessments of a youth's needs and risk factors are reviewed prior to increasing youth's privileges and participation in work projects. There were no youth applicable for off campus activities. The program has an internal alert system in addition to the use of the Department's Juvenile Justice System (JJIS). Alerts are used to promote safety and security, as well as medical, mental health, and or special needs services identified during the classification process and are entered into the system. The program has an alert board located in the staff breakroom area listing all alerts pertaining to the youth. All staff are advised during shift briefings of all alerts. An interview was conducted with the facility administrator confirming classification factors such as mental health, physical health status, and cognitive performance, age, and prior victimization are considered when assigning a youth to a living dormitory. The facility administrator reported the program has a classification meeting where all the evaluations are discussed with the clinical education, medical, and case management staff. Youth, parent, and juvenile probation officer (JPO) also participate. The program has three quadrants on the dormitories: Rare, Precious, and Distinct and the program places youth based on the characteristics of the youth in the quadrant. The program also considers youth being assigned to the proximity of exits by not placing a youth vulnerable to victimization with an aggressive youth. Each time a room is changed, or core group is changed a classification meeting occurs. A review of five youth records documented five youth receiving a reassessment for activities on a monthly basis. Each youth's record had a performance plan, treatment team notes, and performance summaries addressing classification.

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

The program has a written policy and procedures in place relating to gangs. During the admission process and classification process youth are asked about possible gang involvement. A review of five youth records reflected two youth were applicable. One additional recorded was requested and reviewed. All three records documented notification to the Martin County Sheriff's Office being notified by email. One record documented the youth's home county being notified of each youth being involved in a gang. Two records showed no documentation of the youth's home county law enforcement being notified of youth's gang involvement; however, one of youth was identified as a gang member prior to admission to the program. All three youth records documented an alert in the Department Juvenile Justice Information System (JJIS). When applicable educational providers, juvenile probation officers (JPO), and residential counselors are notified.

2.06 Gang Identification: Prevention and Intervention Activities	**Satisfactory Compliance**
A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.	

The program has a written policy and procedures in place regarding gang member identification. The program's practice is to provide intervention strategies when youth are identified as a gang member, affiliated with a criminal street gang, or are at high risk of gang involvement during the

initial intake assessment. Two of five youth records were applicable for review. One additional record was requested and reviewed. Documentation showed each youth was identified as a gang member or an affiliated gang member. A review of each youth's record documented each youth participated in gang prevention and intervention strategies with their case manager using the curriculum titled, "Gangs: Fifty Plus Stories of Fractured Lives". An interview with the case manager validated each youth received a story from the gang book. Each youth read and answered questions pertaining to the passage. Reviewed documentation confirmed the program maintained sign-in sheets to document youth participation in gang prevention and intervention activities. Each record documented the youth's performance plan including relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program.

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

The program has a written policy and procedures regarding the Residential Positive Achievement Change Tool (R-PACT). A review of five youth records documented each youth having an initial R-PACT completed within 30 days of admission. Each youth had an initial assessment maintained in the Department of Juvenile Justice System (JJIS). Five youth records also documented having a 90-day reassessment completed after the initial R-PACT assessment. All reassessment documentation was found in each youth's record. A review of each record in comparison with JJIS noted no inconsistencies.

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.	

The program has a written policy and procedures to ensure Youth Needs Assessment Summary (YNAS) is conducted within thirty days of youth admission into the program. The program documents the assessment in the Department's Juvenile Justice Information System (JJIS). A review of five active case management records validated this practice. While completing the R-PACT and YNAS, the case manager includes documentation verifying contact with the applicable Department of Children and Families (DCF) counselor, and the parent/guardian of the youth who are jointly served by DCF and the Department to identify individual needs and staff responsible.

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

The program has a written policy and procedures in place regarding performance plan development. A review of five youth records documented each youth having an initial performance plan developed within thirty days of admission. Each youth's plan was developed after the youth's initial assessment. Each youth record documented the youth's plan was developed with the treatment leader, youth, administrative representative, living unit representative, and treatment staff. Five youth performance plans were reviewed. All five plans included individualized goals based on each youth's prioritized needs. Each youth's goal included specific interventions which were measurable, included both the youth and staff responsibilities to complete the goals, and projected target dates for completion. A review of each youth's court order indicating no additional court ordered sanctions ordered by the judge. Each reviewed performance plan addressed the youth's top three criminogenic needs. All five youth records indicated the youth were enrolled in education career programing within ten working days of completing the performance plan. Reviewed documentation validated the program sends a transmittal letter and a copy of the plan to the committing court, juvenile probation officer (JPO), and the parent/guardian. Four of five youth records indicated a transmittal letter and a copy of the performance plan was sent within ten working days to all required parties. One youth performance plan was completed on April 13, 2018 but the transmittal letter was not sent out until May 27, 2018. All five performance plans were signed by the youth, treatment team leader, and all parties who have significant responsibility in goal completion. The program mailed all five plans to the parents/guardians, and/or the Department of Children and Families (DCF) case worker to sign and return to the program. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD). One parent/guardian signed and returned the plan to the program. Five interviewed youth reported they participated in the development of their performance plan. Each youth was aware of their current performance plan goals. Each youth indicated they received a copy of their performance plan.

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

The program has a written policy and procedures in place regarding the revision of each youth's performance plan based upon the Residential Positive Achievement Tool (R-PACT) reassessment results, demonstrated progress or lack of progress towards completing a goal, and/or newly acquired, or revealed information. A review of five youth records documented four

youth were applicable for having a plan revision. Each performance plan documented the youth demonstrated progress or lack of progress towards completing a goal. There were no applicable youth eligible for transition.

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

The program has a written policy and procedures in place regarding the transmittal of performance summaries. Five open and three closed case management records were reviewed. All performance summaries were completed every ninety-days and signed by the required parties. All eight records contained completed performance summaries. All performance summaries included youth comments. Copies of the performance summaries were provided to each youth and the original was placed in the case management record. All reviewed performance summaries included the youth's status on goals, overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peer and staff, and other relevant positive or negative events. Each closed record included justification for release from the program. Each reviewed summary was dated and signed by the treatment team leader, facility administrator or designee, and youth. A copy of the performance summaries for the youth were sent to the judge and juvenile probation officer (JPO) within ten working days. In addition, copies of the performance summaries were sent to each parent/guardian. Three closed case management records were reviewed and were applicable for release summaries. All three original performance summaries were sent to the JPO along with Pre-Release Notifications (PRN), copies of the performance plans, performance summary, and all required discharge documentation. A signed copy was retained in the youth's record. All three performance summaries documented the justification for the youth's release and were sent with the PRN. The judge did not object to any of the youth being released from the program. All three closed management records had evidence written notifications were sent to the youth's parent/guardian and a Residential Positive Achievement Change Tool (R-PACT) exit assessment was completed. None of the reviewed case management records were applicable for the Sexually Violent Predator Program (SVPP) and none required a release letter of notification to the victim. Five youth were interviewed. Two youth reported receiving a copy of the performance summary sent to the court. Three youth reported not receiving the performance summary. An informal interview with staff confirmed the program provides copies of performance summaries.

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

The program encourages and facilitates the involvement of each youth's parent/guardian in the case management process. Parents/guardians are invited to participate in the treatment team

process to assist in the design of the youth's Residential Positive Achievement Change Tool (R-PACT) assessment and individualized performance plan. Five case management records were reviewed to confirm the parent/guardian was involved in the case management process. Each reviewed record had a letter advising the parent/guardian of the anticipated scheduled dates for treatment team. Parents/guardians were also invited to attend transition conferences. If the parents/guardians are unable to attend in person, they were invited to participate by telephone. When applicable the program obtained written consent for youth eighteen years of age or older prior to discussing or providing the youth's physical or mental health screening or assessment. An interview with the facility administrator confirmed the parents/guardians are encouraged to participate throughout the entire process. During weekend visits, the parents/guardians are notified of serious events and invited to attend formal treatment team meetings. During the annual compliance review, a treatment team meeting was observed, and the parent/guardian participated by telephone. A case manager is available on the weekends to give updates. All parents are afforded the opportunity to provide feedback by telephone or written communication.

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

The program has a policy and procedures in place which addresses the treatment team process and the members of the treatment team. A review of five youth case management records found each youth participated in an initial treatment meeting. The treatment team is comprised of the youth, therapist, primary counselor, medical staff, education staff, assistant facility administrator, facility administrator, and transition manager. When applicable, the youth's assigned juvenile probation officer (JPO), Department of Children and Families (DCF) case worker, parent/guardian, and gang specialist attends. All required staff provided information using the feedback form prior to the treatment team meeting. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's performance plan. Five reviewed case management records indicated each youth's performance plan incorporated the youth's treatment plan. All five education plans were incorporated into the performance plan. Three applicable youth were in the custody of the Department of Children and Families (DCF) and each performance plan included a DCF plan provided to incorporate in the performance plan. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures in place regarding formal and informal treatment team meetings. Five case management records were reviewed and indicated formal treatment team reviews were conducted at least once every thirty days. Informal meetings were held with each youth bi-weekly to review each youth's performance, including progress on the individual performance plan goals. The performance plan included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions. Reviewed documentation confirmed treatment team meeting attendees consisted of the youth, case management staff, clinical staff, education, medical, and living unit representative. Each youth's juvenile probation officer (JPO), parent(s)/guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress on each youth's goals, behaviors, physical interventions, treatment progress, and Residential Positive Achievement Change Tool (R-PACT) reassessment results. All staff gave relevant input on the youth and agreed on how to proceed to a formal treatment team. An observation of a formal treatment team during the annual compliance review confirmed the youth was present and was allowed to demonstrate skills acquired at the program. A review of the treatment team plan reflected the youth's anticipated release date. The Department's Juvenile Justice Information System (JJIS) also reflected the anticipated release date and was updated every ninety days and at the sixty-day transition conference. Five interviewed youth indicated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program. Two youth indicated they received a copy of the performance summary sent to the court. Three youth indicated they did not receive a copy of the performance summary.

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

The program provides a Type 3 vocational competency development programming provided by the School Board of Martin County. Type 3 programs include Type 1 (personal accountability skills and behaviors leading to appropriate work habits for employment and living standards) and competencies or prerequisites needed for entry into a specific occupation. The career education programing offers communication, interpersonal skills and decision-making skills. The components content includes, but is not limited to exploring career interests, gaining knowledge such as career choices, participating in skill assessments related to such career choices, establishing and nurturing a skill set which is needed to be a successful employee. The program clearly has a written policy directly relating to career education. The program's career education is both age and skill appropriate. The program provides vocational competency development programming. The career education programming offers communication, interpersonal skills

and decision-making skills. The components include, but are not limited to exploring career interest, gaining knowledge such as career choices, participating in skills assessments related to career choices, establishing and nurturing a skill set which is needed to be a successful employee. Three closed case management records and five active case management records were reviewed. Each closed record included a sample application, a résumé, referral to a career source center and appropriate documents essential to obtaining employment such as a State of Florida issued identification, social security number, and a birth certificate. An interview with the lead instructor and facility administrator confirmed the program completes assessments through transitions services regarding career interest. Career Source is also onsite and administers the Test of Adult Basic Education (TABE) and career/vocational inventory-based assessments for youth. While in the program youth can earn career certifications in travel and tourism. According to the lead teacher, students use Kuder Navigation and journey programs to assist with their career exploration. Youth in the program are also able to practice interviewing skills and job searches. Kuder Navigation is designed to help middle school students with career exploration and high school students with locating colleges and financial aid assistance. Kuder Journey is designed towards college students. The program helps to assess the youth's interest, suggest education, and career options. The program utilizes CareerSource which provides job coaching, financial literacy, virtual job shadowing, résumé building, and business plans. A review of three closed case management records verified youth received tourism certificates, financial literacy certificates, Safe Staff certificates, and certifications in cardio pulmonary resuscitation (CPR).

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

The program contracts with the School Board of Martin County to provide educational services to the youth at the program. Reviewed documentation and an interview with the lead educator indicated each youth in the program was provided 250 days of instruction, consisting of 300 instructional minutes a day. Ten of those days are used for teacher training and meetings. A review of the facility logbooks revealed youth attend educational classes from 8:10 a.m. to 2:10 p.m., Monday through Friday. A review of the daily activity schedule and facility logbooks reflected minimal interference with educational instruction hours. Five interviewed youth reported there is not a lot of interruptions during educational instruction.

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

The program completes educational transition plans for each youth including provisions for continuation of education and/or employment. Three closed case management records were reviewed. Documentation reflected each youth's education transition plan was completed prior to the youth being released from the program. The case management records included evidence the youth's case manager and the parent/guardian were aware of the plan documents and post-release discharge plans. Three closed youth records listed key personnel related to transition services included the youth, parent/guardian, education representative, and post-release staff. In all three records, a transition plan was developed with the youth, program staff, education, and aftercare staff for continuation of education and/or obtaining employment. The education transition plan included services and interventions based on the youth's educational

needs, educational placement and specific monitoring responsibilities by individuals responsible for the reintegration and coordination of the provision of services upon release from the program. Three closed youth records included evidence which provided provisions for continued education and/or employment. All three records included a sample employment application, a résumé, a State of Florida identification card, and an appointment with a CareerSource Center.

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

The program has a written policy and procedures addressing transition planning. Three closed youth records were reviewed. Reviewed documentation validated a transition conference was held at least sixty days prior to the targeted release date. The youth, treatment team leader, clinical, medical, and education staff participated in the transition conference as evidenced by the signatures on the transition plan signature page. The juvenile probation officer (JPO) and parent participated by phone. Each youth's JPO, parent/guardian, education staff and any other pertinent parties were invited to provide written input if they were unable to participate in person. One of the three closed youth records reviewed documented the assistant facility administrator's (AFA) signature. Two of the transition plans were not signed by the AFA. The AFA reported during an informal interview he attends most meetings but may have forgotten to sign the transition plan. An observation of an Community Re-entry Team Meeting (CRT) was conducted during the annual compliance review. All pertinent participants including the AFA, were in attendance in person, by phone or provided written input. Reviewed documentation validated all participants in attendance signed the transition plan. Reviewed documentation confirmed transition activities on the youth's performance plan. All reviewed records identified the target completion dates and identified the persons responsible for completion of the transition goals. A revised performance plan was not applicable for all three closed records. A copy of the transition plan was mailed with a request for return with signature to anyone not in attendance and who had the responsibility for completion of transition goals. The program provided documentation which demonstrated a Community Re-entry Team (CRT) meeting was held prior to each youth's release and the youth and case manager participated in the CRT meeting.

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

The program has a written policy and procedures in place to address the development of a youth's exit portfolio. Three closed records were reviewed for compliance with the completion of exit portfolios. All three records contained documentation the exit portfolio was discussed and started at or prior to each youth's transition conference. The portfolio included a State of Florida issued identification card, a copy of the transition plan, calendar with dates/times/locations of follow-up appointments in the community, social security card, birth certificate, vocational certificates, school transcripts, résumé, and a sample job application. Reviewed documentation confirmed educational staff forwarded information to the receiving school board and program staff sent a copy to the juvenile probation officer (JPO). Documentation indicated all three youth were given a copy of the exit portfolio upon release. Youth were provided with completed forms and very clear instructions. All applicable staff were identified during the transition conference to assist the youth in obtaining the required information to assist with successful completion of program goals upon discharge.

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

The program has a policy and procedures addressing the exit conference. A review of three closed case management records found an exit conference was conducted within fourteen days prior to the release of each youth. The juvenile probation officer (JPO) was notified of the release. The exit conference was documented and all participants signed and dated. The program staff noted participants attending via telephone on the signature line when applicable. The date of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation supported the case manager, parent/guardian, education staff, JPO, youth, and other applicable parties participated in the exit conference.

Standard 3: Mental Health and Substance Abuse Services

Overview

The program provides intensive mental health services to all youth in the program. The program is accredited through the Commission on Accreditation of Rehabilitation Services (CARF) since 2010. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide outpatient substance abuse treatment and prevention services for adolescents. The program's clinical director serves as the designated mental health clinician authority (DMHCA) and is a licensed mental health counselor. The DMHCA is responsible for ensuring appropriate coordination, implementation, and oversight of mental health and substance abuse services. The program employs a licensed psychiatrist, two part-time psychologists, and three licensed mental health counselors (the DMHCA/director of clinical services, a licensed therapist/the assistant director of clinical services, and a licensed therapist). One of the program's licensed therapists also serves at the program's certified behavior analyst. A vacancy occurred as of July 27, 2018 for a licensed therapist and a potential candidate has been selected pending background screening. The program had two full-time master's-level non-licensed mental health counselors. All therapists provide mental health and substance abuse services under the direct clinical supervision of the DMHCA. The DMHCA meets daily with the facility administrator during the morning management meeting. The DMHCA meets with the clinical staff weekly to provide clinical supervision, discuss youth-specific clinical issues, and to ensure documentation and deadlines are met. The program has a cooperative working agreement with a licensed psychiatrist for oversight of the program's psychiatric services, supervision of all youth on prescribed psychotropic medication, and follow-up treatment. The DMHCA and the psychiatrist are available for consultation twenty-four hours a day, seven days a week. Clinical services provided by the program include mental health and substance abuse screening and evaluations, mental health and substance abuse treatment planning, individual, group and family therapy, daily counseling, daily therapeutic activities, mental health crisis intervention services, and substance abuse treatment for youth with a dual diagnosis. The program has a suicide prevention plan, a crisis emergency plan, and an emergency care plan in place. The program utilizes the New Horizons of the Treasure Coast, as the crisis stabilization unit. The program provides custody, treatment, and supervision for all youth, utilizing evidence-based or promising treatment practices within a framework based upon restorative justice philosophies, principles, and practices.

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

The program maintains a written policy and procedures outlining the role of the director of clinical services who is the program's designated mental health clinician authority (DMHCA).

The DMHCA is responsible to ensure the timely and accurate completion of comprehensive mental health and substance abuse evaluations, the facilitation of mental health and substance abuse treatment groups. The DMHCA also provides clinical supervision to the program therapists in a face to face setting on a weekly basis, review and sign off on comprehensive assessments, assessments of suicide risk, initial treatment plans, individualized treatment plans and treatment plan reviews, and to complete the clinical department monthly management tool. In addition, the DMHCA must ensure the program clinical treatment programming complies with all requirements outlined within the specialty services guidelines for intensive mental health services. The DMHCA is also responsible for the coordination of onsite psychiatric services provided by a local contracted professional and the coordination of an internal Baker Act on-call rotation, to ensure emergency coverage twenty-four hours a day seven days a week in the event of a mental health and/or substance abuse emergency. An informal interview with the DMHCA confirmed the responsibility for the coordination and implementation of mental health and substance abuse services at the program. The DMHCA confirmed being on call twenty-four hours a day and is scheduled to be on-site Monday through Friday for a minimum of forty hours each week. A review of the DMHCA's licensure reflected a clear and active licensed mental health counselor (LMHC) in the State of Florida as verified on the Florida Department of Health website. The current license expires March 31, 2019.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	**Satisfactory Compliance**
The facility administrator 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 maintains a written policy and procedures outlining the responsibility of the designated mental health clinician authority (DMHCA) for ensuring the licensed clinical staff are performing services they are qualified to provide based on education, training, and experience. The program employs a licensed psychiatrist, two part-time psychologists, and three licensed mental health counselors. The DMHCA/director of clinical services, a licensed therapist, the assistant director of clinical services, and an additional licensed therapist. A review of each licensed staff showed all licenses were clear and active in the State of Florida. The current license expires March 31, 2019. Licenses and job descriptions were obtained and reviewed. Licensed staff is on-site Monday through Friday and on weekend rotation in addition to DMHCA on-call services. One of the program's licensed therapists also serves at the program's behavior analyst. Reviewed documentation showed the LMHC serving as the program's behavior analyst is qualified, based on education and experience.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	**Satisfactory Compliance**
The facility administrator 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 maintains a written policy and procedures outlining the education qualifications, roles, and supervision requirements for the program's master's-level therapists. The program's designated mental health clinician authority (DMHCA) assures the non-licensed clinical staff works under the direct supervision of the DMHCA and qualified based on education, training,

and experience. An interview with the DMHCA reflected all clinical staff licensed and non-licensed receive at least one hour of face-to-face clinical supervision in a group setting. Documentation of direct supervision logs for the last six months verified supervision is occurring weekly and contains all elements outlined on the Department's Direct Supervision Log form, (MHSA 019). Reviewed supervision logs contained documentation of caseload reviews including a review of case history to include specific information related to youth progress and treatment needs/goals, caseload directions, instructions and recommendations, clinical services including a review of fidelity checks/service observations for individual, family, and/or group therapy sessions, clinical services directions, instructions and recommendations, documentation including strengths, findings, trends and/or problem areas, documentation, directions instructions and recommendations, records reviewed, miscellaneous concerns, ethics and legal aspects, miscellaneous directions, instructions, and recommendations, and Standardized Program Evaluation Protocol (SPEP) including training, service delivery, fidelity, and corrective action. Education verification confirmed the non-licensed staff holds a master's-level degree from an accredited university or college. The program carries a license for outpatient substance abuse services under F.S. Chapter 397 through the Department of Children and Families (DCF).

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 maintains a written policy and procedures to ensure all youth admitted to the program are pre-screened and placed by the Department of Juvenile Justice based upon individualized history and identified needs of the youth. An interview with the designated mental health clinician authority (DMHCA) explained a classification meeting is held for each youth upon admission to the program. Within the admission classification meeting, the findings of the Massachusetts Youth Screening Instrument-2nd Version (MAYSI-2), records review, Victimization and Sexually Aggressive Behavior (VSAB), Assessment of Suicide Risk (ASR), and initial interview processes are reviewed. The classification team then identifies needs for referrals, mental health/substance abuse alert status, as well as applicable need for placement on precautionary observation. Five reviewed youth records showed each contained a MAYSI-2 screening completed by program staff upon admission. The program utilizes the MAYSI-2 for all admissions. Each reviewed record documented additional available information to include the commitment packet, upon admission. Each reviewed record showed the MAYSI-2 was completed on the day of admission by trained staff in the Department's Juvenile Justice Information System (JJIS). The programs policy and practice are to refer each admission for an ASR, comprehensive evaluation, and psychiatric evaluation. Each reviewed MAYSI-2 recommended additional assessment based on the results. One record was applicable for an immediate assessment due to suicidal thoughts and was subsequently assessed using the ASR as required on the same day. Each reviewed ASR was completed on the day of admission, and the comprehensive evaluation clearly documented the reason for the assessment and referral based on screening results. An interview with the facility administrator confirmed the program's intake screening process.

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 maintains a written policy and procedures outlining all youth who present clinical concerns during the initial mental health or substance abuse screening, or during the course of the program, shall be referred to a licensed mental health service provider for a comprehensive mental health and/or substance abuse evaluation. The program policy is to complete an updated compressive mental health/substance abuse biosocial evaluation regardless of identified needs for each new admission. Five youth records were reviewed, and each contained a new mental health evaluation completed within thirty days of admission. Each of the reviewed mental health evaluations were signed by the licensed designated mental health clinician authority (DMHCA) within ten days as required. Each new evaluation included demographic information, reason for the evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnosis impressions, and recommendations. Each reviewed mental health evaluation was inclusive of a substance abuse assessment. The program is licensed under F.S. Chapter 397, by the Department of Children and Families (DCF) to provide outpatient substance abuse assessments and treatment services. Each reviewed new substance abuse evaluation was completed within thirty days of admission as required and contained the following required elements including the reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug use, impact of alcohol and other drug use, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression including Diagnostic and Statistical Manual (DSM)diagnosis, and the recommendations. Each reviewed record contained the appropriate signed consent for substance abuse evaluation and treatment. There were no reviewed records which were applicable for an updated mental health or substance abuse evaluation.

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

The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to all youth at the program who are determined to meet clinical criteria to receive the appropriate services. Mental health and substance abuse treatment is provided on-site through the provision of intensive mental health treatment services. The program's 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 carries an active Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. An interview with the designated mental health clinician authority reported the program's comprehensive mental health and substance abuse plan is

developed in collaborative fashion with the clinical director, facility administrator, and regional clinical and compliance staff. The comprehensive mental health and substance abuse plan is reviewed and approved by the corporate officer, facility administrator, and director of clinical services annually, and as necessary. The comprehensive mental health and substance abuse plan is developed and revised in accordance with the specialty guidelines contractually provided to youth at the program. Five youth mental health records were reviewed for assignment to a multidisciplinary team upon the youth's arrival to the program. Each reviewed record reflected the multidisciplinary team was comprised of the youth, program administration, a residential living representative, and other applicable staff responsible for delinquency interventions. Each record documentation validated representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and when possible the parent/guardian participated in the mental health and substance abuse treatment services and planning. Reviewed documentation showed youth determined to need substance abuse treatment shall receive individual, group or family counseling provided by a licensed qualified professional or a non-licensed qualified professional working under the direct supervision of a licensed provider. The program maintains a Chapter 397 license to provide outpatient substance abuse services. The program practice is to offer substance abuse prevention services to all youth, and substance abuse treatment to youth with a substance use/abuse diagnosis. Each of the five reviewed records contained a properly executed Authorization for Evaluation and Treatment (AET) form. Two records contained youth over eighteen-year-old required AET. Each youth record contained a signed substance abuse consent and release form regardless if youth were receiving prevention or intervention substance abuse group therapy services. A review of sign-in sheets and on-site observations during the annual compliance review confirmed mental health and substance intervention/prevention groups are limited to less than ten youth. Individual therapy, group therapy, family therapy and psychosocial skills training services were documented as being received, as prescribed by the treatment plan, in each of the reviewed records' chronological notes section. A review of staff and youth interviews showed five youth and five staff reported youth participate in groups and direct care staff are not facilitating the groups at the program.

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 maintains a written policy and procedures outlining responsibilities and required elements of initial, individualized, review, and discharge planning for mental health and substance abuse treatment services. Five reviewed youth initial treatment plans showed each was completed within the required timeframe on the program's form containing all elements outlined in form MHSA 015. Each initial plan was developed within seven days and signed by a clinical staff person within ten days of completion. Each initial plan was also signed by all treatment team members, who participated in the development of the plan. Each reviewed initial plan included the youth's psychiatric needs. Five reviewed individualized treatment plans

showed each plan was developed within thirty days of admission as required. Each individualized plan was documented on a program form containing all elements of form MHSA 016. Each reviewed plan was signed by the clinical staff person creating the plan, all treatment team members who participated in plan development, and licensed staff member within ten days. Each reviewed individualized plan included psychiatric medication and monitoring details. Five records were reviewed for individualized treatment pan reviews and each was documented on a program form containing all the elements on form MHSA 017. Each plan prescribed services for individual therapy, group therapy, family therapy, psychiatric evaluations and medication management, and yearly comprehensive evaluations. Each reviewed treatment plan review was completed on time (within thirty days) each month. One reviewed record was applicable for a discharge plan and two additional plans were requested and reviewed. Each of the three reviewed records was documented on a program form containing all of the elements outlined on form MHSA 011. None were applicable for notification of suicide risk upon discharge; however, each form contained a statement regarding the youth's lack of suicidal thoughts. Each discharge summary documented services needed, and documented youth and parent/guardian participation (also supported in the exit conference notes). The program's practice is to provide a copy of the discharge plan to the youth and parent upon release and provide a copy to the juvenile probation officer (JPO) by Fed Ex upon release and review of Fed Ex receipts. The signed discharge plans supported notifications/copies were provided to the 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 intensive mental health services for thirty female youth. The program's mental health staff consists of a clinical director who also serves as the designated mental health clinician (DMHCA), an assistant clinic director, a behavior analyst/ licensed therapist, and two master's-level therapists, who are registered mental health counselor interns in the state of Florida. An interview with the DMHCA confirmed the findings of the comprehensive evaluation, youth shall have an individualized treatment plan developed. The plan includes service provisions for all identified treatment needs. A review of current services prescribed on the individualized treatment plan is held during the monthly multidisciplinary treatment team meetings. All youth are provided at a minimum individual, family, and group therapy at the program. Substance abuse treatment is provided to youth identified as having substance abuse treatment needs. Substance abuse prevention and education is incorporated into all youth treatment. The program's regional staff and director of clinical services monitors youth records and conduct fidelity checks of counseling services monthly to ensure youth are receiving services in accordance with their initialized treatment needs. The program offers Standardized Program Evaluation Protocol (SPEP) groups, mental health and substance abuse groups (SAVVY Sisters, Teen Relationships, Living in Balance, and Dialectical Behavioral Therapy (DBT)). DBT curriculum is divided into four groups, DBT skills building, DBT application of skills experiential, DBT impulse control, and DBT Don't Let Emotions Run Your Life curriculum. Substance abuse prevention and education groups are offered to all youth. Monthly fidelity is conducted by the DMHCA on-site. The psychiatrist is on-site weekly, and two psychologists conduct weekly visits to work specifically with sexual offenders, and specialized assessments. In addition to the Massachusetts Youth Screening Instrument-2nd Version (MAYSI-2), youth may receive the Substance Abuse Subtle Screening Inventory (SASSI), the Juvenile Assessment and intervention System (JAIS), Trauma Symptom

Inventory (TSI), and/or the Randolph Attachment Disorder Questionnaire (RADQ) as necessary is indicated during treatment onset or during their stay at the program. The program makes accommodations for families through gas cards, hotel accommodations, and after hours scheduling of family therapy services as needed. A review of treatment planning, reviews, and progress chronological notes reflected each reviewed youth was receiving specialized services as prescribed. An interview with the facility administrator supported the programs intensive mental health services, substance abuse treatment and/or education, specialized consultation with a psychologist for sexual offenders, and services provided by a behavior analyst.

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 maintains an independent psychiatrist agreement with a practicing child and adolescent psychiatry doctor. The reviewed license showed the program psychiatrist carries a medical doctor (MD) license, which was found to be clear and active in the State of Florida as verified on the Florida Department of Health website. The current license expires January 31, 2019. Program psychiatric services include a psychiatric evaluation, psychiatric consultation, medication manager, and medical supportive counseling. Five youth records were reviewed for psychiatric services. Four of five reviewed records indicated each youth entered the program with prescribed psychotropic medications. The program practice is to refer all youth for an initial psychiatric evaluation, regardless of medication status. All five reviewed records supported each youth received an initial psychiatric interview within fourteen days of admission. All reviewed records contained an initial diagnostic interview which included: youth history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) diagnosis, treatment recommendations, prescribed medications (if applicable), explanation of medications, and frequency of medication monitoring. All reviewed records documented the initial diagnostic psychiatric interview on the Clinical Psychotropic Progress Note (CPPN). Each contained a page number three of the CPPN, clearly documenting treatment plan discussion with youth and parent/guardian. The program psychiatrist is on-site weekly and sees youth based on the formal treatment team rotation. Reviewed documentation showed the psychiatrist is actively engaged in youth treatment. The program psychiatrist is on call twenty-four -hours a day. The program psychiatrist has an arrangement with an alternate/fill in psychiatrist for illness and vacations whom carries an MD license in adolescent psychiatry in the State of Florida. The program does not utilize a psychiatric advanced registered nurse practitioner (ARNP) for services. One youth was applicable for psychotropic medication. Consent requirements for youth in foster care and the necessary consent/court orders were in place in accordance to Chapter 65C-35, F.A.C. An interview with the program's psychiatrist supported participation in weekly treatment team, weekly on-site visits, and twenty-four-hour on-call services.

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 maintains a written plan detailing suicide prevention procedure. A review of the program plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The suicide prevention plan is reviewed annually and was last signed on July 10, 2017 by the facility administrator and corporate officer, and on July 20, 2017 by the Designated Mental Health Clinician Authority. An interview with the facility administrator indicated the program provides suicide prevention training throughout the year and conducts emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury at least quarterly.

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

The program has a written suicide prevention plan outlining an established review process for every suicide attempt or reported suicidal thought. The program maintains three complete suicide response kits located in the master control, operations office, and medical office. Each suicide response kit was inspected and included two surgical masks, gauze, needle nose plyers, wire cutters, a cardiopulmonary resuscitation mask, three sets of gloves, bandaging tape, and a knife for life. An interview with the designated mental health clinician authority (DMHCA) reported the program has a system in place for notifying staff of suicidal youth within shift reporting, as well as through the communication board located within the shift report room. Youth on alert status for suicidal behaviors or youth who are on precautionary observation are noted on this communication board. The shift log book identifies and addresses current youth in need of specialized intervention or alert status monitoring. A daily e-mail is also sent indicating the list of youth on precautions. In addition to the communication board, the mental health staff and the facility administrator or designee are notified of any potentially suicidal youth through receipt of an internal mental health/substance abuse referral summary. The facility administrator or designee must review all referrals and acknowledgement of the document. The facility administrator or designee is also contacted by the shift manager on-site or by telephone to notify of youth's potentially suicidal behaviors. The facility administrator and/or therapist is responsible to notify the parent/guardian of potentially suicidal actions. In the event medical intervention is necessary, the nurse may also contact the family to provide additional information as indicated. One record was applicable for suicide prevention services and two additional records were reviewed. Two were applicable for being placed on suicide precautions due to staff observations and one was applicable due to self-reporting suicidal thoughts. Each reviewed record documented an Assessment of Suicide Risk (ASR) being completed the same day the youth was placed on precautionary observation. Each reviewed ASR was completed on the Department’s form MHSA 004. Two of the three reviewed records showed the youth was placed in secure observation following the ASR and one was placed on precautionary observation. Each record reflected observation logs were completed correctly, precautionary observation was authorized, and mental health staff offered supportive services. Three reviewed

Follow-Up Assessments of Suicide Risk (FASR) showed the assessment contained all required elements and was completed prior to the discontinuation of precautionary observation (PO) status. Each documented a conference between clinical staff and the facility administrator prior to the discontinuation of precautionary observation. Each record documented parental/guardian and juvenile probation officer (JPO) notification by telephone or email. Two of the three records reflected an alert indicating suicide risk was immediately entered into the Department's Juvenile Justice Information System (JJIS). One record reflected a JJIS alert indicating suicide risk was entered in JJIS the next day. The youth was placed on PO on July 31, 2018 at 7:11 p.m. and the alert was entered on August 1, 2018 at 5:46 p.m. The program's logbook did reflect the youth was placed on PO at 7:11 pm and a shift report from August 1, 2018 "alpha" shift supported the youth's suicide risk status was posted through the program's internal alert system. Additionally, an email was provided to support the master's-level therapist emailed the staff mentors, case management staff, medical staff, mental health staff, and regional team informing them the youth was on suicide precautions on July 31, 2018 at 7:34 p.m. Reviewed records reflected PO status did not limit any youth activities to an individual cell and one youth record showed participation in incentive activities while on PO. A review of the program log book showed staff were notified of suicide alert status, precautionary decisions and instructions. Each reviewed ASR and FASR was completed within the required timeframe, administered by a licensed clinician, documented a conference with the facility administrator or designee (including the time of the conference). None of the reviewed records showed youth were found to be in immediate crisis. The two youth who were applicable for secure observation placement contained a completed form MHSA 008 within the record, documentation of secure observation room being inspected, and documented constant supervision on a completed form MHSA 006. Both secure observation (SO) placed youth records documented a FASR was completed within eight hours of placement and removal of SO status within twenty-four hours. Both reviewed records documented mental health personnel providing supportive services and a reduction of supervision level after a conference with the facility administrator or designee. Each occurrence of youth being stepped to close supervision was documented within the program's log book. The program has an established review process for serious suicide attempts requiring hospitalization or medical attention, and a mortality review for completed suicide. Five staff were interviewed regarding staff responsibilities when a youth expresses suicidal thoughts. Five staff reported they would notify mental health and search the youth for sharp objects. Four staff reported they would maintain constant sight and sound and document supervision. Zero staff reported they would place the youth in a locked room. Five staff were interviewed regarding the location of the knife for life, wire cutters and needle nose plyers. Five staff reported the suicide response kit was in master control and four reported it was located in the medical office. Two staff reported the suicide response kit was also located in the operations office and one staff reported it was located in the administration office.

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 written suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO). One reviewed youth record was applicable for PO logs and two additional records were reviewed. Each was documented on form MHSA 006 and maintained for the duration the youth was on suicide precautions. Reviewed documentation was completed in real time, and warning signs were documented along with

consultation with clinical staff. Observation of the PO logs were reviewed and signed by each shift supervisor and documented safe housing requirements were met. Three youth interviews conducted during the annual compliance review reflected staff did not leave any youth alone for any period of time while youth were on PO status.

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.	

A review of five mental health staff records and mock suicide drills showed each mental health staff completed the required six hours of annual suicide prevention training and participated in mock suicide drills at least quarterly. A review of mental health drills reflected the program completed at least one drill, each shift, quarterly. Mock drills were also shown to include cardio pulmonary resuscitation (CPR) and automated external defibrillator (AED) demonstrations. The program completed eighteen mock mental health drills since the last annual compliance review. Each reviewed mock suicide/mental health drill included action taken by staff, methods for contacting program staff, provisions of life saving measures and use of the suicide response kit. Each reviewed emergency drill clearly documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. The program practice is to review all mock suicide/mental health drills during the morning management meetings which are conducted Monday through Friday, and during the monthly all staff meetings.

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

The program has a crisis intervention plan to establish a method of crisis intervention services which will be provided to all youth. The crisis intervention plan is reviewed annually and was signed by the facility administrator and corporate office on July 10, 2017, and by the designated mental health clinician authority on July 20, 2017. The reviewed crisis intervention plan includes provision for notification and alert system, means of referral, communication, supervision, documentation, and review. An interview with the designated mental health clinician authority reported the mental health staff is an integral part of the program's day to day operations and offers ongoing low-risk crisis intervention. The program practice is to submit a mental health/substance abuse referral summary (an internal program form) to the mental health staff for any youth demonstrating acute emotional, psychological distress, or self-injurious behavioral issues to receive crisis intervention, assessment, and counseling.

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 facility administrator or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.	

The program has a policy and procedures addressing crisis assessments. Five crisis assessment events were reviewed. Each of the reviewed assessments included the reason for assessment, mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, and recommendations for follow-up or further evaluation, if necessary. Two contained parent/guardian notification although not required as the supervision level remained at standard. Four records were applicable for a Victimization and Sexually Aggressive Behavior (VSAB) to be completed as a result of the incident/referral and all were completed. Four crisis assessments were completed within two hours of referral. One crisis assessment documented the need for crisis assessment on June 25, 2018 at 3:59 p.m. A VSAB was completed on June 25, 2018 at 6:50 p.m. The crisis assessment was completed on June 26, 2018 at 10:27 a.m. by the designated mental health clinician authority (DMHCA). An email copy was provided to support the assistant facility administrator (AFA) notification to the staff mentors, case management staff, medical staff, mental health staff, and regional team of the situation and directions to keep the youth separated from another youth. A review of the program logbooks showed documentation the youth making an abuse call on June 25, 2018 and the Martin County Sherriff's Office responding. An interview with the facility administrator explained the VSAB results were reflected on the internal alert board and discussed during shift change. The result of the crisis assessment was to continue the youth on standard supervision and to keep both youth separated which were the same precaution/instructions implemented under direction of the AFA. No records were applicable for an off-site crisis assessment or the crisis assessment determination of a safety and security risk requiring a follow-up mental health status examination to be completed. All crisis assessment's reflected mental health staff would continue to follow up with youth and all five youth were appropriate for standard supervision. Three crisis assessments were completed by a licensed mental health professional. Two crisis assessments were completed by a master's-level therapist and signed by the DMHCA within twenty-four hours as required.

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

The program has a written emergency mental health and substance abuse plan. The plan includes immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. The plan is reviewed annually and was last signed on July 10, 2017 by the facility administrator and corporate officer and on July 20, 2017 by the designated mental health clinician authority. The plan outlined transport for emergency substance abuse assessment and treatment to Martin Memorial Hospital in Stuart, Florida. The plan outlines transport for emergency mental health evaluation and treatment to New Horizons of the Treasure Coast in Fort Pierce, Florida.

3.17 Baker and Marchman Acts (Critical)	Satisfactory Compliance
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 has a written policy and procedures addressing Baker and Marchman Acts. An interview with the designated mental health clinician authority (DMHCA) reported a licensed professional is available on-site during business hours to conduct Baker Act evaluations for high-risk suicidal youth. Additionally, an administrative duty officer phone listing is maintained and accessible to all staff to provide twenty-four-hour/seven day a week on call coverage. Three records were reviewed for the Baker Act process. Each reviewed record showed the staff response to the youth's identified need for emergency care was a completion of the Assessment of Suicide Risk (ASR), a referral for involuntary examination completed by a licensed clinician, notification to the facility administrator (FA) and DMHCA, and placement on one-to-one supervision. Two of the reviewed records showed one of the youth was transported by the program and the third youth was transported by the Martin County Sherriff's Office. An interview with the FA explained when youth are not in need of medical attention and are not aggressive or actively combative, transports are made by the program staff. The program policy states the receiving unit for all emergency Baker Acts and Marchman Acts is New Horizons of the Treasure Coast or the closest emergency room. An interview with the FA explained youth eighteen or older are generally sent by the local emergency room to be treated at Coral Shores Behavioral Health in Stuart, Florida; since it is the closest receiving facility for adult Baker Acts. Each reviewed record reflected all youth returned to the program on elevated supervision until appropriate assessments and a mental health status examination was completed. The program has not had any Marchman Acts since the last annual compliance review.

Standard 4: Health Services

Overview

Martin Girls Academy is an intensive mental health program providing comprehensive health services to each youth admitted into the program. The medical department is responsible for the overall medical care for the youth committed to the program. All care is under the direct supervision of the designated health authority (DHA) and daily oversight and care provided by registered nurses (RN) and four pro re nata (PRN). RNs provide nursing services seven days a week from 7:00 a.m. to 7:30 p.m. At the time of the annual compliance review the program had one full-time RN and two vacant RN positions. The vacant RN positions were filled; however, the three nursing staff resigned. One worked from June 4-7, 2018, one from July 9-12, 2018, and the other RN worked from August 6-8, 2018. The health services administrator (HAS) position was also vacant at the time of the annual compliance review. The regional HSA provides periodic on-site visits throughout the month and along with the DHA, is on-call seven days a week, twenty-four hours a day. The previous HSA went to PRN status as of March 26, 2018. On April 30, 2018 the HSA position was offered to another candidate; however, the candidate declined. The HSA position was then filled from May 15, 2018 to June 24, 2018 when the applicant resigned. Health services provided to the youth include an admission health services screening for communicable diseases, chronic or active conditions, a comprehensive physical assessment, on-site vaccinations, human immunodeficiency virus (HIV) counseling and testing, sick call, episodic and first aid care, medical referrals and follow-up services, medication administration, and medication management. The program participates in the Vaccines for Children Program through Florida Shots. In addition to the DHA and RNs, the program also maintains an independent contract agreement with a licensed psychiatrist. The program maintained contracted services with a dentist, optometrist, consultant pharmacist, Mobile Imaging of St. Lucie County, Inc., and Mobilex USA

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

The program maintains an independent contractor agreement with a licensed medical physician signed on May 22, 2014. The medical physician is a licensed physician in the State of Florida and is responsible for the overall clinical healthcare services provided to youth in the program. The current license expires January 31, 2020. The medical physician's education and specialty training is in pediatric medicine. The physician serves as the program's designated health authority (DHA) and is scheduled to be on-site one hour each week, on Tuesday's. The program maintains a physician weekly clinic list identifying all youth to be evaluated with the DHA signing in and out. A review of the logs validated the DHA was on-site weekly. According to the independent contractor agreement the DHA is on-call twenty-four hours a day, seven days a week and is responsible for communication with the nursing staff regarding youth medical needs. The program also maintains a separate agreement with a State of Florida licensed medical physician to serve as a backup when the DHA is on scheduled leave. The DHA does not utilize an advanced registered nurse practitioner (ARNP) or physician's assistant (PA). Reviewed documentation supported the DHA maintained current professional liability insurance.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported the DHA signed all healthcare policies and procedures on July 10, 2018. In addition, the facility administrator documented a review on July 5, 2018, the corporate office documented a review on July 9, 2018, and the psychiatrist documented a review on July 10, 2018. The program had turnover in nursing staff since the last annual compliance review. The program maintained a training requirement where newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by a registered nurse. The program maintains a nursing protocol manual developed and approved by the DHA on July 17, 2018. However, the DHA participated in training of the updated health services facility operating procedures and health related protocols on July 10, 2018. Reviewed documentation supported the program's registered nurse received training on the treatment protocols on July 10, 2018. The four pro re nata (PRN) nursing staff documented a training on July 10, 2018 and one on August 17, 2018. An additional training was provided on the sick call procedures and nursing protocol manual on July 18, 2018.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

The program maintains a written policy and procedures ensuring each youth maintains a signed and dated Authority for Evaluation and Treatment (AET) form in the healthcare record. The AET form is signed by the parent/legal guardian and serves as informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter medications which can be treatment by healthcare staff. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the form and to whom the information is released and shared with. A review of five youth healthcare records found three contained an AET and two contained an original release of information form for youth eighteen years of age and older. One of the three reviewed AETs was an original and the other two were copies. Each copy was clearly labeled with the word "Copy" stamped. Each reviewed AET and/or release of information form was filed in each youth's healthcare record in the appropriate section.

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.	

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of five youth healthcare records validated the program sends a list of over-the-counter (OTC) medications approved by the designated health authority (DHA) to each parent/guardian, with a welcome letter and a request to return

the signed consent form. Each reviewed youth healthcare record contained a welcome letter from the nursing department sent to the parent/guardian highlighting several forms requiring parental/guardian consent and signatures. The letter also instructs the parent/guardian of the youth having access to two on-site physicians; designated health authority and psychiatrist. Reviewed healthcare records supported four applicable parents/guardians were notified when significant changes to existing medication occurred. Two youth were eighteen years of age and one consented notifying the parent/guardian. Four applicable parents/guardians were notified when changes in condition and/or medication for youth identified with a chronic condition. There were two applicable reviewed healthcare records of youth requiring off-site healthcare and notification was made by telephone and subsequently in writing. One youth was in the custody of the Department of Children and Families (DCF); however, parental rights were not terminated. Therefore, the program notified the parent/guardian with applicable changes in medical care.

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.	

The program maintains a written policy and procedures ensuring the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of five youth healthcare records validated five youth were prescribed psychotropic medications. According to program policy, no new psychotropic medication shall be initiated without parental consent to youth under the age of eighteen. All efforts to contact the parents/guardians are documented in the youth's healthcare record. Documentation must include the date and time of the actual contact or attempted contact., telephone number called, name of the parent/guardian, name and dosage of medication, general description of the reason the medication was prescribed, risk of the medication, and name of the prescriber. Reviewed documentation supported this practice. Reviewed youth healthcare records supported three of the five youth were under the age of eighteen and required parental/guardian consent. Two youth were eighteen years of age; however, one youth did consent to include their parent/guardian in notification for significant changes in psychotropic medication. The applicable four youth requiring parental/guardian consent documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parent/guardian received a written follow-up copy of the Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note.

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

The program maintains a written policy and procedures ensuring an immunization history shall be obtained for each youth admitted. A review of five youth healthcare records validated nursing staff review each youth's electronic commitment packet to determine whether it contains a complete history of immunizations. Nursing staff obtain a school printout of the youth or utilize the Florida Shots Florida Certification of Immunization to determine if the immunization history is missing or incomplete. Each reviewed healthcare record contained a Florida Certification of Immunization and a Department Immunization Tracking Record, form HS 016. Reviewed

documentation supported the vaccinations were verified within thirty days of the youth's admission. All five reviewed healthcare records indicated each youth received additional immunizations. Four youth received human papillomavirus (HPV), three youth received trumemba vaccination, two youth received the flu vaccination, one youth received menactra vaccination, and one youth received the hepatitis A vaccination. No youth had a completed religious exemption from immunization form filed in the healthcare record.

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.	

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission. A review of five youth healthcare records validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening form FEPHS. All admission screenings were completed by a registered nurse.

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 maintains a written policy and procedures ensuring all staff are made aware when medical or mental health issues exist which may affect the security and safety of the youth and may necessitate the need for emergency medical or mental health services. A review of five youth healthcare records as well as the program's internal alert system validated youth identified with medical, dietary, physical limitations, or healthcare complications were updated accurately as required. The nursing staff ensure all alerts are verified, accurate, and up-to-date and placed on the medical alert roster. The program maintains a separate allergy tracking, special diet orders, and an internal medical alert roster identifying the alert code, restrictions, and medical grade. A review of the Department's Juvenile Justice Information System (JJIS) validated the alerts were updated and/or removed as required. The program maintains copies of the internal alert system in the staff breakroom, master control, and paper copies are provided to staff at shift briefing during change of shift.

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

The program maintains a written policy and procedures establishing a system where all youth are provided with an orientation to the healthcare system upon admission. A review of five youth healthcare records validated each youth received a healthcare orientation on the day of admission. Each youth receives a health education packet specifically designed for female adolescents. Youth and nursing staff sign the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth receive on-going health education which was documented in the healthcare record. Nursing staff also conduct monthly height, weight, body mass indices, and vital signs for each youth. Reviewed healthcare records validated this practice.

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

The program practice is for the designated health authority (DHA) to be notified by telephone of all admissions and when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone and an order is obtained to continue the youth on the prescribed medications. Nursing staff document the notification(s) on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of five youth healthcare records validated this practice.

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.	

The program maintains a written policy and procedures ensuring a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth healthcare records found two applicable youth where a change in physical custody occurred. One additional applicable healthcare record was reviewed where there was a change in custody on two different occasions. Reviewed documentation supported all youth received a healthcare admission rescreening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. Each FEPHS form was completed by the registered nurse.

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

The program maintains a written policy and procedures ensuring nursing staff shall complete the Department's Health Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth healthcare records found a new HRH was completed for each youth on the day of admission. The nursing staff and the designated health authority (DHA) documented their review of the HRH by signing the form. In addition, the DHA documented a review on the completed CPA.

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.	

The program maintains a written policy and procedures ensuring each youth shall receive or have on file a current Comprehensive Physical Assessment (CPA). A review of five youth healthcare records validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority. All sections of the CPA were completed in full utilizing an "O" or an "X". All five reviewed CPAs indicated the youth refused a portion of the examination and the youth documented their signature of refusal on the CPA. Reviewed documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable.

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

The program provides the youth gender-sensitive and trauma informed primary services, gynecological (GYN) care, and obstetrical (OB) services. A review of five youth healthcare records found each youth consented to a qualitative urine pregnancy test at the time of their admission. The test was conducted on each youth and the results were documented in the lab section of the healthcare record. All five youth received a Comprehensive Physical Assessment (CPA) and each documented the gynecological examination was refused by the youth. The program maintains a memorandum of understanding (MOU) with the Florida Community Health Centers, Inc. (FCHC) in Stuart, Florida to provide OB/GYN services to meet the needs of the youth. Through a referral process, the FCHC provides the needed services as soon as reasonably possible. The MOU was signed on January 10, 2018. An interview with the designated health authority (DHA) supported the DHA provides GYN examinations when applicable upon youth permission.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth healthcare records validated each youth had at least one verified tuberculin skin test (TST) documented within the last year to determine exposure to tuberculosis. The TST is conducted annually. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening. All tier I tuberculosis screenings were conducted within twenty-four hours of each youth's admission. There were no applicable youth with symptoms suggestive of active tuberculosis. Reviewed documented practice found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and the Comprehensive Physical Assessment (CPA).

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).	

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). A review of five youth healthcare records found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Each youth was referred to the designated health authority (DHA) for further evaluation. Testing was ordered and was performed for each youth within twenty-four hours. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present.

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.	

The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth healthcare records validated each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. The program's designated health authority (DHA) is authorized to provide pre-counseling, testing, and post-counseling. A review of youth records validated when youth receive pre-counseling, testing, and post-counseling, the youth's health education record was updated in the healthcare record. The results were placed in a sealed envelope marked 'Confidential' with the youth name, program name and address, date of test, and youth signature documented on the outside of the envelope. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not include HIV status as part of the internal alert system. Five interviewed youth indicated they could request a HIV/AIDS test.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Completed sick call request forms are placed in a secured box in the cafeteria/multi-purpose room. The program maintains an independent contractor agreement with Sugarhill Dental Care to provide a licensed dentist to ensure professional dental services are provided to youth. The agreement was signed on May 12, 2016. The program maintains an independent contractor agreement with a licensed optometrist. The agreement provides for on-site services on an as-needed basis. The optometrist maintained current professional liability insurance with an expiration date of August 1, 2019. The program offers youth the opportunity to sick call seven days a week, two times daily conducted by the licensed nursing staff. Sick call is scheduled Monday through Friday from 7:00 a.m. to 7:30 a.m. and 2:10 p.m. to 2:30 p.m. Saturday and Sunday sick call is scheduled from 12:00 p.m. to 12:30 p.m. and 4:30 p.m. to 5:00 p.m. A review of five youth healthcare records validated each youth completed a sick call request form at least one time during their stay. The registered nurse documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. However, program procedures outlined the healthcare staff will automatically refer the youth to the designated health authority or dentist for an evaluation and treatment. The dental sick call is incorporated into the healthcare sick call process. When a licensed healthcare staff is not on-site, all sick call request forms shall be turned into the staff mentor for review. The staff mentor is required to review the sick call complaint promptly but no longer than two hours after the

request was submitted. The staff mentor will determine if the sick call requires immediate attention. Licensed healthcare staff are on-call and are available for consultation to determine if the sick call requires immediate attention and/or for instructions. The program currently has five staff mentors, and each received medical technician training delivered by the regional health services administrator.

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.	

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treatment appropriately through the sick call system. The program maintains designated health authority (DHA) approved protocols for non-licensed staff to deal with healthcare situations. The protocols clearly indicate no substitutions are permitted without the authorization of the DHA. A review of five youth healthcare records found each youth submitted a sick call request form during their stay. Sick call is completed by the registered nursing staff when they are on-site. Procedures are in place for the staff mentors to review the sick call request form to determine if it requires immediate care. Completed sick call request forms are filed in chronological order in the nursing chronological note section of the youth healthcare record. Reviewed documented practice found all sick calls, were documented on the Department's Sick Call Index and on the Sick Call Referral Log. Observations of two sick call encounters indicated the youth are assessed in the medical clinic by the registered nurse. The youth provided verbal consent for the review team to observe the sick call encounter. The youth were escorted to the medical clinic by a direct care worker. The direct care worker stood by the door inside the clinic during the assessment. The youth signed the bottom of the Sick Call Request form upon completion of the sick call encounter. Five interviewed youth found one youth indicated they can be seen immediately and four youth indicated within one day of submitting a sick call request. All five youth indicated they could see a dentist if they had tooth pain and all five indicated they could see the doctor when requested. Five interviewed staff indicated nursing staff provide sick call in the program.

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

The program has a written policy and procedures in place for controlled observation. Youth placed in controlled observation shall have timely access to medical care, as outlined in Florida Administrative Code, 63M-2.002. Four controlled observation reports were reviewed during the annual compliance review and documentation verified youth were placed in controlled observation due to active aggression, violent behavior, and physically out of control. The reviewed reports indicated medical services and/or prescribed medications were provided for each youth while placed in controlled observation. During this annual compliance review, there were no youth who required medical attention while in controlled observation, and there were no youth which would require daily visit from medical staff due to remaining in control observation for a twenty-four-hour period.

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 maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth healthcare records found three youth requiring episodic and/or first aid care. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting. Nursing staff also maintained an episodic/first aid/emergency care log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). The program maintains one automated external defibrillator (AED), five first aid kits, and three suicide response kit containing a knife-for-life, wire cutters, and needle nose pliers. The AED was observed in master control. The suicide response kits were observed located in master control, medical, and operations and five surveyed staff each knew their location. The first aid kits were observed located in the operations office, medical, and master control. Two first aid kits were opened and reviewed for the approved contents. The two first aid kits in master control were assigned to the program vehicles. The first aid kits and suicide response kits are checked weekly and the AED is checked monthly by nursing staff.

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 maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. The program also maintains a written policy and procedures ensuring the program based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains one AED located in master control. Nursing staff conduct monthly checks to ensure it is functioning adequately. The AED provides audio instructions on step-by-step procedures. The assistant facility administrator demonstrated the AED and validated it was in working order. The AED batteries expire in March 2026 and were last changed in March 2018. The AED pads expire in December 2019 and were last changed in July 2018. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. The registered nurses each maintained current certifications in CPR/AED and basic first aid. The program conducts mock medical drills monthly on each shift. Reviewed practice found the program conducted a CPR/AED drill six times on each shift in the last twelve months. Observations during the tour of the program found postings informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were maintained in master control, medical clinic, and the operations office. Five interviewed staff indicated staff are allowed to call 9-1-1 if a youth has a medical emergency. Three staff indicated they would call a supervisor to notify 9-1-1, one staff indicated a code white would be called and 9-1-1 would be called, and one staff indicated they would notify 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.	

The program maintains a written policy and procedures ensuring evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care formHS033. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth healthcare records found three youth requiring off-site care and/or emergency care. One of three youth records documented parental notification; two youth were eighteen years of age. The Summary of Off-Site Care Form was completed for each youth and filed in the healthcare record. Reviewed documentation supported the DHA reviewed each completed off-site care form and applicable discharge paperwork as evidenced by the DHA signature and date. One youth required follow-up care and the youth was scheduled to receive services as prescribed.

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.	

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the period evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth healthcare records indicated four youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening form. All five youth were classified with a medical grade of five. There were two youth currently undergoing treatment for physical health condition which included a body mass index (BMI) greater than thirty. Reviewed practice is to calculate the youth's BMI utilizing the Centers for Disease Control and Prevention (CDC) BMI Percentile Calculator for Child and Teen. There was one youth identified as pregnant and undergoing care through the program and referrals to the Florida Community Health Centers, Inc. in Stuart, Florida to receive obstetrical (OB) and gynecological (GYN) care. Reviewed records supported each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated youth are evaluated at a minimum of every sixty days. The psychiatrist evaluates the youth every thirty days. There was no indication of lapses in care or missed periodic evolutions. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The DHA and/or psychiatrist diagnosis the medical condition with a prescribed medication treatment plan. Approximately every sixty days the DHA conducts a periodic examination of the youth, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. The Department's Problem List was updated as required for each applicable youth. The interviewed facility administrator indicated nursing staff attend morning meetings to discuss any pertinent medical issues staff need to be made aware. In addition, healthcare staff attend treatment team meetings and provide applicable information.

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

The program maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the education is verified and indicated. Nursing staff complete the Facility Entry Physical Health Screening to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. A review of five youth healthcare records indicated each youth was admitted into the program on prescribed medication; four youth on psychotropic medication and one youth on pre-natal vitamins. Review of the nursing admission notes documented the youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication. The nursing staff verbally notified the DHA on the youth's day of admission; four in person and one by telephone. Program practice is to notify the DHA of all admissions. The DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. The program sends a Pharmacy Notification identifying the prescribed medications to 1st Choice Pharmacy. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian.

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.	

The program maintains a written policy and procedures ensuring all medications have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of five youth healthcare records validated each was applicable for medication management and each documented a current and valid prescription order. Five youth were admitted into the program on prescribed medication; four on psychotropic medications and one on pre-natal vitamins. The medications prescribed prior to admission were continued as ordered. Each reviewed youth healthcare record indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. Each time the doctor's order sheet clearly documented the medication and dosage. Over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET) were administered in accordance with the physician's order.

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.	

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations of the medical clinic found all medications securely stored and inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart. Narcotics and other controlled medications were observed securely stored in the medication cart. The program practice is to store the medications in a locked box located in the locked medication cart. Oral

medications were not stored with injectable or topical medications. The program maintains a refrigerator for medications requiring refrigeration. The program had vaccinations stored in the refrigeration during the annual compliance review week. The program securely stored sharps (needles, syringes, scissors, suture removal kits) separate from medications. The program maintains a written process for the disposal and destruction of expired and/or discontinued medications. The program also maintains an exemption certificate from the Department of Health for biomedical waste. The program utilizes Stericycle Steri-Safe for monthly medical waste services. All non-controlled medications are sent back to 1st Choice Pharmacy for credit. All controlled medications are disposed of by the consultant pharmacist and witnessed by nursing staff. Disposal practice is to place the medication in Rx Destroyer and document the disposal on the Medication Administration Record.

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

The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by nursing staff. Syringes and sharps (needles, syringes, scissors, suture removal kits, etc.) are counted through a perpetual inventory and are verified weekly. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2018. The program maintains a policy and procedures manual for 1st Choice Pharmacy signed by the facility administrator, designated health authority, health services administrator, and consultant pharmacist on September 22, 2017. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator, health services administrator, designated mental health clinician authority, designated health authority, and consultant pharmacist. Agenda and minutes are maintained highlighting risk reduction measures, notable trends medication treatment errors, medication errors, mock emergency drills, youth chronic conditions and youth psychotropic medications. The program elected to not obtain a Drug Enforcement Administration (DEA) license; therefore, the program does not carry floor stock controlled substances and is not required to do biennial inventories. The program maintains written procedures for the disposal of narcotics and other controlled substances. Disposal practice is to place the medication in Rx Destroyer and document the disposal on the Medication Administration Record (MAR). Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. Three youth with prescribed psychotropic medications found the inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts.

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 maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program maintains a Modified Institutional Class II Type B permit with an expiration date of February 28, 2019. The program maintains a Community Pharmacy Schedule II and III. The approved certification with 1st Choice Pharmacy with an expiration date of February 28, 2019. All controlled substances are maintained in the securely locked box within the securely locked medication cart located in the medical clinic. Observations found the medications are obtained through 1st Choice Pharmacy. The medications are in blister packs documenting the number of pills in each prescription order. Controlled medications are administered by the registered nursing staff. Nursing staff are on-site seven days a week from 7:00 a.m. to 7:30 p.m. The program currently has one full-time registered nurse (RN) and four pro re nata (PRN) registered nurses. The health services administrator and two RN positions were vacant at the time of the annual compliance review. The program has five non-licensed staff mentors trained to administer over-the-counter medication when nursing staff are not on-site. The youth's individual controlled medication inventory record is updated after each administration. Shift-to-shift inventories are conducted by two RNs. A review of three random youth prescribed psychotropic medication and a review of the inventories were found 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.	

The program maintains a written policy and procedures ensuring medications shall be provided pursuant to a physician order written in the youth's individual healthcare record or pursuant to a youth's current prescription container if a youth's medications are administered from a current individual container with a current patient specific label. Oral prescription medications shall be administered, according to instructions. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. A review of five youth healthcare records found each youth was prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice Pharmacy Medication Administration Record (MAR) to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All five reviewed healthcare records indicated the youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Four youth were on prescribed psychotropic medications and one youth was prescribed pre-natal vitamins. The five reviewed youth healthcare records supported the MAR documented the youth received the medication(s) as ordered. The MAR clearly indicates medication start dates and stop dates, when applicable. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. A review of the Central Communications Center (CCC) reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. In addition, program nursing staff documented weekly psychotropic medication side effects on the Weekly Psychotropic Medication Monitoring Tool.

Refusals were clearly documented on the MAR and nursing staff complete the Department's Refusal of Treatment form when a youth refuses a medication dosage.

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.	

The program maintains a written policy and procedures ensuring authorized prescribers, including consultants, shall utilize the prescribed medication list when providing appropriate healthcare to youth. Prescribed medication used for physical health conditions, psychological, and/or psychiatric conditions, and medications specifically prescribed for pain relief, inclusive of narcotics and other controlled substances, shall be administered in a single-dose under the direct supervision of the healthcare staff to ensure the youth receives the medication as ordered. The program has one full-time registered nurse (RN) and four pro re nata (PRN)RNs. Nursing staff are on-site seven days a week from 7:00 a.m. to 7:30 p.m. The full-time RN is scheduled to work four twelve-hour days. At the time of the annual compliance review the health services administrator (HAS) and two RN positions were vacant. Each RN maintained current licenses in the State of Florida. The program also has one regional health services administrator providing on-site services. A review of five youth healthcare records validated each youth was prescribed medications. No youth required parenteral medication at the time of the annual compliance review; however, procedures are in place for only the RN to administer the medication. Interview with the RN indicated nursing staff administer vaccinations upon an order from the designated health authority. Reviewed Medication Administration Records (MAR) for each youth, as well as the prescription, validated the youth received the medication as ordered and at the scheduled time frames. Refusal of medications were clearly documented on the MAR and the Refusal of Treatment form was also completed and filed in the youth's healthcare record. Observations of medication administration by the RN indicated the medication was administered in accordance with the five rights of medication administration. The RN opened the clinic Dutch door and the youth approached one at a time and identified self, telling the nurse the medication prescribed and side effects. Two of five youth indicated they were experiencing side effects at the time of medication administration and initially refused the medication; however, they changed their mind and returned and received their prescribed medication. The medication cart was stationed against the wall adjacent to the opened Dutch door. The youth specialist stood beside the youth when the medication was administered. The RN and youth specialist then checked the youth's mouth to ensure the medication was swallowed and instructed the youth to cough. The RN did not pre-pour the medication from the blister pack subsequent to administration. Three of six observed medication administration were administered in unsweetened applesauce due to the youth history of cheeking medication. The medical clinic and working space was observed to be clean and well organized. The observed process was structured and interactive. Five interviewed youth indicated all youth were taking medications and all youth indicated the nursing staff administered the medications. Five interviewed staff each indicated the nursing staff provides medication to the youth. Five staff mentors were trained and can provide over-the-counter 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.	

The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained staff. Non-licensed staff shall provide self-administration medication only when licensed healthcare staff are not on site. The designated health authority (DHA) developed and approved non-licensed staff medical and emergency protocol guide for staff to utilize when assisting with self-administration of over-the-counter (OTC) medications. Reviewed documentation supported the program has five trained non-healthcare staff mentors to provide (OTC) medications to youth when nursing staff are not on site. Nursing staff are scheduled on site from 7:00 a.m. to 7:30 p.m., seven days a week. Nursing interviews and reviewed documentation supported the non-licensed staff have not provided OTC medications to the current youth. Five interviewed staff and five interviewed youth indicated nursing staff provide medications 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.	

The program maintains a written policy and procedures ensuring youth diagnosed with a Diagnostic and Statistical Manual – Fifth Edition (DSM-5) mental disorder and is prescribed medication, the psychotropic medication shall be provided pursuant to a physician's order. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. The program maintains an independent psychiatrist agreement with a State of Florida licensed psychiatrist who maintains professional liability insurance, expiration August 1, 2019. The psychiatrist is scheduled to be on-site two hours every week, on Wednesday from 8:00 a.m. to 10:00 a.m. Reviewed psychiatrist list logs validated the psychiatrist was on-site each week during the review period. The program's practice is to refer a youth admitted with prescribed psychotropic medications to the psychiatrist for an initial psychiatric evaluation within fourteen days of admission. The program's psychiatrist utilizes the Department's Clinical Psychotropic Progress Note (CPPN) for the initial evaluation. The CPPN is also utilized for youth who are subsequently prescribed psychotropic medications. A review of five youth healthcare records validated four youth were prescribed psychotropic medications upon admission. A review of one additional youth healthcare record of prescribed psychotropic medications subsequent to admission was also conducted. Each youth was assessed by the psychiatrist and prescribed psychotropic medications. Reviewed documentation supported medication monitoring is conducted by the psychiatrist at least monthly. The psychiatric evaluation was documented on the CPPN. The program practice is to complete the CPPN in the Lauris system. The psychiatrist also completes the Abnormal Involuntary Movement Scale (AIMS) for prescribed dopamine blocking medications to monitor Tardive Dyskinesia, which is also reviewed monthly by the psychiatrist. Nursing staff documented daily side effects on the Medication Administration Record (MAR) and weekly side effects on the Weekly Psychotropic Medication Monitoring Tool. Administration and counts were also documented on the TrueCore Controlled Medication Inventory Record. The program did not have standing orders for psychotropic medications and there were no emergency treatment

orders for psychotropic medications. The psychiatrist does not provide the program with pro re nata (PRN) order for psychotropic medications.

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 maintains a written policy and procedures ensuring there is an approved plan for infection control. The infection control plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal regulations and guidelines. The plan was reviewed and approved by the facility administrator, corporate officer, and designated health authority on July 10, 2017. The infection control plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorists agents, chemical exposures, and methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste. The program documents a transport log for monthly medical waste pick-up through Stericycle Steri-Safe. The program maintains a current operating permit through the Department of Health for biomedical waste. The program did not have instances in which the Martin County Health Department, Center for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) were notified of an infectious disease.

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

The program's control of infectious and communicable disease plans included staff training during the pre-service phase and in-service training, annually. A review of five staff training records found each staff received the required training. A review of five youth healthcare records and five staff training records validated all received training on infection control to include prevention of communicable diseases and prevention of blood-borne pathogens.

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 maintains a written exposure control plan addressing risk assessment, methods of compliance, engineering and work-place control, and training requirements in order to provide a safe environment for youth, staff, and visitors. The infection control plan is combined with the

program's exposure control plan. The plan was reviewed and approved by the facility administrator, corporate officer, and designated health authority on July 10, 2017. The program's exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910). The exposure control plan included a comprehensive process for needle stick post-exposure evaluation and the plan is available to all staff. The program reports there were no incidents involving a contagious disease requiring the quarantine or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. Interview with the facility administrator (FA) indicated the exposure control plan is located in the FA office, assistant FA office, master control, and operations office. The plan is available and accessible to all program staff. Education on handling exposures is conducted several times a year and is completed in all-staff meetings, through the Department's Learning Management System (SkillPro), and through drills.

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

The program has a policy and procedures to ensure all youth are provided gender-specific and trauma informed primary services, gynecological care, and obstetrical services. All female youth are screened for pregnancy upon admission utilizing the Facility Entry Physical Health screening and the Health-Related History. All female youth admitted have a urine pregnancy test with their verbal consent. Youth admitted pregnant shall immediately begin receiving prenatal care. The program maintains nursing protocols and treatment plans developed by the designated health authority (DHA) for pregnant youth. The program had one applicable pregnant youth since the last annual compliance review. A review of the youth healthcare record supported prenatal care began upon admission and at recommended intervals. The youth was admitted at thirty-three weeks pregnant and was experiencing some medical concerns. The DHA provided orders for additional testing and services. The program maintains a memorandum of understanding (MOU) Florida Community Health Centers, Inc. (FCHC) in Stuart, Florida to provide prenatal, obstetrical (OB), and gynecological (GYN) services to pregnant youth. Reviewed documentation supported the youth received services through FCHC as required. Reviewed documentation supported the youth received a human immunodeficiency virus (HIV) pre-test counseling, testing, and post-test counseling conducted by the DHA. The DHA conducted focused medical evaluation at least every thirty days. The program worked with the Department of Children and Families (DCF) in placing the infant in the custody of the youth's grandmother.

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Satisfactory Compliance
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.*	

The program has a policy and procedures to ensure all youth are provided gender-specific and trauma informed primary services, gynecological care, and obstetrical services. Pregnant youth are provided nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. The program had one applicable pregnant youth since the last annual compliance review. A review of the youth healthcare record supported the youth received daily Ensure, a nutritional supplement, in addition to the youth standard meals and snacks. Reviewed documentation supported the youth received health education on alcohol and drug use, smoking, nutrition, sexually transmitted infections, and contraception. In addition, the youth received health education on prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. The youth received lactation consultation from the designated health authority (DHA) and the facility administrator who is a registered nurse with a background in labor and delivery.

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

The program ensures all non-healthcare staff involved in the supervision or treatment of pregnant youth receive appropriate healthcare education. A review of five youth training records supported each staff received healthcare education in the daily monitoring and observation for indications of danger signs related to pregnancy. In addition, staff received training in labor and delivery and post-partum care of youth. Reviewed documentation supported all training was entered in the Department's Learning Management System (SkillPro).

Standard 5: Safety and Security

Overview

Martin Girls Academy is a thirty-bed, high and maximum risk, hardware-secure residential treatment program for female youth ages thirteen to twenty years of age. The program is operated by TrueCore Behavioral Services, Inc. and is located adjacent to the Martin County jail and the entire facility and grounds are surrounded by a fourteen-foot security fence topped with razor wire. To enter the facility through the main gate, staff and visitors must announce themselves to the master control staff prior to entry into the first security gate. A second security gate opens once the first gate is closed and locked. Visitors sign-in and surrender their personal vehicle keys, prior to a search by staff using a hand-held metal detector. Visitors are not permitted to bring in any items for visitation. Staff may only enter through an alternate entrance and exit located on the north side of the facility where the employee parking lot is located. However, staff must identify themselves to master control to have the security gate opened. Considering the program is a high and maximum risk treatment facility, youth do not participate in any off-site activities. Should special circumstances arise for medical and/or for court, youth are secured with mechanical restraints prior to entering the program's two vehicles, which are equipped with security metal framing in the passenger area. The program has a total of forty-one security cameras mounted throughout the facility all in working order. The security video recording has the ability to save data for up to thirty-days.

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

The program has a written policy and procedures to ensure youth are supervised according to the contract and the Departments policy. The program promotes safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth and redirect inappropriate behavior, and consistently applying the program's positive performance system. Youth and staff observations were conducted by the annual compliance review team throughout the review week. The program conducts youth movement throughout the day for various activities as outlined on the daily activity schedule. An interview with supervising staff verified they immediately knew how many youth they were supervising. A review of the program logbooks verified counts and movements were documented by master control in the facility logbook. Observations of youth movement for four days included movement from classroom to classroom, from the dorm to the outside recreation area, and to the multi-purpose room. During the observations, staff were actively supervising youth. Prior to any movement, staff informed master control of the count and waited for permission to move the youth. The contract requirement for staff ratios is one staff for every five youth during the awake hours, with one staff for every six youth during the sleep hours. Staff-to-youth ratios were in compliance according to the program's contract at all times when observed by members of the annual compliance review team. During outdoor activities or movement, staff were strategically placed to ensure proper line movement and to ensure there were no physical obstructions of their view

of the youth. Five staff were interviewed, and each knew what to do when a count cannot be reconciled.

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 comprehensive policy and procedures in place describing their collaborative behavior management system (BMS). A review of five youth records reflected youth are initially introduced to the intervention during the orientation process. A full description was outlined in the youth handbook. The description governing conduct of positive and negative behavior, including the classroom activity, was also observed to be posted throughout the program. The responsive approach established by the program was unique to the characteristics of the identified female population. The BMS utilized by the program was developed by the National Council on Crime and Delinquency (NCCD) for Girls and Young Women, with oversight provided by the program's director of mental health services. An interagency agreement with the school board of Martin County, reflected written policies regarding the conduct and disciplining of students while enrolled in the education program were provided by the provider. An interview with the facility administrator (FA) reflected youth earn points every half-hour based upon criteria including dress code, tasks, boundaries, tone, and being in assigned area. There are five graduate levels with each requiring a little longer time period, coupled with more percentage positive points to advance to the next level. Youth earn positive incentives daily, weekly and monthly for positive behavior. Points may be redeemed through a boutique as a reward to youth for positive behavior. Youth can receive the following items through the boutique; hair accessories, personal hygiene products and snacks. Negative consequences are monitored through a tracking system where consequences are reflected on their point card where points are not earned and a referral is warranted for more severe behaviors. A review of five staff in-service training records found all had completed training in 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 has a comprehensive policy and procedures in place describing their collaborative behavior management system (BMS). The policy requires staff to explain the justification of sanctions imposed, with allowing the youth an opportunity to explain their behavior. The program does not utilize room restrictions for BMS disciplinary infractions. The BMS does not

deny youth of any basics rights such as increased length of stay, meals, clothing, sleep, special services, nor does their BMS allow for group punishment, punishment by other youth, or isolation in a locked room. Negative consequences are monitored through a tracking system where consequences reflect on their point card where they do not earn points and can also earn a referral for more severe behaviors. A review of five staff in-service training records found all had completed training in the BMS. Five youth were interviewed and indicated a thorough understanding of the programs behavior management system consisting of a level system based upon points earned.

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

The program has a written policy and procedures in place for staff to conduct and document ten-minute checks. Staff are required to document room checks every ten minutes on the ten-minute check logs when youth are in their sleeping quarters. Staff ensure flesh or a body part is visible to confirm the youth's presence and are not allowed to enter a youth's room unless there is either a safety and/or a security issue observed. Staff document the actual time of the room check and initial on the ten-minute check log sheets verifying who completed the room check. If a youth is not in their room, an "X" is marked in the box for the time of the room check. The room check forms identify the youth by name and room number. A review of ten-minute check logs from six different days and two different shifts, along with the corresponding video recording, indicated checks were consistently conducted and documented in real time. Five staff were interviewed and stated room checks are conducted every five minutes when youth are placed in their room for sleeping or non-punishment reasons. Supervisors are required to conduct three room checks each night and visibly see flesh of each youth in their room. Supervisors then document, in red, on the ten-minute log sheets to include the time of the check and initials. A review of supervisor ten-minute checks from six different days and corresponding video recording indicated the checks were conducted and documented in red on the ten-minute check logs.

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 written policy and procedures to track the daily census. Youth are accounted for at all times by a physical count and random head counts when requested by master control. A review of logbooks for the past six months documented youth counts were conducted at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. Observations of youth counts during the annual compliance review indicated prior to any youth movement, master control was contacted to inform of the number of youth being moved and to what location. Interviews with five staff were consistent with their responses regarding how and when youth counts take place. All five staff provided different responses when asked what to do when there was a discrepancy in the count. The program's policy requires a second formal count when an inaccurate count is called in. If the second formal count is consistent with the assigned number of youth, the formal second count shall be cleared. If the second formal count is not consistent with the assigned number of youth, a third formal count will be conducted using the internal census report. If the third formal count does not clear, the program conducts an emergency count and implement escape response plan procedures. Five staff were interviewed regarding the procedure for a discrepancy with the count. One staff responded there would be an informal count, one staff stated a supervisor is notified to follow up and determine what went wrong, another staff stated the facility administrator (FA) is notified to follow up and determine what went wrong, a fourth staff responded all movements will stop while available staff search the building and all youth are moved to the recreation yard, and a fifth staff responded a lockdown is conducted while available staff continues to look for youth.

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

The program has a written policy and procedures for logbook documentation. Master control maintains a bound logbook with numbered pages. The logbook documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from

population, admission, releases, calls to the Department's Central Communications Center (CCC), Florida Abuse Hotline, and special instructions from supervisors pertaining to the supervision of youth. Each entry is legible and made in ink with no erasures or white-out areas. All errors are struck through with a single line and initialed by the staff member making the correction. A review of the facility logbooks for the past six months verified this practice. The program conducts staff briefings prior to the beginning of each shift. Incoming staff are briefed on the previous shift and sign the shift report to acknowledge information was shared. Observations of staff briefings and a review of the program shift reports verified information is shared with incoming staff prior to the beginning of the shift.

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 written policy and procedures for key assignment, inventory, tracking, and storage of keys. The program has a daily key log to track keys. The log indicates the name of staff and what type of key is assigned according to the staff duties. Facility keys are kept in master control in a locked key box. When staff arrives to work, access to the facility is granted by master control. Staff submit their personal keys and receive a facility key. Staff initial the key log next to their name at the beginning and at the end of each shift. Personal keys are placed in the key box next to the corresponding staff's name. Medical staff have a separate key box located in master control. Only medical staff have access to the key box. When medical staff report to work, they enter master control, obtain the facility key, and deposit their personal keys in the medical key box. A review of the key inventory matched the actual keys in use. Damaged keys are turned over to master control and maintenance personnel is notified to have the key replaced. The program also has a list of staff who are assigned permanent keys. Staff authorized to possess permanent keys sign an acknowledgment form indicating a key identification number and the number of keys issued. A random check of three staff indicated none had personal keys on their person. An interview with master control staff indicated if lost keys are not found within two hours, the incident is reported to the Central Communications Center (CCC). Five staff were interviewed, and each indicated they are aware of the key control process including how keys are assigned, the process for missing keys or lost keys, damaged keys, and restricted keys.

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 facility administrator 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 written policy and procedures in place for a system addressing contraband. The policy delineates items and materials identified as contraband. During the orientation process youth are provided a youth handbook containing a list of contraband items and materials. In addition, youth are informed of the consequences if found in the possession of contraband items. A review of supporting documentation found the program maintains a hardbound three-ring binder in monthly chronological order dating back for six months to verify room and area searches were conducted on each shift, coupled with unannounced spontaneous room searches. Shift reports, supervisor checklists, fidelity check forms, common area search forms, perimeter checks forms, coupled with housekeeping documents supported areas of the facility, grounds, and youth rooms were consistently monitored for contraband. Youth are searched prior to and at the end of every activity. Additionally, the program's practice is to search incoming and outgoing mail in the presence of youth. An interview with the facility administrator indicated staff found to be in the possession of contraband are subject to discipline up to and including termination. Illegal contraband found in the possession of youth is turned over to law enforcement for disposal pursuant to the program's updated contraband policy including the contraband guideline.

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 written policy and procedures to ensure searches and full body visual searches are conducted according to Florida Administrative Code (FAC) at the time of admission, after off-campus activities, and visitation. Searches are conducted by two staff of the same gender as the youth being searched and are conducted in a private area. Parents/guardians are notified of searches during visitation by way of the parent intake letter, which is sent at the time of youth admission. Youth are searched after school, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus activities and/or appointments, suspected of contraband, or are a security risk are searched, as validated by a review of program search forms. Observations of searches were conducted after school and during transport. Youth are provided instructions

regarding the search and subsequently searched by a same gender staff, conducted in a manner not to degrade the youth, and based on the Protective Action Response (PAR) training manual. Five staff were interviewed, and each stated youth are searched after every movement and if a youth is suspected in possession of contraband. Five youth were interviewed, and indicated searches occur when returning from off campus, after outdoor recreation, when items are missing, after visitation, after meals, and after work detail.

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

The program has two operable vans to transport youth at the time of the annual compliance review. Both vehicles were observed to be equipped with an up-to-date fire extinguisher, first aid kit, seatbelt cutter, window punch, and operable seatbelts for each passenger. A review of annual vehicle inspections verified completion of the annual safety inspections, and maintenance repair invoices reflected repairs were completed when needed. The rear and side doors of the vans could not be unlocked from the inside. Observations of a youth transport indicated staff and youth were wearing e seatbelts.

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 written policy and procedures to ensure safe secure transportation of youth and staff. The program has two operable vehicles to transport youth. Inspections of each van verified each has an up-to-date fire extinguisher, first aid kit, seatbelt cutter, and window punch. First aid kits remain in the master control area until ready for use. Rear passenger doors are unable to be opened from the inside. The program maintains a list of staff who have eligible driver's licenses, which is updated monthly. The program assigns a ratio of one staff to five youth during transport, not including the driver. Observation of a transport verified the youth was not unsupervised at any time and the appropriate staff-to-youth ratio was within the contractual requirements. Staff are provided a fully charged cellular telephone to communicate during emergency situations when transporting youth. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate staff vehicles. This was validated through staff interviews. Inspection of ten randomly selected personal vehicles in the employee parking lot found all doors were secured. Five staff were interviewed and asked what type of communication device staff are provided with during transport and all responded a program cellular telephone.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures which outlines the safety and security audit/inspection process. The policy and procedures reflected the requirements of Florida Administrative Code (F.A.C.) 63E-7.013. In addition, the policy specifies the maintenance supervisor as the person responsible for completing the facility security audit and safety inspection while documenting the conditions of the facility on the specified safety inspection form. A review of the program's safety inspection logbook for the past six months found the safety inspections were completed consistently once every week. The inspection forms were identifying areas of the facility in need of maintenance with an anticipated date of the completed repair. An example was vehicle number one, had a deficiency identified on July 23, 2018, in need of repair to the rear air conditioning. The following week's safety inspection report dated July 31, 2018 indicated the deficiency was corrected and was no longer listed as a needed repair. Examples of what staff routinely check are video cameras, the digital video recording (DVR), painting project in the dormitory, and emergency lighting. An interview with the facility administrator (FA) indicated the program utilizes an internal quality improvement process, coupled with management and cross departmental staff meetings. When a deficiency is identified, the department head for the applicable area is responsible for follow-up and corrective action as warranted. The department head may place staff on a performance improvement plan pending the corrective action identified the deficiency as related to a staff error. Further follow-up is verified through fidelity checks with each respective department.

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 for tool management. The policy addresses storing and inventory of tools, as well as class type. Maintenance tools are kept in the maintenance shop in an area inaccessible to youth. A tool inventory is kept for each tool. A review of the inventory matched the tools maintained in the secure area without exception. Tools are organized in a locked cabinet with a list of each tool maintained within. All tools are classified as A-list tools by the program and are prohibited for use and/or handling by youth at any time. Observations of the tool storage area found it was clean, neat, with no items missing. A review of staff training records and youth case management records indicated staff and youth are trained in the use of class B tools only. Five youth were interviewed, and all responded they use mops and brooms. Five staff were interviewed, and all responded youth are not permitted to use class A 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 in place for youth tool handling and supervision. A storage closet which includes a broom, mop, mop bucket, plunger, and dust pan is designated for the dorms. Youth are not allowed to handle tools unless a risk assessment is completed to determine if the youth is eligible to handle class B equipment. A minimum of one staff to every

five youth is required during active tool use. A review of five youth case management records indicated a risk assessment is completed prior to a youth handling tools. Youth were not observed using tools, during the annual compliance review week. An interview with the assistant facility administrator (AFA) indicated youth are prohibited from the use of class A tools. Five staff were interviewed and stated youth are allowed to use mops, brooms, and scrub brushes. Five youth were interviewed, and all responded they are permitted to use mops and brooms.

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

The program has a policy and procedures for outside contractors when work projects are needed in the program requiring the use of tools. When a contractor comes on campus, they are provided a visitor's contraband list outlining unauthorized items and contractor guidelines to review and sign. On the reverse side of the form, the contractor must read and sign an acknowledgement of their understanding of the program's Prison Rape Elimination Act (PREA) awareness practice. A review of randomly selected documents, along with the corresponding work invoices, verified the contractors were on-site on the same date the documents were signed. An interview with the maintenance supervisor indicated when contractors are on-site, youth are not allowed in the vicinity of the work area. The program's written policy requires the maintenance supervisor to inventory all the contractor tools and equipment brought into the secured area. While the work is being performed, the maintenance supervisor and/or another staff is assigned to the contractor at all times to ensure the work is being completed and all tools are accounted for. An inventory of the contractor tools brought on-site is conducted at the conclusion of the work performed.

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) states emergency drills will be conducted at random times and under varied conditions. Drills are documented in the program's emergency drill logbook and include the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A random sample of the program's fire and safety drill forms for the past six months were reviewed. Drills were performed on varied shifts and included all staff on duty. The forms also included debriefing documentation and feedback for the drills performed. Observations of the program during the annual compliance review indicated evacuation plans are posted throughout the facility. An interview with the facility administrator (FA), reported mock drills for COOP, fire, medical and mental health are conducted monthly on all three shifts. Five youth were interviewed, and each indicated drills are conducted at least monthly and they have been instructed on what to do in case of an emergency. Five staff were interviewed and stated they have participated in major disturbance, chemical spills, escape, and fire drills within the program.

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

The program has a continuity of operations plan (COOP) which encompasses a coordinated disaster plan. The plan provides for basic care and custody of youth in the event of an emergency or disaster. The plan was forwarded to the Department for approval on May 18, 2018. Review of the plan indicated alternative housing in the event of an emergency or disaster. The updated COOP included fire and prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or attacks, staff roles and responsibilities, equipment and needed supplies, youth information, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. An interview with assistant facility administrator (AFA) indicated a copy of the COOP is located in the medical clinic, master control, AFA's office, and in administration.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The facility administrator 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 written policy and procedures in place relating to the storage and inventory of flammable, poisonous, and toxic items and materials. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. All chemicals were found to be stored in an area inaccessible to youth. The area was behind two locked doors, and a locked chain-linked fence, stored in a locked metal cabinet. The maintenance supervisor and the assistant facility administrator (AFA) have keys to the area where cleaning items are kept. A review of the Safety Data Sheets compared with the number of items and quantity remaining was observed to be accurate.

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

The program has a policy and procedures which prohibits youth from handling any flammable, poisonous and/or toxic items or materials. Youth do not clean, handle, or dispose of any toxic, bio-hazardous, bodily fluids or human waste. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. All chemicals were found to be stored in an area inaccessible to youth. Five youth were interviewed and four of five responded they are permitted to use paint under the direct supervision of staff, while another youth responded she was permitted to use a window cleaner. The area was behind two locked, doors, and a locked chain-linked fence, stored in a locked metal cabinet.

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 for the disposal of toxic and/or hazardous materials. The policy includes the procedures in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 Code of Federal Regulations (CFR) 1910.1030. The program's maintenance supervisor stores all flammable, poisonous, toxic material in a secure area inaccessible to youth. The program did not dispose of any toxic chemicals since the last annual compliance review. According to the maintenance supervisor hazardous materials are not used except for insect/bug spray. However, the chemical is used in its entirety; consequently, disposal is not performed. Martin County Solid Waste Company is used to dispose of any toxic or hazardous items. Food items are not prepared on-site as the local county school system prepares the meals off-site. Therefore, there are no kitchen waste products to dispose. The program's policy does follow the Occupational Safety and Health Administration (OSHA) standards for the disposal of hazardous materials. The Safety Data Sheets (SDS) were maintained to record the type and quality of materials used by the program maintenance supervisor. The maintenance supervisor, who is responsible for the disposal process received training on the how to manage, and who to contact regarding the proper disposal of toxic materials. There were protective masks, gloves, and eye protection wear maintained in the maintenance area. Observation of the dorm area indicated there is a designated storage room for mops, buckets, brooms, and a utility sink and/or floor drain is used to dispose of liquid waste resulting from janitorial work details. An interview with the facility administrator (FA) validated the maintenance supervisor's practice.

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

The program provides a variety of recreation and leisure activities for youth in the program. Activities are planned to expose youth to a variety of recreation and leisure choices and activities. A review of the program's activity schedule and logbooks verified a variety of activities are provided to the youth, including leisure and recreational activities to promote cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Observations of youth during outside recreation verified youth participate in teamwork, healthy competition, and physical fitness. The activity schedule is from 6:00 p.m.to 7:00 p.m. on weekdays and varies on weekends based upon special events held at the program. The program utilizes a watercooler, which is placed outside during recreation, to prevent youth from over-exertion, heat stress, and dehydration. A review of five youth case management records indicated the program incorporates therapeutic activity into the youth's treatment plan based on the development levels and needs of the youth. Five staff were interviewed and indicated the type of recreation and leisure activities are provided to youth are cards, basketball, volleyball, walk, jump rope, x-box, watch television, and board games for at least one hour. Five youth were interviewed and indicated they are allowed to have outdoor recreation to include; soccer, cards, basketball, volleyball, walk, jump rope, monkey in the middle and four corners for at least one hour. For leisure activities, each indicated they are allowed to play board games or watch television. The program has a full-time recreation therapist to coordinate activities. The bachelor's-level recreation therapist holds a degree in recreation therapy from Florida

International University. The provider's contract does not specify a time frame of previous employment of working directly with youth; however, since the recreation therapist could only verify previous employment of eighteen months of working with youth, according to the facility administrator, they were granted an exception to hire the staff into the position by the south regional director of residential services on October 31, 2017, due to difficulty locating a qualified candidate.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures in place for youth to have visitation and communication with family members in order to maintain family and community ties. Youth are informed of visitation during the orientation process. The program encourages visitation from the parents/guardians by sending out a welcome letter upon the youth's admission, informing them of the days and time for visitation, who is allowed to visit, and the corresponding rules of

visitation. A list of authorized visitors and correspondence is placed in the youth's case management records. Youth are provided writing materials and a self-addressed stamped envelope to send letters to family members. Youth are allowed to have unimpeded access with the courts, attorneys, juvenile probation officer, and/or the Department of Children and Families (DCF) case worker, if applicable. A review of five youth case management records indicated each record contained an approved correspondence, visitation and telephone log. Observations of the program indicated the visitation and telephone schedules were visible posted in the youth's living area. Five youth were interviewed, and each stated they are given the opportunity to communicate with family members by mail, telephone, and during visitation.

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 has a written policy and procedures in place to document inspection of the controlled observation room. Searches are conducted and documented on the controlled observation report narrative section. In the past six months' records reflected controlled observation was utilized 100 times. A review of ten controlled observation reports indicated the confinement room and youth were searched prior to placing youth in controlled observation. Further review of the documentation indicated the youth was searched by a same gender staff member.

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

The program has a written policy and procedures addressing the implementation of controlled observation. Each use of controlled observation is authorized by a supervisor to determine if it would further jeopardize the safety and security of the program and if the youth's behavior becomes of an emergency safety situation where there is an immediate risk of the youth physically harming themselves, staff, or others. Staff will discuss with the youth the reason for controlled observation and the expected behavior for removal. There were one hundred controlled observation incidents documented in the controlled observation log within the past six months. A review of the controlled observation reports documented the date and time the youth was placed in confinement and the reason the youth was placed in controlled observation. A health status checklist was completed by a healthcare professional on the same date the youth was placed in confinement. Ten youth records were reviewed. Three youth were released within either two hours or less, while seven youth remained in controlled observation in excess of two hours. Therefore, an extension of placement and approval was authorized as required. Staff maintained the controlled observation report (RS 001) and Controlled Observation Safety Checks (RS 002) were consistently utilized during the youth's observation time frame. The facility administrator (FA) and/or designee may authorize an extension when the release of the youth would threaten their safety or the safety of others.

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.	

The program has a policy and procedures which requires safety checks to be completed on all youth placed in controlled observation. Checks are conducted at a minimum of fifteen-minute intervals. There were 100 reports of youth placed in controlled observation in the past six months. Certain youth had multiple experiences of controlled observation placement covering this time frame. A review of ten controlled observation reports indicated staff observed the youth's behavior and documented safety checks every ten minutes. Each entry indicated the time, code explaining youth's behavior while in controlled observation, and the staff's initials who observed the youth. All reviewed youth reports reflected a health status checklist reflecting a visual check of the youth current status, justification for continuing controlled observations when applicable, medical alert if necessary, medications if pertinent, along with the disposition and facility administrator (FA) and/or designee signature for reintegration. Seven out of ten reviewed reports reflected the youth remained in controlled observation exceeding two hours. All extensions were approved by the facility administrator (FA) and/or designee. No youth were in controlled observation exceeding twenty-four hours

Program Name: Martin Girls Academy
Provider Name: TrueCore Behviroal Solutions, LLC
Location: Martin County / Circuit 19
Review Date(s): August 21-24, 2018

MQI Program Code: 1138
Contract Number: 10139
Number of Beds: 30
Lead Reviewer Code: 159

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.02 Five-Year Rescreening	