STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Melbourne Center for Personal Growth

AMIkids, Incorporated
(Contract Provider)
1000 Inspiration Lane
Melbourne, Florida 32934

Review Date(s): November 17-December 2, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Kamille Payne, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Teresa Andersen, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 5)
Paul Czigan, Office of Accountability and Program Support, Regional Monitor (Standard 3 & Interviews)
Cindy Jones, Office of Education, Deputy Director of Education (Standard 2)
Tamara Mahl-Adkins, Office of Accountability and Program Support, Regional Monitor (Standard 4)
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Gustavo Mazorra, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Amanda Thomas, TrueCore Behavioral, Orange Youth Academy, Clinical Director (Standard 3)
Bonita Williams, Office of Accountability and Program Support, Regional Monitor (Standard 2)

Program Name: Melbourne Center for Personal Growth
Provider Name: AMIkids Inc.
Location: Brevard County / Circuit 18
Review Date(s): November 17-December 2, 2020

MQI Program Code: 1270
Contract Number: R2119
Number of Beds: 32
Lead Reviewer Code: 161

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 Initial Background Screening *	
1.14 Internal Alerts System and Alerts (JJIS)*	
2.04 Classification Factors, Procedures, and Reassessment for Activities	
2.10 Performance Plan Revisions	
2.15 Treatment Team Meetings (Formal and Informal Reviews)	
2.22 Safety Planning Process for Youth	
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	
3.04 Mental Health and Substance Abuse Admission Screening	
4.02 Facility Operating Procedures	
4.16 Medication/Sharps Inventory and Storage Process	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Limited
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Non-Applicable
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	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)*	Limited
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Guardian 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	Limited
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Satisfactory
2.10	Performance Plan Revisions	Limited
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)	Limited
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
2.22	Safety Planning Process for Youth	Limited

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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	Limited
3.04	Mental Health and Substance Abuse Admission Screening	Limited
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Limited
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Limited
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable
4.19	Licensed Medical Staff*	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	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervision of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Satisfactory
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Melbourne Center for Personal Growth is a thirty-two-bed program, for thirteen to eighteen year old males, located in Melbourne, Florida. The program is operated by AMIkids Incorporated through a contract with the Department. The program provides substance abuse treatment overlay services. In addition, the program fosters each youth by providing Seven Challenges, Aggression Replacement Training, and the Council for Boys and Young Men. Additional treatment services provided includes family, individual, and group therapy. Program administration is comprised of an executive director, director of operations, director of case management, director of education, and director of clinical services. Case management services are provided by the director of case management, one case manager, and one transition specialist. Mental health and substance abuse services are contracted through AMIkids Behavioral Health. Mental health and substance abuse staff at the program include the director of clinical services, who serves as the designated mental health clinician authority, and three non-licensed mental health clinicians.

During the annual compliance review period, a new contractor began providing mental health and substance abuse services; therefore, four additional provider licensed clinicians provided services and oversight during the transition. Medical services are offered 7:00 a.m. to 7:00 p.m. Monday through Thursday and from 8:00 a.m. to 6:00 p.m. Saturday and Sunday and are provided by one full-time and one part-time registered nurse and the designated health authority who is a licensed medical doctor. Educational services are provided by teachers employed with the program. The layout of the program includes an administration building, education building, and dormitory building. The program has seventeen operating security cameras providing coverage. At the time of the annual compliance review, the program had no vacant positions. During the annual compliance review, the review team was required to transition off-site on the first day due to the COVID-19 pandemic and completed the rest of the review virtually with the program. Additional review days were necessary due to the transition to ensure the review team and program enough time to review documentation, respond to requests, and conduct required observations virtually.

Standard 1: Management Accountability

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

The program hired thirteen new staff and five new contracted mental health staff during the annual compliance review period. Each of the thirteen staff and five contracted staff had background screenings completed in the Agency for Healthcare Administration's Clearinghouse system prior to the date of hire. There was documentation in each of the thirteen staff and five contracted staff's personnel records indicating the staff's criminal history was reviewed. The thirteen newly hired staff were applicable for a pre-employment assessment tool and each passed the tool, which was maintained in the personnel record, prior to hire. The five contracted staff were all clinical staff; therefore, the five contracted clinical staff were not applicable for a pre-employment assessment tool. Each of the thirteen staff and five contracted staff were added to the program's roster in the Clearinghouse system. One staff was rehired by the program during the annual compliance review period; however, the program did not submit a new background screening in the Clearinghouse system. The program reported the staff had an eligible rating and retained prints in the Clearinghouse system. The annual compliance review team reported this incident to the Central Communications Center (CCC), as required. The center had no new volunteers or interns during the annual compliance review period. The program submitted their Annual Affidavit of Compliance with Level 2 Screening Standards on January 28, 2020, which includes the teachers who are program staff.

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

A review of the program's staff, contractor, and volunteer roster found five program staff were applicable for a five-year background rescreening during the annual compliance review period. Each of the five staff had a completed and eligible background rescreening in the Agency for Healthcare Administration Clearinghouse system within the required timeframe. The program did not have any volunteers on-site during the annual compliance review period due to the COVID-19 pandemic.

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

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

- *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a policy and procedures regarding the provision of an abuse-free environment utilizing trauma responsive principles. The policy requires the youth to be given unimpeded and immediate access to the Florida Abuse Hotline without intimidation or reprisal. A tour of the program found the required postings for the Florida Abuse Hotline and Central Communications Center (CCC) telephone numbers. Staff are to adhere to a code of conduct, which is found in the employee handbook and outlines staff responsibilities for an abuse-free environment. The code of conduct states staff are subject to disciplinary action or termination for a violation of the code of conduct. Eighteen staff records were reviewed for initial background screening or five-year rescreening and each staff record contained a signed code of conduct. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on July 7, 2020. The program did not have any allegations of abuse during the annual compliance review period.

An interview with the executive director confirmed the program's code of conduct and staff consequences for violating the code of conduct. In addition, the executive director reported youth are allowed to call the Florida Abuse Hotline and any incidents are reported to the shift supervisor who will call the CCC if needed and notify program administration. All allegations of abuse and calls to the Florida Abuse Hotline or CCC are tracked and discussed during management meetings. Five youth were interviewed and each youth reported feeling safe at the program and had never been stopped from calling the Florida Abuse Hotline. Four of the five youth stated staff are respectful to youth and never use profanity, threats, or intimidation. One youth reported a staff used profanity toward him and was disrespectful; however, another staff took care of it right away. None of the five youth had ever exchanged personal messages with staff through social media. Five staff were interviewed and each reported the procedures for calling the Florida Abuse Hotline included allowing youth to call whenever they request to do so. Four staff reported they would notify the supervisor, three reported the supervisor would make

the call, three reported the youth would make the call, and one reported they would notify the executive director if a youth wanted to call. None of the five staff had ever witnessed a staff deny a youth a call to the Florida Abuse Hotline. Each of the five staff reported never hearing other staff use threats, profanity, or intimidation; however, one staff clarified they heard a staff use profanity toward a youth once. The staff was dealing with personal issues and the interviewed staff immediately intervened and addressed the situation with the staff.

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

The program had no incidents of physical, psychological, or emotional abuse in the program during the annual compliance review period; therefore, this indicator rates as non-applicable.

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

The program had nine Central Communications Center (CCC) reports during the annual compliance review period, five of which were reviewed. Each of the five reviewed CCC incidents were reported within the required two-hour timeframe. Four of the five were applicable for documentation in the program's logbook, each of which were found, as required. A review of internal incident reports and youth records found no additional incidents which should have been reported to the CCC. The program has had an increase in CCC reports since the last annual compliance review period; however, the increase in reports was due to the COVID-19 pandemic, as the program is required to report all testing of youth and staff. An interview with the executive director confirmed staff are trained in CCC reporting procedures and all incidents are tracked in the logbook and discussed during management meetings.

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 had two Protective Action Responses (PAR) incidents during the annual compliance review period, each of which was reviewed. Both PAR incidents included reports from all involved staff by the end of the staff's workday, were reviewed by all required staff within the appropriate timeframe, and maintained in a central file. A post-PAR interview was conducted with each youth within thirty minutes of the incident. Neither of the incidents resulted in an injury to youth, required the use of mechanical restraints, or necessitated a call to the Florida Abuse Hotline or Central Communications Center (CCC). A review of internal incident reports and youth records indicated no additional PAR incidents which did not have a report. The program's PAR rate during the annual compliance review period was 1.18, which is below

the statewide Residential PAR rate of 2.10. The program had a decrease in PAR incidents since the last annual compliance review period. The program submitted a PAR Plan on January 31, 2020, which was approved by the Department. The executive director reported all PAR incidents are reviewed with the shift involved in the incident and during management meetings. Five staff were interviewed and four staff reported never using PAR at the program; however, each of the staff explained the PAR reporting process and specified they try to process with youth before and after the PAR incident.

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

Five staff were reviewed for pre-service training requirements and each completed more than the required 120 hours of training during their first 180 days of hire. Each staff completed all required training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention, emergency procedures, and child abuse reporting. Four the of the staff completed training in the Prison Rape Elimination Act (PREA). One staff did not complete PREA training; however, the staff completed the training during the annual compliance review. Each of the five staff completed all contract-required trainings. Three of the five staff did not complete training in human trafficking and two of the five staff did not complete training in active shooter; however, these trainings were not required trainings during the initial 180 days of hire. Additional documentation was provided indicating human trafficking and active shooter trainings were completed by each of the staff during the annual compliance review. Four of the five staff had all training documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. One staff did not have first aid and CPR trainings documented in SkillPro; however, the training sign-in sheet and certifications were provided. Certification was provided to demonstrate all CPR, first aid, and PAR instructors were qualified to facilitate training. The program has a pre-service training plan which was submitted to and approved by the Department's Office of Staff Development and Training on January 24, 2020.

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

Five staff were reviewed for in-service training requirements during the 2019 calendar year. Each staff completed more than the required twenty-four hours of training, including training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR). Four of the five staff completed training in professionalism and ethics. Three of the five staff completed training in suicide prevention. One of the remaining two staff completed one of the required four hours of instructor-led training and one staff did not complete suicide prevention training in the Department's Learning Management System (SkillPro). None of the five staff completed human trafficking or active shooter trainings; however, these trainings were not required in 2019. Two of the five staff were applicable for supervisory training and each completed more than the required eight hours of training in the

areas of management, leadership, personal accountability, employee relations, and communication skills. All training was documented in SkillPro within thirty days of training completion. The program has an in-service training plan, which was submitted and approved by the Department's Office of Staff Development and Training on January 24, 2020, and a training calendar which is revised, as needed, to track required training. An interview with the executive director revealed all staff which are counted as direct care staff and require training in PAR and documentation supported each received training, as required.

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

The program has a policy and procedures which outlines the grievance process and required response timeframes. The policy states there is an informal phase where youth attempt to resolve the complaint with staff, a formal phase where a youth completes a grievance form which requires a written response, and an appeal phase where the grievance is reviewed by the executive director. An interview with the executive director confirmed the grievance process. The program had one grievance within the last twelve months which was maintained in the grievance binder. The one grievance addressed behavior management points and was responded to within the required timeframes. Five youth interviews were conducted and each reported youth can ask for assistance in filling out a grievance. Four of the youth reported grievance forms are kept on the wall, two youth specified there are three phases to the grievance process with timeframes for response. Three of the youth reported never having to fill out a grievance. Five staff interviews were conducted and four reported the supervisor reviews grievances, three reported the executive director reviews grievances and the forms are posted on the wall, and two reported youth can ask for assistance in filling out a grievance.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program's contract outlines the required interventions as Impact of Crime (IOC), a promising practice, and Council for Boys and Young Men (Boy's Council), a practice with demonstrated effectiveness. Six clinicians delivered the interventions during the annual compliance review period and reviewed documentation confirmed each clinician had the required credentials outlined in the program contract, as well as completed training in the curriculum. Further, each clinician had the appropriate education and experience to provide the services. An interview with the executive director confirmed education, training, and experience are considered when assigning staff to deliver interventions. A review of the program schedule and group sign-in sheets found the program delivered both outlined interventions, as indicated and according to the group schedule. The program activity schedule outlines structured activities throughout the day, meeting the requirement for planned programming.

Five youth records were reviewed and each had documentation indicating the youth was enrolled in both IOC and Boy's Council. The interventions addressed a priority need included on each youth's performance plan, as indicated by the Residential Assessment for Youth (RAY). Five youth were interviewed and each reported they participated in groups, four specified IOC and three specified Boy's Council. Each of the five youth discussed new skills they had learned as a result of group participation and reported they have the opportunity to practice these skills during group and in planned programming.

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

The program has a policy and procedures requiring all youth to receive life skills training through groups and skills practice in structured programming. The program's contract outlines the program is required to provide life skills to youth. The program utilizes Aggression Replacement Therapy (ART) and Substance Abuse Skills Training (SAST) to provide life skills to youth. An interview with the designated mental health clinician authority (DMHCA) verified the groups offered. The groups address communication, interpersonal relationships and interactions, conflict resolution, anger management, and critical thinking. A review of the group schedule and group sign-in sheets found the program provided groups, as required. In addition, the program provides additional life skills training during planned programming to prepare youth to return to the community, which includes resume writing and mock interviews. Five youth were interviewed and each reported they participated in groups, all five specified ART and three specified SAST. Each of the five youth discussed new skills they had learned as a result of group participation and reported they have the opportunity to practice these skills during group and in planned programming.

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 has a policy and procedures addressing the provision of restorative justice programming. In addition, the program's contract requires Impact of Crime (IOC) groups. A review of the activity schedule and group sign-in sheets found the program provided IOC groups, as required. Due to the COVID-19 pandemic, the program has been unable to take the youth off-site for restorative justice activities or have guest speakers in the program. Documentation was found in the logbook indicating the staff had youth participate in clean-up and maintenance activities around the program as restorative justice activities. The IOC groups and program restorative justice activities are designed to assist youth in accepting responsibility, teach youth about the impact of their crimes, expose youth to victim's perspectives, and provide opportunities for reparation activities. An interview with the executive director confirmed restorative justice is provided through IOC groups, guest speakers, and mentors, when volunteers are allowed in the program. Five pre-service and five in-service training records were reviewed and each documented training in restorative justice was completed. Restorative justice activities were not able to be observed during the annual compliance review. Five youth were interviewed and each reported they participated in groups, four specified IOC. Each of the five

youth discussed new skills they had learned as a result of group participation and reported they have the opportunity to practice these skills during group and in planned programming.

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

A review of the program's contract found the program provides The Council for Boys and Young Men (Boy's Council) as the gender-responsive group. A review of the activity and groups schedules, as well as group sign-in sheets found the program delivered Boy's Council groups, as required, and provided gender-specific programming to youth, which targets the primary target population, throughout the daily activities. An interview with the executive director and designated mental health clinician authority (DMHCA) verified the gender-responsive services offered to the youth in the program. Five youth were interviewed and each reported they participated in groups, three specified Boy's Council.

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

The program has a policy and procedures regarding the internal alert process. The policy states the internal alerts will be kept in a log which must be reviewed by all staff prior to the start of their shift and all alerts entered into the Department's Juvenile Justice Information System (JJIS). Five youth records were reviewed and sixteen alerts were found among the five youth in the internal alert log and in JJIS. Eleven of the sixteen reviewed alerts were entered or updated late in JJIS and one was not entered at all. One alert was entered into JJIS seventy-three days late, three alerts were entered sixty-six days late, two alerts were entered thirty-one days late, two alerts were entered twenty-seven days late, one alert was entered twenty-five days late, one alert was entered seventeen days late, and one alert was entered nine days late. All of the mental health alerts were entered and updated by a licensed clinician. All other alert types were entered and updated by the program nurse. The current JJIS and internal alert log were consistent with the exception of the one medical alert which was found in the internal alert system and not in JJIS. A review of case management, medical, and mental health records found there were no additional alerts which should have been entered. An interview with the executive director verified any staff can place a youth on alert status; however, the nurse is responsible for entering and closing alerts in JJIS. It should be noted this was the program's previous practice. Since the program utilizes a new provider, the process has been updated, as reflected above. The executive director reported all alerts are discussed during the weekly

management meeting. Five staff were interviewed and each staff reported alerts are communicated to them through the alert log and in daily briefing.

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 separate case management, medical, and mental health records. All reviewed records included all required information on the file tabs and maintained in the youth record. The case management records are maintained in a locked file cabinet in the director of case management's office, the medical records are maintained in a locked file cabinet in the nurse's office, and the mental health records are maintained in a locked file cabinet in the designated mental health clinician authority's (DMHCA) office. All of the records and file cabinets containing records were clearly labeled as "Confidential."

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

The program has a policy and procedures outlining the opportunity for youth to provide input in the program. A review of documentation found the program has a student advisory board which meets monthly and has conducted quarterly surveys of youth to solicit input. The student advisory board documentation reflected the youth made recommendations for programming, recreation, and other requests. A supervisor conducts the meetings and confers with the executive director to discuss the youth recommendations. An interview with the executive director confirmed the opportunities for youth to provide input in the program as student council, quarterly surveys, and large group where all youth meet and discuss any issues in the program. Five youth were interviewed and each reported they can provide input through large group, peer representatives on student council, and on a feedback form.

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

The program has a community advisory board which meets quarterly. Due to the COVID-19 pandemic, the meetings were conducted utilizing video conferencing during the annual compliance review period. Reviewed agendas, meeting minutes, and sign-in sheets found the board meeting included all required members, except for a parent/guardian representative; however, the program's parent exit survey offers each parent/guardian the opportunity to receive information regarding participation on the advisory board. The reviewed documentation supported the board's involvement in program planning. An interview with the executive director revealed the board provides fiscal oversight, advocates for youth, and is involved in the hiring of management staff at the program. A board member was unable to be interviewed during the annual compliance review.

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

The program has a policy and procedures which establishes administration must gather data, communicate with staff, and provide a system to minimize turnover. The program administers quarterly surveys to youth, exit surveys to parent/guardians, and quarterly surveys to staff to solicit feedback on the programming. The results of these surveys and the outcomes of Department reports, including the Comprehensive Accountability Report (CAR), Trauma Responsive and Caring Environment (TRACE) and Monitoring and Quality Improvement annual compliance reports are shared during staff meetings and the results are incorporated into program planning. A review of meeting agendas, minutes, and sign-in sheets verified the program's practice. The reviewed documentation supported All-Staff meetings were held monthly and supervisor meetings were held weekly.

Five staff were interviewed, four reported meetings are held monthly and one reported meetings are held bi-monthly. The staff reported meeting topics include youth information, changes to the program, Department changes, and training. Three staff reported management communicates the results of reports, and two staff stated management does not share information. Four staff reported communication in the program is very good and one staff reported communication is fair. All five staff believed they could provide feedback and input in the program. An interview with the executive director confirmed the youth and parent/guardian surveys and Department reports are discussed during manager and staff meetings to identify areas of improvement. The interview with the executive director revealed the program employs efforts to minimize turnover and address staff morale issues, such as performance pay, celebrating birthdays, gifts, and utilizing quarterly staff surveys to solicit input to improve the work environment. Documentation of efforts to increase staff morale was observed through postings hung at the program and meeting minutes. The executive director expressed low pay for direct care staff is a struggle for the program.

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

The program has a policy and procedures requiring staff be evaluated on their performance at least annually. Five pre-service and five in-service staff records were reviewed for evaluations. Eight of the ten records included an annual performance evaluation, the remaining two records did not contain an evaluation; however, the staff had not been with the program long enough for an evaluation. The staff records included a position description which clearly identified their job duties. The staff were each reviewed utilizing a tool which evaluated them based on the outlined job duties in their respective position descriptions. The program maintained all staff required by the contract with the Department.

Five staff interviews were conducted, two staff reported evaluations are conducted yearly, one reported they are conducted every six months, one just started at the program and had not received an evaluation, and one reported they had received one evaluation so far and was unsure how often they occurred. The executive director reported performance evaluations occur annually.

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

The program has a policy and procedures necessitating at least one hour of large muscle activity be provided to the youth each day through a variety of activities based on the youth's needs. During the annual compliance review period, the program utilized a recreation therapist who met all requirements of the program's contract; however, the position is no longer requirement based on a contract amendment executed September 9, 2020. A review of the activity schedule found youth were afforded at least one hour of recreation each day, as well as an additional hour of structured leisure time. A review of the recreation schedule depicted a variety of activities each day of the week and was found posted in the dormitory. A review of the logbook and observations during the annual compliance review confirmed recreation was conducted, as scheduled. The logbook documented conditions were reviewed to determine if recreation would be held indoors or outdoors and observations confirmed water was available during outside recreation. The recreation and leisure activities afford youth the opportunity to explore interests, promote social and cognitive development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program utilizes youth surveys, large group, and the student advisory board to elicit input from youth in program planning, which was documented to often include recommendations regarding recreational offerings. Five youth were interviewed and each reported they receive at least one hour of recreation a day which includes basketball, football, stretching, weights, games, and card games. Five staff were interviewed and each reported youth receive two hours of recreation each day, all of which is structured, and includes basketball, football, exercise, soccer, games, and cards.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures addressing the process for notifying the youth's parent/guardian upon admission into the program. Each of the five reviewed youth records included documentation indicating the program notified the youth's parent/guardian within twenty-four hours of admission. Reviewed documentation reflected written notification was mailed to each youth's parent/guardian, juvenile probation officer, and committing court within twenty-four hours of admission.

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

The program has a policy and procedures reflecting the orientation process for youth entering the program. A review of five youth records found each record included documentation indicating youth completed the orientation process, which included all required elements, upon admission. All records contained a signed acknowledgement form by the youth indicating the orientation process documenting the required topics were discussed during orientation. Five youth were interviewed and each of the five youth reported orientation included information about the program.

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

The program has a policy and procedures regarding the written consent process for youth eighteen years of age or older. One of the five reviewed records was applicable for youth eighteen years of age or older; therefore, two additional applicable records were reviewed. Each of the three applicable youth records included signed consent forms for youth eighteen years of age or older, as required.

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

The program has a policy and procedures addressing the classification factors, procedures, and reassessment for activities process. Each of the five reviewed youth records included the classification form which documented the youth's assignment to clinical and case management staff and a living area. The classification forms included all required elements with few exceptions. The forms did not document the youth's age, perception of vulnerability, and history of potential or verified human trafficking. The program provided an updated form during the annual compliance review which included all required elements and will be used for incoming youth.

All five reviewed records contained reassessments completed by the program during treatment team meetings. Reassessments were completed prior to increasing the youth's privileges or freedom of movement and prior to participation in work projects or other activities involving tools. Each reassessments included all required elements. The program has a process in place to track youth alerts and inform staff of alert information, which includes alerts regarding mental health, medical, safety and security, and classification. An interview with the executive director confirmed the classification process is used to determine the youth's assigned dormitory.

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

The program has a policy and procedures addressing notification of law enforcement when a youth identified with gang affiliation enters the program. One of the five youth records reviewed was applicable for gang affiliation. There were no other applicable records during the annual compliance review. The one applicable youth record documented the youth was identified as a gang associate prior to the youth's admission to the program and the juvenile probation officer (JPO) entered the applicable alert into the Department's Juvenile Justice Information System (JJIS). The youth's record included documentation indicating local law enforcement, as well as law enforcement in the youth's home county, the youth's JPO, and local school district were notified of the youth's admission to the program.

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 policy and procedures addressing the provision of prevention and intervention activities for youth identified as a gang member/associate. A review of group sign-in sheets found the program facilitated Impact of Crime (IOC) groups for youth during the annual compliance review period. In addition, the program uses ARISE curriculum, which includes gang-related topics. The program previously utilized the Brevard County Sheriff's Office (BCSO) to provide guest speakers to youth quarterly; however, due to the COVID-19 pandemic, BCSO has not been on-site. One of the five youth records reviewed was applicable for gang affiliation. There were no other applicable records during the annual compliance review. Reviewed documentation in the applicable youth record confirmed the youth's participation in IOC and completed assignments from the ARISE curriculum. The youth's performance plan included a goal addressing gang involvement. During an interview, the executive director confirmed the program uses IOC and the ARISE curriculum to address gang involvement.

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

The program has a policy and procedures requiring each youth entering the program to receive an initial Residential Assessment for Youth (RAY) and RAY Re-Assessments every ninety days thereafter. Each of the five reviewed youth records included a completed RAY, which was maintained in the Department's Juvenile Justice Information System (JJIS). The RAY assessments were completed within thirty days of each youth's admission. None of the youth records reviewed were applicable for a RAY Re-assessment; however, the program provided the one additional applicable record from the annual compliance review period for review. The applicable record contained a RAY Re-assessment which was completed within ninety days of the initial assessment. The re-assessment was maintained in the youth's record and in JJIS.

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

The program has a policy and procedures requiring the administration of the Youth Needs Assessment Summary (YNAS) for each youth within thirty days of admission and prior to the completion of the individual performance plan. Each of the five reviewed youth records included a completed YNAS. Each YNAS was completed prior to the individual performance plan and within thirty days of admission.

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 letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.*	

The program has a policy and procedures regarding the development of an individual performance plan and transmittal of the plan to required parties for each youth in the program. Each of the five reviewed youth records included a performance plan which was completed within thirty days of the youth's admission and after completion of the initial assessment. Each of the performance plans documented signatures from the youth, representatives from administration and living unit, treatment staff, educational staff, and all other parties with significant goal completion. Four of the five plans included signatures by the treatment team leader; the remaining plan did not. All five records documented a copy of the plan was sent to the youth's parent/guardian for review and signature; however, none of the signature pages were returned to the program. None of the youth were under the supervision of the Department of Children and Families.

Each of the performance plans included goals based on the youth's individualized needs, top three criminogenic needs, delinquency interventions, transition activities, youth and staff responsibilities for goal completion, and target completion dates. The program is no longer required to have a recreation therapist; however, each performance plan included recreation goals/objectives. None of the youth were applicable for court-ordered sanctions. Documentation in each of the five reviewed records indicated the program mailed copies of the performance plan to the youth's committing court and assigned juvenile probation officer within ten days, as required. Five youth were interviewed and each of the five youth reported participating in the development of their performance plan, knew their performance plan goals, and received a copy of their performance plan.

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

The program has a policy and procedures regarding performance plan revisions for youth while in the program. Four of the five reviewed youth records contained performance plans which were applicable for revisions based on progress and completion dates of goals; the remaining youth did not require revisions. A review of the four applicable revised performance plans found each plan was the same as the initial performance plan, with no changes made to document the youth's progress or lack of progress toward goal completion. A review of treatment team meeting notes documented discussions of progress or lack of progress occurred; however, the revised performance plans did not reflect the updates.

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

The program has a policy and procedures regarding performance summaries and transmittals for youth in the program. None of the five reviewed youth records were applicable for performance summaries and transmittals; therefore, six additional applicable youth records (three open and three closed records) were reviewed. Each of the three open youth records and three closed youth records documented performance summaries were completed every ninety days. Each of the performance summaries documented the youth's status, overall treatment progress, academic status, behavior, level of motivation/readiness of change, behavior adjustment to the program, and significant positive and negative events. Five of the six performance summaries included interaction with peers and staff; however, the one remaining performance plan did not include interaction with peers and staff. Reviewed documentation confirmed each of the youth received a copy of the performance summary, with the original maintained in the youth record. Three of the six youth performance summaries had documentation to confirm the youth was allowed to read and add comments prior to signing. Each of the performance summaries reviewed had signatures and dates from all required parties involved in the youth's treatment while in the program. Reviewed documentation reflected the program mailed a copy of the performance summary within ten working days to the youth's committing court, juvenile probation officer (JPO), and parent/guardian within ten business days, as required. The program did not have any youth in the custody of the Department of Children and Families during the annual compliance review period. None of the youth were applicable for the Sexually Violent Predator Program (SVPP).

The three closed youth records were applicable for a release/discharge summary; the three open youth records were not applicable. Each of the three closed records included a release/discharge summary completed prior to the youth's release. Each of the release/discharge summaries included the youth's status, overall treatment progress, academic status, behavior, level of motivation/readiness of change, behavior adjustment to the program, interaction with peers/staff, and significant positive and negative events. Each of the original signed release/discharge summaries were sent with a Pre-Release Notification to the JPO by e-mail at least forty-five days prior to the youth's tentative release date. In addition, documentation reflected the program provided each JPO with the youth's performance summaries, transition plan, and psychological/psychiatric reports. Victim notification was not required for any of the three reviewed youth closed records. The court did not object to any of the youth's tentative release dates. The program mailed a written notification to the youth's parent/guardian and a Residential Assessment for Youth exit assessment was completed upon approval. Five youth were interviewed and four reported they received a copy of the performance plan; one reported not receiving a copy.

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

The program has a policy and procedures for encouraging parent/guardian involvement in case management services while youth are in the program. Each of the five reviewed youth records documented the program's attempted telephone contacts and sent written invitations to the parent/guardian, encouraging their participation during meetings. Each of the five reviewed youth records included documentation of parent/guardian involvement in the assessment process, development of performance plans, progress reviews, and formal/informal treatment team meetings. Three reviewed closed youth records included documentation reflecting parent/guardian involvement in transition planning. The program notified the parent/guardian of meetings through telephone contacts, letters, and face-to-face contacts. A treatment team meeting was unable to be observed during the annual compliance review. The executive director reported the program uses telephone contact, the availability of skype/video conferencing, family visits, and mail to communicate with the family and encourage involvement. Five youth were interviewed and two reported their parent/guardian is actively involved in their case management activities; the remaining three youth reported staff try to engage their parents/guardians; however, the parents/guardians are not involved.

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 identifying treatment team members. A review of five youth records for treatment team meetings documented the meetings were attended by the treatment team leader, youth, administrative representative, treatment staff, education staff, juvenile probation officer, and parent/guardian; however one meeting was missing the signature of the treatment team leader and one meeting was missing the signature of the administrative representative. When applicable the transition manager, and gang prevention specialist attended treatment team meetings. There was documentation indicating direct care-staff attended treatment team in five of the twelve reviewed formal treatment team meetings, which require a direct care representative. The meetings were attended by the case manager, therapist, psychiatrist, and nurse. None of the youth were applicable for inclusion of a human trafficking specific service provider.

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 policy and procedures regarding the incorporation of other plans into each youth's performance plan. During the annual compliance review period, the program has not had any youth in the custody of the Department of Children and Families. Each of the five reviewed performance plans included academic and treatment plan references, as required.

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

The program has a policy and procedures outlining the process of formal and informal treatment team meetings. Each of the five reviewed youth records indicated the youth had formal treatment team meeting at least every thirty days, for a total of twelve formal treatment team meetings among the five youth. Each of the formal reviews documented the youth's name, date of review, comments from treatment team members, youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, and youth demonstrating skills acquired in the program and treatment progress. None of the youth reviewed were applicable for Residential Assessment for Youth Re-assessment. Five of the twelve formal treatment team meetings did not include a signature from a direct-care staff . One treatment team meeting documented only the youth and administration signatures. The remaining formal treatment team meetings had all required signatures. The information documented on the treatment team forms remained the same for each of the meetings, except in the area of education; the information was not individualized for each youth. Sections of the forms were not completed correctly in their entirety.

Each of the five youth records indicated informal treatment team meetings were conducted bi-weekly and included all required elements. A comparison of the Department's Juvenile Justice Information System (JJIS) and treatment team meeting documentation confirmed the anticipated release dates for each youth matched. A treatment team meeting was unable to be observed during the annual compliance review. Each of the five interviewed youth stated staff review their performance plan goals, behavior, and progress. Each youth confirmed they are given the opportunity to demonstrate skills learned during treatment team meetings.

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

The program has a policy and procedures in place regarding career education. The program provides Type 2 career education programming and vocational certificates are offered to all youth. The youth investigate individual career choices based upon their personal abilities and interests through My Career Shines. During participation in My Career Shines, youth learn to create resumes and complete job applications. The certification programs offered at the program include Safe Staff Food Handling Certification, Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Certification, National Center for Construction Education and Research (NCCER) Core, and cardiopulmonary resuscitation (CPR) and first aid certifications. The certification information was provided by the lead educator and was verified through an interview with the executive director. Three closed youth case management records were reviewed and all three records contained a resume, multiple completed job applications, and documentation indicating the youth researched their local Career Source Center's address and hours of operation. Two of the youth had State of Florida identification cards, while the remaining record contained documentation indicating their birth certificate was not available; and a request was made for the certificate to be applied for. An interview with the lead educator confirmed the career education opportunities for youth in the program.

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

The program has a policy and procedures regarding educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of the required instruction is distributed over 250 days. The district-approved calendar and the daily school schedule were reviewed and found to have incorporated 250 days of instruction, to include six fifty-minute class periods a day, providing for the minimum of twenty-five hours of instruction a week. In addition to the daily class schedule, the program offers a forty-five minute "Critical Thinking" time which provides tutoring and time for any make-up assignments. All youth are enrolled in an academic schedule and receive credit, as appropriate. An interview with the lead educator indicated the school schedule is adhered to with no deviations. A review of nine school days in the program logbook verified the youth attended school according to the daily schedule. Video of education was unable to be viewed due to the COVID-19 pandemic; however, the youth were observed during the annual compliance review to be engaged in school, as designated on the daily schedule. Three of the five interviewed youth indicated there were no interruptions during the school day, while two indicated there were. One youth further explained this was due to the youth working in the kitchen and arriving late to class and the other youth did not provide an explanation.

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

The program has a policy and procedures requiring an educational transition plan to be collaboratively developed upon the youth's admission into the program. Three closed youth case management records were reviewed and confirmed the program's instructional staff and the youth completed an education transition plan, upon admission, which included services and interventions based on each youth's assessed educational needs, post-release education plans, recommended post-release placement, and specific monitoring responsibilities for individuals responsible for the reintegration and coordination of the provision of support services. The development of the plan, and subsequent plans, such as the Electronic Educational Exit Plan (EEEP), included key members including the youth, parent/guardian, education representative, post-release staff, and school district personnel responsible for providing guidance services. One youth earned a General Equivalency Diploma (GED) upon entry into the program; however, an education transition plan and EEEP were still developed. During the youth's commitment, the youth enrolled in and completed the Certified Production Manager course, provided through Eastern Florida State College. Five youth were interviewed and three indicated the program was preparing them for continuing education or employment very well and the other two responded they were well prepared.

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

The program has a policy and procedures outlining the process for transition planning and Community Re-Entry Team (CRT) meetings. Three closed youth records were reviewed for transition planning, conferences, and CRT meetings. Each of the three youth records had documentation reflecting the transition conference was held at least sixty days prior to the youth's tentative release date. The youth's juvenile probation officer (JPO), parent/guardian, education staff, and other pertinent parties were invited in advance by mail, telephone, and e-mail. Documentation for each of the three transition conferences indicated the youth, treatment team leader, and other members were in attendance, as required. Documentation for two of the three conferences reflected participation by the executive director; the remaining conference did not. The treatment team leader obtained signatures of all attendees for each meeting. A copy of the meeting notes were mailed to the youth's parents/guardians and JPOs to review and sign; however, none of the parent/guardians or JPOs returned the form with signatures. During the transition conference, the attendees reviewed transition activities and revised the youth's performance plan, target completion dates, and persons responsible for completion. The program has not had any youth in the custody of the Department of Children and Families during the annual compliance review period.

Each of the three youth records included documentation indicating a CRT meeting was conducted prior to the youth's tentative release date. Documentation from each meeting included an email invitation to the scheduled meeting and verified the youth and case manager participated in the meeting, as required.

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

The program has a policy and procedures regarding the completion of an exit portfolio prior to each youth's release/discharge from the program. Each of the three reviewed closed youth records included documentation indicating the exit portfolio was initiated during the transition conference. Two of the three reviewed exit portfolios included all required documents. The remaining exit portfolio documented the youth was unable to obtain a state identification card or birth certificate. The documents were requested; however, the program was unable to obtain the documents for the youth due to youth not being able to go off-site and outside providers being

unable to come on-site, as a response to the COVID-19 pandemic. Documentation confirmed each exit portfolio was verified during the youth's exit conference. Upon release/discharge, the youth was provided the completed exit portfolio and the juvenile probation officer was provided a copy.

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 which outlines the process for conducting an exit conference for each youth in the program. Three closed records were reviewed and documented each youth's exit conference was conducted after the juvenile probation officer was notified of the youth's tentative release date. The program conducted each exit conference at least fourteen days prior to the youth's release. Reviewed documentation confirmed the exit conferences were held separate from the Community Re-Entry Team meetings. The status of each youth's transition activities was discussed and finalized during the exit conference. The exit conference forms included all required signatures, confirming participation in the exit conference for all reviewed youth records. A review of the Department's Juvenile Justice Information System and youth records found the admission date and release date matched for each of the three reviewed youth.

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

The program has a policy and procedures outlining the process for safety planning for youth while in the program. Each of the five reviewed youth records included a safety plan. The safety plans for each of the five youth included warning signs, baseline behaviors, crisis recognition, coping strategies, intervention, and debriefing preferences. The initial safety plans were completed within fourteen days of each youth's admission. The safety planning forms for each of the five youth documented the youth, program staff, and parent/guardian assisted to develop the plans. Each reviewed safety plan clearly documented recommendations from previous assessments and evaluations.

A total of eleven safety plans were reviewed among the five youth. Five of the eleven reviewed plans were the initial safety plans and remaining six were updated safety plans. Three of the six updated plans were completed late. Two plans were completed seventeen days late and one was completed twenty-nine days late. The safety plans are kept in the conference room where all staff have access to review.

During an interview, the executive director stated the safety plans are reviewed monthly and updated as needed. Five staff were interviewed and three reported the safety plans are located in administration in a binder. The remaining two staff did not know where the safety plans were located. Three of the five staff reported not knowing the formal process of reviewing the safety plans; however, one of the three stated plans are reviewed every time a new youth is admitted. One of the five staff reported the plans are reviewed twice a week, and one stated the youth meets with the case manager. In regard to reviewing the plans, two staff reported not recalling the last time they reviewed the plans, one reported not having seen the safety plans, one

reported reviewing the safety plans a month ago, and one reported reviewing the safety plans when they got to the program for their shift. Five youth were interviewed and four stated they participated in the development of their safety plans, one reported not knowing what a safety plan was.

Standard 3: Mental Health and Substance Abuse Services

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

The program subcontracts mental health and substance abuse treatment services, including provision of psychiatric services, with AMIkids Behavioral Health Incorporated. The contract indicates the program's licensed mental health clinician (LMHC) is to serve as the designated mental health clinician authority (DMHCA) in the position of the clinical director. The clinical director's license is clear and active in the State of Florida and expires March 31, 2021. The program has a back-up DMHCA who holds a clear and active license in the State of Florida as an LMHC, which expires March 31, 2021. The position description of the clinical director/DMHCA states they are a full-time staff who is to be on-site at least forty hours a week and responsible for the coordination and implementation of the mental health and substance abuse services in the program. The primary responsibilities include oversight, operation, and supervision of mental health and substance abuse assessment, treatment planning, and service delivery. Additionally, the DMHCA is responsible for oversight of case management services within the program.

An interview with the DMHCA revealed they are on-site daily, Monday through Friday and performs weekend rotations. The DMHCA described they directly coordinate the implementation of treatment services provided by the treatment department's clinicians. The DMHCA develops the treatment group schedule, while assisting the clinicians in developing schedules for individual and family services related to mental health and substance abuse treatment. The DMHCA coordinates with the corporate director of treatment services regarding necessary trainings to facilitate specified treatment interventions. The DMHCA provides direct services including clinical supervision to non-licensed clinicians, support sessions, when necessary, completion and oversight of suicide risk assessments, creation and oversight of initial and individualized treatment plans, group facilitation, and family and individual counseling. Reviewed documentation confirmed the DMHCA schedule requires them to be on-site for a minimum of five days a week, for forty hours a week, and on-call twenty-four hours a day, seven days a week.

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

The program subcontracts mental health and substance abuse treatment services with AMIkids Behavioral Health Incorporated. The program maintains all clinical positions required by the contract with the Department. The contract provides for the designated mental health clinician authority (DMHCA) and back-up DMHCA, as well as clinical services from other clinicians employed with the provider on an as-needed basis. During the annual compliance review period, two additional licensed mental health staff provided services to youth. Both of the clinicians were found to have clear and active licenses in the State of Florida with expiration dates of March 31, 2020, one as a licensed mental health counselor (LMHC) and one as a licensed clinical social worker (LCSW). All clinicians provided services they were qualified to provide. The program has a Chapter 397 license to provide substance abuse services, which expires May 6, 2021.

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

The program subcontracts mental health and substance abuse treatment services with AMIkids Behavioral Health Incorporated. The program maintains all clinical positions required by the contract with the Department. A review of the contract and an interview with the designated mental health clinician authority (DMHCA) found the program schedules staff on-site seven days a week. The DMHCA ensures non-licensed clinical staff provide services they are qualified to provide. Three non-licensed clinicians provided clinical services during the annual compliance review period. Each of the three clinicians were master's-level therapists with the required education, training, and experience. A review of supervision documentation found one non-licensed clinician did not receive on-site supervision by a licensed clinician for six weeks in which they provided services. Another non-licensed clinician did not receive on-site supervision for four weeks they provided services. All other supervision was conducted, as required, and documented on a form which contained all required elements. One non-licensed clinician administered an Assessment of Suicide Risk (ASR) during the annual compliance review period. A review of the one applicable non-licensed clinician's record determined the clinician completed all required training to complete an ASR. The program has a Chapter 397 license to provide substance abuse services, which expires May 6, 2021.

3.04 Mental Health and Substance Abuse Admission Screening	Limited Compliance
The mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

The program has a policy and procedures addressing the mental health and substance abuse admission screening process, staff training in screening assessments, and process for identified youth in need of further evaluation. Procedures require each youth to receive a Massachusetts Youth Screening Inventory, Second Edition (MAYSI-2) screening and Assessment of Suicide Risk (ASR) on the day of admission and are then referred for a new comprehensive mental health and substance abuse assessment regardless of the results of the MAYSI-2. An interview with the executive director confirmed the use of the MAYSI-2 for screening youth upon admission. Program procedures include the program's intake screening for suicide risk form is utilized to determine potential risk, document a review of the Department's Juvenile Justice Information System (JJIS) alerts, related previous precautionary observations, previous mental health diagnosis, and psychotropic medication prescriptions, if applicable. A review of five youth records revealed each record contained a MAYSI-2 screening completed on the day of admission by staff trained in the administration of the instrument. None of the youth had hits on the MAYSI-2 for suicide risk; however, each of the five youth received a referral for an ASR and comprehensive assessment and were placed on precautionary observation. Each referral documented the referral reason as history of substance of abuse regardless of additional information obtained from the mental health and substance abuse screening process. Each ASR was completed on the same day by a qualified clinician and youth were stepped down to standard supervision. The program documented the results of the screening and the referral in an e-mail to notify the clinical director and executive director. A review of the program's intake screening for suicide risk form revealed there were places on the form to document a review of previous screening instruments, JJIS alerts, and other documentation; however, three of the five youth records showed no indication documentation was reviewed and the other two included a review of JJIS alerts and the Department's commitment packet.

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

The program has a policy and procedures which indicate each youth's needs shall be identified through a combined mental health and substance abuse comprehensive evaluation. Five youth records were reviewed and each youth was referred for a comprehensive mental health and substance abuse evaluation. All five reviewed records found the referral indicated the reason for the evaluation as substance abuse history; however, three of the records indicated the youth had hits on MAYSI-2 assessment which were not included on the referral or evaluation. Each record included a new mental health and substance abuse comprehensive evaluation which documented all required elements and was completed within the required timeframe. The evaluations were each completed by non-licensed staff and reviewed by a licensed clinician within the required timeframe.

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.*	

Five youth records were reviewed and each indicated the youth were assigned to a treatment team upon arrival to the program, which included all required members as documented on the initial treatment plan for each youth. A review of individual treatment plans and weekly progress notes reflected each of the five youth received individual therapy, psychosocial skills training, and group therapy, as prescribed in the individual treatment plans, which included the frequency of all prescribed interventions. Four of the five youth received family therapy, as outlined; however, the remaining youth's record included documentation regarding barriers to completing family therapy. All services were provided by a licensed clinician or non-licensed clinician under the supervision of a licensed clinician, each of which possessed the required education, training, and experience to provide services. Each of the five youth records included a valid Authority for Evaluation and Treatment and Substance Abuse Consent and Release forms. Treatment notes were documented on a form which included all required elements.

Weekly progress treatment notes and group sign-in sheets found all groups were administered, as outlined, with less than ten youth in mental health groups and fifteen youth in substance abuse groups. Groups were provided by clinicians qualified to facilitate the curriculum. Groups were unable to be verified by video during the annual compliance review; however, observations utilizing video conferencing confirmed groups were conducted, as outlined on the activity and group schedule. An interview with the designated mental health clinician authority verified the treatment services provided to youth. Five youth were interviewed and each reported they receive individual and family therapy.

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.*	

Five youth records were reviewed and each included an initial comprehensive mental health and substance abuse treatment plan developed on each youth's day of admission utilizing a form with all required elements. Each plan was completed and signed by a non-licensed clinician. All plans were reviewed and approved by a licensed clinician within ten days, as required. Three of the five initial plans were signed by all required treatment team members; two plans were missing signatures from the living unit representative. Two of the five youth were

applicable for inclusion of psychiatric needs on their initial treatment plans which was found as required.

Each of the five records documented the youth's individual treatment plan was created within thirty days of admission utilizing a form which included all required elements. Each plan was completed and signed by non-licensed clinician and reviewed and approved by a licensed clinician within ten days, as required. Each of the five individual plans were signed by all required treatment team members. Two of the five youth were applicable for the inclusion of psychiatric needs on the individualized treatment plans, which was found as required. Each of the five youth records included treatment plan reviews every thirty days, as required, and were documented on a form which included all required elements. A review of individual treatment plans and weekly progress notes reflected each of the five youth received individual therapy, psychosocial skills training, and group therapy as prescribed in their individual treatment plans, which included the frequency of all prescribed interventions. Each of the youth was prescribed daily group interventions to include psychosocial skills and monthly family therapy, two youth were prescribed monthly individual therapy, three youth were prescribed biweekly individual therapy, and two youth were prescribed psychiatric monitoring monthly. Four of the five youth received family therapy as outlined; however, the remaining youth's record included documentation regarding barriers to completing the family therapy.

Three closed youth records were reviewed for mental health and substance abuse discharge plans. Each discharge plan was documented on a form which included all required elements, including services needed for daily maintenance of positive behavior. There was documentation the plan was discussed with each youth and their parent/guardian and a copy of the plan provided. None of the youth were applicable for being a suicide risk at discharge.

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

The program is contracted to provide substance abuse treatment overlay services (SAOS) which was confirmed through an interview with the executive director. The program has a Chapter 397 license to provide substance abuse services. The program schedules mental health/substance abuse staff to be on-site seven days a week. Clinicians have caseload which does not exceed sixteen youth. Documentation supported the program provides individual and family therapy, as prescribed, group therapy seven days a week, daily therapeutic activities, and random urinalysis. Sign-in sheets confirmed substance abuse groups were conducted, as prescribed, with less than fifteen youth in each group. Youth with co-occurring disorders are provided mental health therapy, as prescribed. Documentation of provided services found the program's psychiatrist met with youth bi-weekly through tele-health in accordance with alternative measures approved by the Department due to the COVID-19 pandemic. The psychiatrist is a medical doctor who is board eligible, licensed under Chapter 458 Florida Statutes with an expiration date of January 31, 2022, who provides psychiatric evaluations, prescribes medication, participates in treatment planning, and conducts medication monitoring.

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

The program has a policy and procedures in place which address the provision of psychiatric services. The program has a subcontract with AMIkids Behavioral Health Incorporated which covers the provision of all mental health and substance abuse services including psychiatric services. The subcontract includes the psychiatrist will provide psychiatric evaluations, medication management, and be available for consultation twenty-four hours a day, seven days a week. A review of documentation revealed the psychiatric services are provided by a medical doctor who is board eligible licensed under Chapter 458 Florida Statutes with an expiration date of January 31, 2022. The back-up psychiatrist is a medical doctor who is board eligible licensed under Chapter 458 Florida Statutes with an expiration date of January 31, 2022. A review of documentation revealed all psychiatric services were provided by tele-health in accordance with alternative measures approved by the Department. A review of documentation from provided services confirmed the psychiatrist provided services bi-weekly throughout the annual compliance review period.

Two of the five reviewed youth records were applicable for psychiatric services; therefore, one additional applicable record was reviewed. All three applicable youth entered the program on psychotropic medications, received a referral for services, and were evaluated by the psychiatrist within the required timeframe. Each initial psychiatric interview was documented on a form which included all requirements of the Clinical Psychotropic Progress Note (CPPN) and included page three for prescribed medication. Two of the three youth received medication monitoring every thirty days, as required. The remaining youth record was missing complete documentation of one month of medication monitoring. The missing month included a page three of the CPPN with the psychiatrist's signature; however, the rest of the psychiatric notes accompanying a monthly medication monitoring could not be found. Each youth's medication monitoring included all required information for prescribed psychotropic medications. Each record contained documentation indicating telephone contact was made with each youth's parent/guardian to obtain consent for a change in the youth's medication. None of the youth were applicable for Tardive Dyskinesia monitoring.

An interview with the psychiatrist revealed they provide initial psychiatric evaluations to youth referred for evaluation or to youth who are admitted on psychotropic medications including monthly medication monitoring. The psychiatrist provides follow-up evaluations to youth on psychotropic evaluations or as-needed to all youth. In conjunction with each youth's treatment team, the psychiatrist discusses youth who may benefit from an evaluation. The psychiatrist indicated the procedures for reviewing important medical issues pertaining to youth receiving psychiatric services. The psychiatrist confirmed they are available for consultation by telephonic communication with representatives from the treatment team as needed twenty-four hours a day, seven days a week.

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

The program has a suicide prevention plan which includes all required elements. The plan is reviewed annually and was last reviewed by the executive director on April 1, 2020 and the designated mental health clinician authority (DMHCA) on November 9, 2020. The back-up DMHCA, who provided services prior to the DMHCA's hire, reviewed the plan on April 1, 2020.

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 process to ensure youth at risk of suicide are placed on precautionary observation and maintained until the youth are safely able to step down to standard supervision. The procedures include a process for notifying the youth's parent/guardian and juvenile probation officer (JPO). In addition, the policy establishes a review process which includes all required elements. Five youth records were reviewed and documented each youth was placed on precautionary observation (PO) upon admission to the program. Each youth was immediately placed on constant supervision and a referral was made for an Assessment of Suicide Risk (ASR). Each youth's PO was authorized and mental health staff provided supportive services to youth. Each of the five youth received an ASR, documented on the Department's form, within the required timeframe by a licensed clinician or a qualified non-licensed clinician and reviewed and approved by a licensed clinician within twenty-four-hours. Each ASR documented the program informed the youth's parent/guardian and JPO.

An alert was found in the Department's Juvenile Justice Information System (JJIS) for four of the five youth, as required. One youth's alert was closed nine days late. Each of the youth was stepped to standard supervision following a conference with the designated mental health clinician authority (DMHCA) and executive director, which was documented on the ASR. None of the youth were applicable for continued PO or a follow-up ASR. None of the youth were in crisis at the time the ASR was conducted and none of the ASRs took place outside of the program. All youth maintained on PO were able to participate in activities in safe housing areas, which were clearly identified on the PO logs and the youth were not restricted. One non-licensed clinical staff conducted ASRs during the annual compliance review period. A review of the applicable non-licensed staff's record confirmed completion of the required training and five co-assessments as required. A review of the logbook found clear documentation reflecting the youth were placed on and removed from PO, as well as instructions to the staff regarding the youth's PO, if needed. An interview with executive director found all youth on PO are documented in the logbook and staff are required to review the logbook prior to any shift. The

supervisor communicates any youth on PO to the incoming supervisor at the end of their shift. The program does not utilize secure observation.

The program has three suicide response kits. Two kits are maintained in areas frequented by youth, one in the dormitory building and one in the education building. The kits were maintained with the first-aid kits and included all required items. The third kit is maintained in the locked medication cart, which is kept in the clinic in the administration building and away from youth. The kit in the medication cart included the knife-for-life and a pair of needle nose pliers with wire cutters incorporated into the tool. The requirement for the needle nose pliers and wire cutters to be separate tools was communicated to the program. The program immediately bought and added a wire cutter to the kit. Five staff were interviewed on what to do in the event a youth expresses suicidal thoughts, each reported they would notify their supervisor, four staff reported they would notify mental health and place the youth on constant sight and sound, three staff reported they would document the supervision.

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

Five youth records were reviewed and each were applicable for placement on precautionary observation (PO) upon admission. Each youth's record included a PO log to document supervision utilizing the Department's form, which included all required elements. Each PO log documented safe housing areas and the appropriate level of supervision. Behavior observations were completed and documented in real-time in thirty-minute intervals, as required. Each PO log was signed by the shift supervisor and mental health staff. None of the youth were applicable for warning signs while on PO. Youth interviews verifying supervision on PO were unable to be conducted during the annual compliance review, as the review was transitioned off-site.

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

The program has a policy and procedures in place which address suicide prevention training including suicide drills. A review of five staff pre-service and five in-service training records revealed all pre-service staff and three in-service staff received six hours of suicide prevention training, including four hours of instructor-led training and two hours of web-based learning in the Department's Learning Management System (SkillPro). One in-service staff was missing SkillPro training and the remaining staff completed one hour of instructor-led training. Reviewed documentation confirmed suicide drills were conducted on each of the three shifts at least quarterly and staff participated, as required. Each reviewed suicide drill included all required elements. Staff had the opportunity to review any drill they did not participate in. Two of the five interviewed staff indicated suicide drills were conducted monthly, two staff indicated twice a month, and one staff indicated quarterly. An interview with the executive director indicated emergency response drills are conducted quarterly on each shift.

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 an integrated crisis and emergency mental health and substance abuse plan which includes all required elements. The plan is reviewed annually and was last reviewed by the executive director on April 1, 2020 and the designated mental health clinician authority (DMHCA) on November 9, 2020. The back-up DMHCA, who was providing services prior to the DMHCA's hire, reviewed the plan on April 1, 2020.

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

The program has a policy and procedures addressing Crisis Assessments. An interview with the executive director and designated mental health clinician authority indicated there were no occasions in which a Crisis Assessment was completed during the annual compliance review period. A review of five youth records and program logbooks did not reveal any instances in which a crisis assessment should have been completed; however, the program has a process in place to provide Crisis Assessments, if needed.

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

The program has an integrated crisis and emergency mental health and substance abuse plan which includes all required elements. The plan is reviewed annually and was last reviewed by the executive director on April 1, 2020 and the designated mental health clinician authority (DMHCA) on November 9, 2020. The back-up DMHCA, who was providing services prior to the DMHCA's hire, reviewed the plan on April 1, 2020.

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

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

Standard 4: Health Services

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

The program has a policy and procedures to address the designated health authority (DHA) responsibilities and qualifications. The program's DHA is a physician with specialty training in pediatrics, who holds an unrestricted license meeting all requirements for independent and unsupervised practice in the State of Florida expiring on January 31, 2021. The program's contract requires the DHA to be on-site two hours a week.

A review of the last six months of DHA sign-in logs indicated the DHA was on-site once a week, with no more than nine days between visits, for a minimum of two hours; however, documentation reflected the DHA was often on-site two hours and fifteen minutes or more, as youth needs dictated. The only exception was on November 5, 2020; the DHA was on-site for one and a half hours. The DHA has coverage provided in case of scheduled absences or vacation by a physician with specialty training in pediatrics, who holds an unrestricted license meeting all requirements for independent and unsupervised practice in the State of Florida expiring January 31, 2022.

Both the DHA and the back-up physician did not have any disciplinary cases or public complaints on record. The DHA's liability insurance expires on December 31, 2020. The DHA indicated communication is completed weekly with the medical staff by telephonically, texting, emailing, and in-person regarding the healthcare needs of the youth at the program. The DHA is responsible for communication with the program staff regarding each youth's medical needs. The DHA provides opportunity for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The DHA indicated the DHA's role at the program includes performing all comprehensive physical assessments (CPA), completing chronic clinic visits, sick call, when needed, and medication management. The DHA evaluates and develops medical policies, procedures, nursing protocols, non-health care protocols, and oversees all administrative responsibilities for the program. The program does not utilize an advanced practice registered nurse or physician's assistant.

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

The program has policy and procedures outlining the program's healthcare needs and treatment protocols to guide youth medical care. The designated health authority (DHA) and executive director (ED) signed and dated all respective treatment protocols and facility operating procedures (FOP); the DHA signed on February 6, 2020 and the ED on February 7, 2020, acknowledging an annual review. The DHA approved all treatment protocols and standing orders. The psychiatrist did not review or approve FOPs regarding psychiatric services. The nursing staff signed a cover page which documented all FOPs, treatment protocols, and other procedures acknowledging a review. The program did not have any new healthcare staff during the annual compliance review period.

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.	

In all five individual healthcare records (IHCR) reviewed, a legible copy of the original valid Authority for Evaluation and Treatment (AET) form was maintained. One IHCR included a court order determining permanent guardianship was given to the youth's grandmother, who signed the AET form. In one other IHCR, a release of information was found signed by the youth who had turned eighteen while in the care of the program. In all five IHCRs, completed parental notifications were filed behind the AET forms. The nursing staff interview indicated when a new youth arrives to the program, the registered nurse (RN) will review the medical record sent by the Department or another program for a current AET form. If there is not an AET form, the RN will review the Department's Juvenile Justice Information System (JJIS) for a current AET, if none can be found, a request for the parent/guardian signature is sent with the AET form to the parent/guardian; this will be sent twice, each time noting the date it was sent to the parent/guardian. If there is no response, the RN will seek help from the juvenile probation officer (JPO) to obtain either a signed AET or a court order. The nurse indicated if the youth is eighteen years of age or older, the program utilizes the required Department form. The program did not have any youth in the custody of the Department of Children and Families (DCF) during the annual compliance review period.

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

Four of the five reviewed youth individual healthcare records (IHCR) were applicable for parental notification/consent. Two applicable IHCRs included documentation for parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET) form, as required. One of the five IHCRs was applicable for and contained parental notification regarding medication prescribed to the youth prior to admission to the program was discontinued. Three youth had been prescribed a new medication while in the program and verbal attempts to obtain parental consent were documented in the progress notes. In all four applicable IHCRs, written notifications were sent to the parent/guardian utilizing the required Department form and a staff member witnessed all telephone call attempts and conversations made to the parent/guardian, which was documented in each IHCR.

Two of the four IHCRs were applicable for a new psychotropic medication, discontinuation of a psychotropic medication, or a significant change in drug dosage. In the two applicable records, parent/guardian verbal consents were documented on page three of the Clinical Psychotropic Progress Note (CPPN) and the parent/guardian signed the CPPNs to provide written consents after receiving the Acknowledgement of Receipt of CPPN form. None of the records included vaccinations/immunizations, significant changes to existing medications, off-site emergency care, hospitalizations, surgeries/invasive procedures, and dental procedures, or consent for youth in the custody of the Department of Children and Families (DCF). In all five IHCRs reviewed, the shot records were verified within thirty days of the youth's admission. None of the youth required any vaccinations, nor did the parent/guardian refuse consent. The nursing staff interview indicated the nurse prints out the immunization records from each youth's electronic commitment packet (ECP) or from the youth's Department medical record upon the youth's

admission to the program. The nurse will access the Florida Shots website at the time of admission or prior to in order to print out a copy of the youth's immunization form, if the immunization form is available.

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

In all five youth individual healthcare records (IHCR) reviewed, the Facility Entry Physical Health Screening Form (FEPHS) was completed on the date of the youth's admission by the registered nurse (RN). The program did not have any youth who left the physical custody of the program during the annual compliance review period. The nurse reported a RN completes all FEPHS forms at admission.

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

The program has a policy and procedures which outlines the required orientation topics. The program's contract requires additional orientation topics. In all five youth individual healthcare records reviewed, documentation confirmed the youth received an orientation on the day of admission to the program, which included all required topics. Orientation and health education topics were documented on the required Department form.

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

In three of the five youth individual health care records (IHCR) reviewed, the youth was admitted with a known or suspected chronic condition, which was documented on the chronic conditions log. Each IHCR contained a referral completed by the designated health authority (DHA) in email form on the day of admission. None of the youth required an emergency response upon admission.

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

In all five individual healthcare records (IHCR) reviewed, a new Health Related History (HRH) was completed within seven days of the youth's admission and prior to the completion of the comprehensive physical assessment (CPA). The designated health authority (DHA) reviewed each HRH, which was documented by a checkbox on the CPA. The nursing staff interview indicated the registered nurse (RN) completes the HRH during the youth's admission.

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

The program has a policy and procedures which indicates all youth must receive a comprehensive physical assessment (CPA) and any youth with symptoms suggestive of active tuberculosis (TB) shall not be placed in the general population until medically cleared by the designated health authority (DHA), or designee. The policy states when any part of the CPA exam, specifically the genital exam, is refused by the youth, the clinician shall write, "youth refused," "not indicated," or a similar term. Youth shall initial any part of the exam refused. In all five youth individual healthcare records (IHCR) reviewed, the program utilized the Department's CPA form. In all five IHCRs, a new CPA was completed, as required, within seven days of the youth's admission, by the DHA, documenting the medical grade. Each of the CPAs reflected all sections of the CPA were completed and all refusals were documented, as required. In all five IHCRs, the Department's Problem List was updated where applicable. All five IHCRs included documentation on the CPA, the Facility Entry Physical Health Screening (FEPHS) form, and the Infectious Communicable Disease (ICD) form indicating a TB test was completed within the last year. Focused evaluations completed by the DHA were documented in each youth's record. The nursing staff interview indicated the DHA completes a new CPA within seven calendar days of a new youth's admission to the program. The nurse indicated if a new youth presents with symptoms suggestive of TB on admission, the youth will not be placed in general population until medically cleared by the DHA or designee, or an outside physician, such as from a local hospital. The program utilizes the screening questions on the FEPHS form to help determine the youth's potential exposure to TB prior to their admission.

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

In all five youth individual healthcare records (IHCR) reviewed, documentation confirmed each youth was clinically screened and evaluated for sexually transmitted infections (STI) and was referred to the designated health authority (DHA) for further evaluation. Each of the IHCRs documented testing was ordered; however, three of the five youth refused the testing and a refusal form was maintained in each IHCR. The remaining two IHCRs had a signed consent form and the testing was performed. Both applicable IHCRs documented the testing, screening results, clinical evaluation, and diagnosis were documented on the Infectious Communicable Disease (ICD) form filed in the lab section of each IHCR. None of the five youth had been out of the program's custody.

In all five IHCRs, reviewed documentation indicated each youth was offered Human Immunodeficiency Virus (HIV) counseling and testing. Three of the five youth refused testing, which was documented in each IHCR. Documentation reviewed in the remaining two IHCRs indicated the youth received an HIV test, consent forms were completed, and the results of the tests were kept in a confidential manner consistent with Florida Statute. The two applicable IHCRs contained a sealed envelope which contained the HIV test results and included a signature of the DHA acknowledging review. The program's alert system did not document any HIV alerts. The program's provider for pre and post-test counseling, as well as HIV testing, who holds an active 500/501 certificate from the Florida Department of Health (DOH). All five interviewed youth indicated youth can ask for an HIV test if they want one.

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

The program has a policy and procedures which outlines the requirements of sick call. The policy includes the provision the shift supervisor reviews all sick call requests as soon as possible, but no later than within four hours after the request is submitted, when there is not a licensed healthcare staff on-site. The program does not utilize restricted housing. The program's contract indicates sick call is to be conducted four times a week. The sick call hours are posted in front of the clinic and specify sick call is conducted daily at 9:00 a.m. and 5:00 p.m. In all five youth individual healthcare records (IHCR) reviewed, the youth did not present with similar sick call complaints three or more times within a two-week period. Four of the five IHCRs were applicable for sick call requests. In the four applicable IHCRs, each youth completed a Sick Call Request form. Each completed Sick Call Request form is placed in the locked sick call box, located in the dormitory main area, and checked by the registered nurse (RN) each day. The program keeps sick call forms in the dormitory for youth access. In all four applicable IHCRs, the RN conducted the sick call and the completed the Sick Call Request forms were maintained in reverse chronological order in each IHCR. Each sick call was documented on the Sick Call Index and the Sick Call referral log. One IHCR was applicable for an episodic event, which was documented on the sick call index by mistake. A sick call was not observed during the annual compliance review. Four of the five interviewed staff indicated the nurse reviews the sick call forms, and the remaining staff said it is the supervisor. All five staff stated the nurse conducts sick call. Four of the five interviewed youth indicated the youth can be seen immediately after asking for a sick call, the remaining youth stated it would take more than three days to be seen by the nurse.

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

The program has a written policy and procedures addressing episodic and emergency care. One of the five youth individual healthcare records (IHCR) reviewed was applicable for youth receiving episodic care; therefore, two additional applicable records were reviewed. In the three applicable IHCRs reviewed, one youth was seen on-site by the registered nurse (RN) who documented the event in subjective, objective, assessment, and plan (SOAP) elements charting. The two remaining youth were seen by non-healthcare staff who provided the episodic care and documented the event on the On-Site Health Care by Non-Health Care Staff form. The form included all required information and was reviewed by the RN within twenty-four hours, as required.

The program has three first-aid kits; one in the dormitory, one in the education hallway, and one for transportation, which is kept in the clinic. All three kits were stocked with designated health authority (DHA) approved items. The healthcare staff inventory and restock the first-aid kits monthly and as needed. The program has three suicide response kits. Two kits are maintained in areas frequented by youth, one in the dormitory building and one in the education building. The kits were maintained with the first-aid kits and included all required items. The third kit is maintained in the locked medication cart, which is kept in the clinic in the administration building

and away from youth. The kit in the medication cart included the knife-for-life and a pair of needle nose pliers with wire cutters incorporated into the tool. The requirement for the needle nose pliers and wire cutters to be separate tools was communicated to the program. The program immediately bought and added a wire cutter to the kit.

The program has three automated external defibrillators (AED) with procedures maintained with the device. One AED is located in the dormitory, one in the education hallway, and one in the clinic. The nurse conducts weekly checks of each AED. All three AED batteries expire in December 2023 and the pads April 22, 2022. All three AEDS were found to be in working order when the staff conducted a self-test.

The last two quarters of emergency drills were reviewed and indicated the drills were completed once every quarter on each shift, announced and unannounced. The program was unable to provide the remaining two quarters of drills due to filing them; however, the drills were reviewed during the previous annual compliance review and found to be conducted, as required. The drills simulated an episodic care event which called for immediate first aid and/or administration of cardiopulmonary resuscitation (CPR) techniques, AED use, and the initiation of the emergency procedures to follow when a life-threatening emergency does occur. Reviewed documentation indicated the executive director, director of case management (DCM), director of operations (DO), and maintenance staff are trained in the use of an epinephrine autoinjector and the assistance in self-administration of medications by non-healthcare staff. All five reviewed pre-service and five in-service training records indicated the staff were trained in CPR, first aid, and AED. The program's emergency numbers are posted in the clinic inaccessible to youth.

All five interviewed staff indicated the staff can call 9-1-1 for a medical emergency. One staff stated they would notify the supervisor. Four of the five interviewed youth stated they would be able to see a doctor if needed, the one remaining youth reported they would not be able to see a doctor. Four of the five youth indicated the youth would not be able to see a dentist if they wanted to, the remaining one stating he would. The program reported youth are only allowed to see the dentist in the event of an emergency due to the COVID-19 pandemic.

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

None of the five individual healthcare records (IHCR) reviewed were applicable for off-site care. The program had two youth applicable for off-site care, each of which included multiple events. In the two applicable IHCRs, each youth required three off-site emergency care visits and the IHCRs documented attempts to contact the parent/guardian for each instance. Each of the six events had a Summary of Off-Site Care form completed and filed in chronological order in the IHCR, including all discharge and other documentation. For each of the six events, the designated health authority (DHA) acknowledged review of the off-site care findings, instructions, and information by signing and dating the documents. Both youth required follow-up appointments, which were tracked by the nurse and each youth received appropriate, timely follow-up care, as needed. The nurse reported they track all follow-up appointments utilizing a calendar kept in the clinic and documents all off-site care in an excel spreadsheet.

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

Three of the five youth individual healthcare records (IHCR) reviewed were applicable for youth with a chronic condition identified on the Facility Entry Physical Health Screening Form (FEPHS) form; one youth had a high Body Mass Index (BMI) and the remaining two youth had anaphylactic allergies. All three applicable IHCRs documented the youth had a medical grade of two or higher, were placed on the chronic illness list, had periodic evaluations tracked and completed on-site, and the Department's Problem List was updated, when needed.

None of the three youth had been in the program long enough to receive more than the original evaluation; therefore, three additional IHCRs were reviewed. In the three applicable IHCRs reviewed, the youth had a chronic condition identified on the FEPHS forms; all three had to take medications on an ongoing basis. Each applicable IHCR documented the youth had a medical grade of two or higher, the youth was placed on the chronic illness list, and the Department's Problem List was updated when needed. None of the youth were receiving anti-tuberculosis (TB) medication. The three applicable IHCRs documented periodic evaluations were tracked and the youth received an evaluation at least every three months on-site, and prior to the renewal of expired medications. The executive director indicated important medical issues pertaining to each youth at the program are reviewed with the healthcare staff during the weekly manager meeting. The designated health authority (DHA) indicated periodic evaluations are done every ninety days, the evaluations are documented in the IHCRs, and the nurse keeps track of and schedules the follow-up. The registered nurse (RN) indicated they are responsible for keeping a log of all youth with chronic conditions and to make sure these youth are seen by the DHA at least once every ninety days or less. The chronic evaluation follow-up appointments are tracked on the calendar/planner the RN maintains.

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

The program has a written policy and procedures addressing medication management and the disposal and destruction of expired and/or discontinued medications. The program's policy states the program does not utilize restricted housing. In two of the five youth individual healthcare records (IHCR) reviewed, documentation confirmed the youth was taking medications at the time of admission. One additional applicable IHCR was reviewed for medication management. Each of the youth was taking medications at the time of admission and the medications were verified prior to acceptance into the program. The program utilized the Department's form to document verification, which was maintained in each record, and the designated health authority (DHA) was contacted to obtain an order to resume the medications prescribed prior to the youth's admission into the program. Four of the five original IHCRs, as well as the additional IHCR reviewed, each youth received medications while on-site. Each of the applicable IHCRs documented the medications were given pursuant to current prescriptions, had a valid order, and the DHA placed the order on the Practitioner Order form for medications to continue, be discontinued, changed, or new medications to be added. Three of the five youth received over-the-counter (OTC) medications not listed on the Authorization for Evaluation and Treatment (AET) form according to approved protocols.

In all five applicable records, the standard Department Medication Administration Record (MAR) was used. The MARs documented the start and stop dates of all medications, each medication entry was initialed by the staff who administered the medication, and the nurse conducted weekly side effect monitoring. Both nursing and non-healthcare staff were found to have administered medication on each MAR; therefore, the staff and youth initialed the MAR for all instances of medication administration. The MARs reflected the staff who administered the medication maintained the Six Rights of Medication Delivery/Administration. In one IHCR, documentation indicated the youth refused the medication, signed the medication refusal form, and initialed the MAR. One IHCR had a discrepancy identified. The youth's medication was changed and a new MAR was started reflecting the updated dosage, changing from a daily dosage to one dose every other day. The old MAR documented the staff and youth initials on the last day after receiving the medication. On the new MAR, the same date was used as on the old MAR, which had the staff and youth initials again, seeming as if the youth received the medication twice on the same date. The program indicated the staff made a mistake by entering the information on the same date, it was supposed to be on the date after. The mistake was not identified and continued throughout the entire MAR/month, documenting the date wrong each time the medication was given to the youth. The program reported the documentation error to the Central Communications Center (CCC) during the annual compliance review; however, the call was deemed non-reportable as the error was in documentation and not medication administration.

The process for the disposal and destruction of expired and/or discontinued medication requires the nurse and pharmacist to place the medication together in a container of the approved medication disposal solution. All medications which have been discontinued are stored in a separate lock box located in the locked storage cart, inside the locked nurse's office until time of disposal/destruction. The medications are recorded on a medication destruction log which is signed by either both nurses, or the nurse and pharmacist before placement in the disposal solution.

During the annual compliance review, medication pass was observed. The nurse identified the youth, ensured the medication provided was correct, and had the youth sign the entry in the MAR. Each youth taking oral medications had to drink water and open and swab their mouth to ensure no medication remained. The nurse did not pre-pour the medications. One of the youth refused the medical device prescribed and signed a refusal form, with the direct care staff signing on the form as a witness. During the medication pass, the nurse identified a youth who had refused medications the night before, when the nurse was not on-site; however, a refusal form was not found. The nurse ensured the youth, a witness, and the staff who administered medication the night before signed the appropriate documentation indicating the refusal.

One of the five interviewed youth indicated the nurse provides medication and the remaining four stated they do not take medications. All five interviewed staff indicated the nurse dispenses the medication to the youth. One of the five staff stated the doctor can, and another staff stated whomever is certified is allowed to provide medications to youth. The registered nurse (RN) indicated when a youth is admitted to the program while on medication, the Department's Medication Receipt, Transfer, and Disposition Sheet, copies of current MARs, and medications come with the youth, and the youth and a witness will count the medication to verify the amount. If the medication arrives in a bubble pack, or other "original" medication container from the Department, the nurse does not need to verify the medication prescription. If the medication arrives in an outside pharmacy container the nurse will utilize the Department's Prescription Medication Verification Checklist form or document in the nursing progress notes the verification

of the medication. If the youth arrives while no nurse is on-site, the non-healthcare staff can verify the medication using the Department form and give it to the nurse on-site to file the information in the youth's record.

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

The program has a written policy and procedures addressing the disposal and destruction of expired and/or discontinued medications, as well as reporting criteria for inventory discrepancies. The program has a process in which it can identify Medication Administration Record (MAR) inventory discrepancies by use of the perpetual inventory, maintained by the nurse. If it is discovered a medication is missing and the nurse is not present, the shift supervisor will contact the nurse to verify if the medication had been on hand during the last nursing shift. Once it is determined the medication is indeed missing, the shift supervisor will contact the executive director and the director of operations, the program will be put immediately in lock down, and a search is initiated. Notification to the designated health authority (DHA) and Central Communications Center (CCC) will occur. The process for the disposal and destruction of expired and/or discontinued medication calls for the nurse and pharmacist to place the medication together in a container of an approved medication disposal solution. All medications which have been discontinued are stored in a separate lock box located in the locked storage cart, inside the locked nurse's office until time of disposal/destruction. The medications are recorded on a medication destruction log which is signed by either both nurses, or the nurse and pharmacist before being placed in the disposal solution.

The medication cart was observed during the annual compliance review to be clean and organized. Over-the-counter (OTC) medications and stock items were maintained separate from youth-specific medications. In addition, oral, injectable, and topical medications were kept in different areas within the cart. The medication cart was locked and maintained within the locked nurse's office, inaccessible to youth. The program has a refrigerator designated for medications only. At the time of the annual compliance review, no youth received refrigerated medications; therefore, only stock tuberculosis (TB) tests were maintained in the refrigerator. The remaining stock medications were maintained in a locked stock medication cart within the locked nurse's office. At the time of the annual compliance review, the program only had one youth with controlled medication. The controlled medication was maintained in the locked medication cart in a separate lock box, inaccessible to youth.

The shift-to-shift inventory count was maintained for the medication on the youth's individualized Controlled Medication Inventory, as well as the remaining dosage documented after each medication pass. The count of the medication and the inventory matched. A review of the last six months of sharps and OTC medication inventory indicated perpetual, as well as weekly inventories were conducted, other than one missing weekly inventory for OTC medications. The nurse conducted weekly inventories; however, discrepancies in counts for five different medications were found. The inventory documented medications were added and subtracted with the dates this occurred, but when the weekly inventory count was made it would not add up correctly, as well as dates not added in chronological order on the form. A count of three different sharps was completed by the nurse during the annual compliance review week. One of the sharp counts was off by one scissor; however, the scissor was found in the locked nurse's

office. Counts for three different OTC medications were done by the nurse during the annual compliance review week; the inventory and count matched.

A review of training for non-healthcare staff assistance with the self-administration of medication indicated the executive director (ED), director of case management (DCM), director of operations (DO), and maintenance staff were trained. The nurse indicated all prescription medications, including psychotropic medications are verified by the nurse on duty and then placed immediately in the medication cart which is securely locked and maintained in the nurse's office behind a locked door. Psychotropic medications are placed in a small lock box within the medication cart. The perpetual inventory count for youth specific medication is recorded on each youth's MAR. The nurse keeps a daily perpetual inventory count log of all OTC medications which are secured in a locked stock storage cart, which is maintained in the locked nurse's office. The nurse indicated the pharmacist comes on-site once a month to check the MARs, verify expiration dates on OTC medications and supplies, ensure the pharmacy license is kept up to date, and ensure the pharmacy permits, pharmacist's license, and nurse licenses are displayed properly and inaccessible to youth. The pharmacist ensures the medication refrigerator is kept clean and in good working order, monitors for any medication errors or deficiencies in the medical department, and discusses any findings with the nursing manager, executive director, and DHA. The pharmacist files his report and keeps a book with all monthly, quarterly, and annual reports and all pharmacy related documentation.

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

The program has infection control procedures in place which include prevention, containment, treatment, and reporting requirements related to infectious diseases in accordance with the Occupation Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The infection control plan was reviewed by the designated health authority (DHA) and executive director (ED) on November 12, 2020. The infection control procedures included all required elements. The program's exposure control plan was written in accordance with OSHA standards and is available to staff in the ED's office and the clinic; it is reviewed and signed annually by the ED. The plan included risk assessment and methods of compliance. The ED interview reiterated the location of the plan and the plan being reviewed by all staff annually. The program contacted the Central Communications Center (CCC) regarding one staff who tested positive for COVID-19 on July 23, 2020 as required. The program did not have any other instances of infectious disease during the annual compliance review period. The program has an occupational/facility exposure file in electronic form on the provider's secure risk management site; however, there were no instances of occupational or facility exposure during the annual compliance review period. Any staff tested for COVID-19 was reported, as required, and documented in the program's CCC/incident file, as well as on the secure risk management site. The program did not have any incidents of three or more reportable infectious diseases or quarantining/hospitalization of ten percent or more of the total population of youth or staff during the annual compliance review period. The nurse

reported the nursing staff trains all youth and staff on the infection control and exposure control plan.

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

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

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program's contract requires nursing coverage to be provided by registered nurses (RN), but no less than a licensed practical nurse with a RN supervising, for a minimum of thirty hours a week. The program has one full-time and one part-time RN, both having current and active licenses in the State of Florida, expiring April 30, 2021 and July 31, 2022, respectively. A review of both RNs cardiopulmonary resuscitation (CPR) certifications indicated both are current and valid.

Standard 5: Safety and Security

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

The program has a policy and procedures regarding active supervision of youth. The program has a staff-to-youth ratio of one staff to eight youth while youth are awake. The ratio for youth during sleeping hours are one staff to ten youth. Observations were completed during the annual compliance review, where positive interaction between youth and staff were observed. A staff was asked by an annual compliance review team member how many youth they were supervising, at which time the staff was able to state the amount without counting. The program maintains a full schedule of activities for the youth which is posted throughout the program, including the youth dormitories and dayroom. Through observations, it was determined youth were participating in activities throughout the day, including meals, education, training, and recreation.

The staff consistently implemented the program's behavior management system. The youth were engaged in activities, with proper supervision and not roaming freely. The program does not maintain video footage in the sleeping dormitories; therefore, observations of youth in sleeping rooms was unable to be completed. Five interviewed staff stated youth counts are conducted after every movement and if there is a discrepancy, all movement stops until the missing youth is accounted for. Three staff explained the procedures when the count cannot be reconciled. Each staff stated all movement stops, a search is made for the missing youth, and the executive director and director of operations is notified.

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

A review of the program's behavior management system (BMS) confirmed it is clearly written. The BMS includes the levels, rules governing conduct, and positive and negative consequences. The BMS further states the rewards outnumber the consequences by seven-to-one (7:1), which is a requirement of the program's contract. The BMS is included in the youth handbook, and posted in the youth's dormitories and in the dayroom, which includes the rules and positive and negative consequences. Education staff are staff of the program; therefore, are all trained on the BMS as such. Five youth case management records were reviewed and each contained a signed orientation checklist confirming receipt of the youth handbook. The program's BMS has not changed since the last annual compliance review and includes all required elements. The staff consistently implement the program's BMS, which was observed

during the annual compliance review. Negative consequences are in direct relation to the severity or seriousness of inappropriate behavior.

The program's executive director (ED) stated the program's incentives include top five outings, increased phone time, access to token economy, position in meal line and seating for movie time, ability to attend challenge events, off-campus incentive trips, off-campus community service activities, and off-campus education field trips, ability to wear certain clothing, and eligibility to participate in dive drive and floating classroom, when applicable. Off-campus activities have ceased due to the COVID-19 pandemic. The ED further stated the program's BMS utilized is a point card system and level system combined. According to the policy and through interviews with staff and youth, it was confirmed there are opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a seven to one ratio. Five interviewed staff explained the program's BMS and listed program incentives. Each stated things cannot be taken from youth as a consequence. Five interviewed youth explained the program's consequences used as part of the BMS, as well as rewards earned.

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

The program has a policy and procedures which includes staff receiving feedback on implementation of the program's behavior management system (BMS). All program position descriptions were reviewed; the teacher and direct care staff position descriptions contained the responsibilities of the program's BMS. All program evaluations for all staff positions contained the evaluation of the implementation the program's BMS. Through an interview with the executive director (ED), it was confirmed youth are able to explain their behavior. In addition, youth informed of consequences on the program's Disciplinary Work Detail form. The ED explained staff always attempt to resolve any youth behaviors by communication with the youth rather than impose consequences. The ED stated the shift supervisors review and monitor point cards during and at the end of each shift. The director of operations (DO) reviews point cards weekly to monitor consequence and rewards and to ensure rewards outnumber consequences. The ED stated staff are monitored informally on a daily basis by the shift supervisor, DO, and ED to ensure consistent implementation of the BMS. In addition, shift supervisors and staff are monitored formally by the DO. Staff are monitored formally which is documented on annual evaluations. The program does not utilize room restriction.

Five interviewed staff stated youth are verbally informed of consequences which is included on their point cards. Two staff stated they are provided feedback on their implementation of the BMS during the daily shift debriefs, while three stated feedback is provided, as needed. Five interviewed youth explained the process of the BMS, the levels and moving through each level, and rewards and consequences for the BMS. Each youth stated they are not permitted to punish other youth. Each youth stated staff are fair and consistent with the reward process.

Three youth stated the BMS is “very good,” while two stated it is “good.” A review of ten staff training records confirmed four staff received in-service training and five staff received pre-service training on the program’s BMS, and the remaining staff did not complete BMS training in 2019. The program’s teachers are staff of the program; therefore, the teachers receive the same training related to the BMS as all staff.

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 maintains seventeen cameras, all of which were operational at the time of the annual compliance review. The video recordings are stored for thirty days. The program does not utilize cameras in the youth dormitories; therefore, an observation of youth in sleeping rooms was not completed. A review of ten-minute log sheets was reviewed for the last six months, documenting all checks were completed on time, with the exception of two which were completed four minutes and ten minutes late, respectively. All other checks were consistently conducted every ten minutes. The executive director stated the program maintains seventeen cameras and recordings are stored for thirty days; however, cameras are not utilized in the youth dormitories. Five interviewed staff stated checks are conducted every ten minutes during sleeping hours.

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

The program has policy and procedures regarding youth census, counts, and tracking. Counts were observed during the annual compliance review during transitions from recreation to lunch and from education to group. A review of the logbooks for the last six months confirmed counts were conducted after every movement to include, but not limited to, the beginning of each shift, after each outdoor activity, and during emergency situations. The logbook entries included total daily census counts, new admissions, releases, transfers, and youth temporarily away from the program. Five interviewed staff stated youth counts are conducted after every movement; and if there is a discrepancy, all movement stops until the missing youth is accounted for.

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.	

A review of the program's logbooks found each to be bound with numbered pages. The logbook's binding was taped, where each had a tattered spine on the logbook; however, none were coming apart, nor missing any pages. All entries were made in ink with no erasures or white-out areas. There were no logbook entries destroyed or removed. Each shift supervisor maintains the logbook on their person at all times, as the program does not have a master control. A review of the logbooks for the last six months confirmed any errors were struck through with a single line, dated, and initialed by the staff correcting the error. All entries included the dates and times of the events, the names of the staff and youth involved, brief descriptions of the events, and the names and signatures of the staff making the entries. The logbook further included all pertinent information for the program. All incidents reported to the Florida Abuse Hotline and the Central Communications Center (CCC) were documented. The program does not have a master control, nor does it utilize shift reports or debriefing logs; however, all debriefing information was included in the logbook. The logbooks documented all staff review the previous two shifts, by signing and dating the logbooks upon starting their shift to document they reviewed its contents.

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

The program has a policy and procedures regarding key control which includes the control and use of keys, key assignment, and usage including restrictions on usage, inventory, and tracking of keys, secure storage of keys not in use, missing or lost keys, and reporting and replacement of damaged keys. The program permanently assigns keys to administrative staff, shift supervisors, mental health staff, medical staff, teachers, and kitchen staff; therefore, no facility keys are issued upon entry to work or to direct care staff and no keys are returned upon leaving work. A review of the key inventory confirmed select staff are assigned permanent-issued keys and each staff signs for the keys upon assignment. Three staff's keys were observed and matched to the key inventory, with no discrepancies. The inventory listed the keys assigned to each specific staff; however, it was not clear the keys on the key ring matched the specific keys on the inventory, as the individual keys were not marked. The staff keys and visitor keys were stored in a locked box, in a locked storage room. The door entering the locked storage room has a drop box on it allowing staff to drop personal keys in the drop box prior to beginning their shift, if no administrative staff are available. This drop box is not accessible from the outside and requires entry into the locked storage room to access the dropped keys. Restricted keys are located in a locked box at all times in the director of operations (DO) office. Neither lockbox is

accessible to youth, nor staff who are not permitted to have access. In an interview with the executive director, it was validated the program has not had any damaged keys, nor any lost keys since the last annual compliance review; however, the ED explained the process for lost and damaged keys. There were no Central Communications Center (CCC) incidents related to incidents involving key control. The DO indicated restricted key access is only permitted by the DO, ED, and team leaders. Five interviewed staff explained the key control process.

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

The program has policy and procedures which documents the program's system to prevent contraband entering the facility. The program's policy, as well as the youth handbook defines all items considered contraband. The youth receive the handbook at orientation; and staff receive the staff handbook and policies upon hire. The youth handbook lists the consequences if found with contraband. A review of the logbooks for the last six months confirmed searches of the physical plant, the facility grounds, and the youth. The program was unable to provide documentation of searches for incoming or outgoing mail; however, the program did provide a list which documents all incoming and outgoing mail and who it is mailed to or from. The program's policy addresses staff who are found in possession of contraband in the program, which states staff are subject to disciplinary action up to and including dismissal and includes supervisors and administrators. The program's policy includes notifying law enforcement if any contraband is found and considered illegal. The program completes bi-weekly contraband checks of all youth dormitories and youth lockers. The contraband search sheets document what items are confiscated and how it is disposed. A review of the program logbooks for the last six months was conducted and all searches were documented. The executive director (ED) indicated there has been no illegal contraband confiscated since the last annual compliance review. The ED explained the procedures for confiscation of illegal contraband and its disposal.

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.	

Youth searches were observed during the annual compliance review. The youth were treated with dignity and respect. Each search was conducted by the appropriate number of staff and gender. Each search observed was completed with thoroughness and each followed the search instructions. All searches observed were conducted according to the Protective Action Response (PAR) training manual. Searches were observed after youth transitioned from education to group and from recreation to mealtime. Transportation, visitation, off-campus activities, or an admission did not take place during the annual compliance review; therefore, were not observed. Five staff were interviewed and each stated youth searches are conducted after every movement. In addition, one of the staff stated youth are searched during intake and another staff stated youth are searched after any off-campus activities. Two of the staff stated youth are also searched when items are missing, and three stated searches are done after work activity. One of the five interviewed youth stated youth searches are conducted when returning from off-campus, four stated after outdoor activities, after meals, and every movement.

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

The program utilizes one program van for youth transportation. A review of the program's vehicle invoices confirmed the van received an annual inspection on January 10, 2020. The program is not a secure high-risk or maximum-risk program; therefore, the program's vehicle does not contain a safety screen. The executive director indicated all staff and youth wear seat belts during every transport. A check of vehicles was completed during the annual compliance review and did not find any vehicles unlocked. In addition, an annual compliance review team member observed a program staff conducting a random search of vehicles during perimeter searches. Through observation of the program van it was determined the van contains a fire extinguisher, seat belt cutter, window punch, and the appropriate number of seat belts. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.

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

The program has a policy and procedures regarding youth transportation which outlines the Department's policy. The policy indicates a cell phone is utilized during a transport; the ratio during a transport is one staff to five youth unless there are five or less youth, then at least two staff are required. A transport was not conducted during the annual compliance review; therefore, a transport was not observed. According to the program's policy, one staff of the same gender is always on the transportation of youth.

The executive director (ED) indicated all staff and youth wear seat belts during every transport. If any youth display a risk factor during an assessment, the ratio of staff to the youth is one-to-one according to the ED. The program conducts driver's license checks annually. No youth are left unsupervised in a vehicle, nor are youth permitted to drive program or staff vehicles. The ED reported staff-to youth ratios are maintained during transports. Five interviewed youth stated they have never seen anyone place contraband in a transport vehicle and they feel staff drive the transport vehicles safely. Three of the five interviewed staff stated they have a two-way radio when they drive a transport vehicle and two staff stated they have a two-way radio and a telephone when they drive a transport vehicle. All five staff stated they are not permitted to use their personal vehicle to transport youth. The staff were asked if the vehicle is searched prior to and after each use where three stated yes and two stated no. When asked what emergency equipment is taken on transports, two staff stated first aid kits and three stated the glass cutter and window punch. In addition, three of the staff stated youth information is taken and two stated the tool bag is taken. The five staff stated in an emergency they would call 9-1-1, and four also stated they would contact their supervisor. Three of the staff stated the ratio during a transport is one staff to five youth; one staff stated two staff to five youth; and one staff stated two staff to one youth or three staff if the count exceeds eight youth.

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

The program has a policy and procedures which outlines the audit process and delegates the director of operation (DO), compliance specialist, maintenance staff, or executive director (ED) as responsible for completion of audits and follow-up. The ED stated the maintenance staff, DO, and shift supervisor primarily complete the program's weekly safety and security audits. The process is clear and reflects the corrective action steps and completed date when deficiencies are documented. The program's policy meets the requirements of the Department's Rule. A review of the weekly audit documentation confirmed each was completed weekly, for the last six months. All documented deficiencies noted the corrective action and the completed date on the weekly audits. The ED was able to explain the program's process for completing the weekly safety and security audits.

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

The program has a policy and procedures which addresses the issuance, inventory, and control of all program equipment and tools. The policy indicates machetes, bowie knives, and other long blade knives are prohibited. The program maintains yard tools to include metal rakes, plastic rakes, shovels, and lawn mowers, as well as class B tools. The program does not have any other type class A tools on-site. The program maintains class B tools to include brooms, mops, and dust pans. A review of five selected items were found on the program's inventory list , as required. Tools are stored in a locked shed on the property. All tools are maintained on a shadow board. While the annual compliance review team was on-site, a shovel handle was broken. The executive director (ED) stated the broken shovel was reported to the director of operations (DO) when the shovel broke. The tool was not replaced/disposed of while the annual compliance review team was on-site. The ED further stated the DO or designee will take the broken shovel and dispose of it at the local waste management dump site. The tool inventory

log and the shadow board indicate the shovel was broken. When the DO replaces the broken shovel, the tool inventory log will indicate the shovel has been replaced.

A review of five pre-service staff training records, confirmed all staff received training on the intended and safe use of tools. Youth are trained on the intended and safe use of tools quarterly and training was provided in January, April, August, and November 2020. A review of the program's inventory confirmed tools were inventoried before and after work activities. All Class A tools were inventoried on each shift for the last six months, with the exception of July 2020 where the tools were only inventoried once daily, which is the minimum requirement. All class B tools were inventoried monthly for the last six months, as required. The program had no missing tools since last annual compliance review; however, the maintenance staff explained the program's process. Five staff were interviewed and all stated youth are permitted to use mops and brooms. In addition, one staff stated youth are permitted to use the lawnmower; one stated wash cloths when cleaning; one stated dustpans and serving spoons in the kitchen and one stated a shovel and rake.

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 regarding the supervision requirements when youth use tools. The policy states youth are reassessed and reclassified, if warranted, prior to participation in work projects, or other activities involving tools. In addition, youth are searched after participating in work projects involving the use of tools. The program's staff to youth ratio during a work project is no less than one staff to five youth. The ratio during disciplinary work assignments is, at a minimum, one staff to every three youth. Five youth were interviewed and one youth stated youth are permitted to use dust pans and shovels on work detail; one stated a toilet brush; three stated a shovel, lawnmower, wheel barrel, and weed eater during work detail. All five stated they are permitted to use mops and brooms. A review of five youth case management records confirmed all records contained initial risk assessments and current reassessments. No work activities were completed while the annual compliance review team was on-site; therefore, there were no work activities were observed.

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

The program has a policy and procedures regarding outside contractors. A review of three invoices confirmed the process was followed according to the program's policy. All three outside contractors completed the sign-in sheets and documented the inventory of tools when the contractors arrived and exited the program. The process contains all required guidelines. The program's policy states allowances can be made by the executive director or designee if absolutely necessary, for providing approval for personal cellular phones, equipment/electronic devices capable of taking pictures and/or audio/video recordings, including smart watches in the secure area.

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 Planning (COOP) was reviewed and stated evacuation and emergency response drills shall be conducted on a monthly basis for each shift, which includes fire drills. A review of the program's evacuation and emergency response drills for the last six months confirmed drills were completed each month on each shift; in addition, for the months of June and September 2020, multiple drills were completed, five drills and six drills respectively. The evacuation and emergency response drills included armed intruder, bomb/terrorist, chemical spill, escape, hostage, riot/major disturbance, and tornado drills. A review of fire drill documentation confirmed drills were completed each month, on each shift for the last six months; however, according to the executive director (ED) fire drills were not completed the months of March, April, and May 2020 due to the program following the Centers for Disease Control and Prevention guidelines and social distancing, as a result of the COVID-19 pandemic. Each drill form, for both the fire drills and evacuation and emergency drills, contained the required documentation. The program evacuated during the annual compliance review period due to a hurricane.

The COOP was utilized and followed for this evacuation. Egress plans were posted throughout the program. All program fire extinguishers were inspected October 2020. The ED stated fire, mental health, medical, and evacuation drills (i.e. hurricane/tornado) are performed at least quarterly on each shift and fire drills are conducted monthly. Five interviewed youth indicated they have been instructed on what to do in case of a fire. Five interviewed staff stated they have participated in fire drills, in addition to emergency and evacuation drills, including major disturbance, bomb threat, hostage situation, chemical spills, flooding, weather, terrorism, and escape. Two staff stated fire drills are conducted twice a month; two stated every week; and one stated three times a month.

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

The Continuity of Operations Plan (COOP) is conspicuously posted in the program, readily available to staff members, youth, and visitors. The COOP is located in the youth dormitory, education building, and administration building. The COOP was reviewed, updated, and signed by the executive director (ED) March 23, 2020. The COOP, which includes alternative housing plans, was reviewed and signed March 25, 2020 by the residential regional director. The program's disaster plan and COOP are combined into one plan. The program maintains extra food and water as the provision of supplies, which is required for continuous operation and services during emergency or disaster situations. The ED stated the COOP plan is available for staff and is available in the common area in each building. The program's COOP contained the

signed Delegation of Authority, which was signed March 19, 2020 and the cooperative agreements, which were signed March 24, 2020. The COOP contained the vendor contact list, emergency and staff contact numbers, and county cooperation checklist, which were reviewed March 23, 2020. All additional required elements were included in the COOP. The program maintains critical identifying information for each youth in an administrative hard-copy file which is located in medical, located in the administration building. In the event of an emergency situation, the program can quickly retrieve this information. The administrative hard-copy file includes all the required information for each youth.

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

The program has a policy and procedures regarding the storage and inventory of flammable, poisonous, and toxic items and materials. The program stores cleaning products and gasoline on-site. The cleaning products are located in the kitchen area in a locked closet, inaccessible to youth. The gasoline is stored in a locked block shed outside the administration building, inaccessible to youth at all times. The inventory logs for the flammable, poisonous, and toxic items were reviewed and found the inventory was completed for the gasoline weekly and when used, as required, for the months of May, June, August, and October 2020 and daily for the months of July and September 2020; however, the inventory was missing for October 31, 2020 and “June 31, 2020” was added to the June inventory. The program indicated this was an error on their part by adding June 31 to their inventory. The inventory for the cleaning supplies was completed daily and when used, as required, for the last six months. The inventory for five selected chemicals were observed. All five items on the inventory matched what the program had on-site. The gasoline inventory was reviewed and matched the amount of gasoline on-site. The program maintains a list of positions and titles, for those staff authorized to handle flammable, poisonous, and toxic items, which is located in the program’s disposal logbook. The list includes shift supervisors, directors, kitchen staff, and maintenance staff. Safety Data Sheets (SDS) were available for each chemical and compared with the inventory; the program maintains SDS on-site for all chemicals. The SDS are located where the chemicals are stored.

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

The program has a policy and procedures regarding youth handling and supervision of flammable, poisonous, and toxic items and materials. Five interviewed youth stated they do not use any chemicals; however, the staff do spray the cleaners on surfaces and the youth are permitted to wipe down cleaner. Chemicals are stored in a locked closet in the kitchen and are inaccessible to youth. Youth are not permitted to handle or dispose of any bio-hazardous material, bodily fluids, or human waste. There was not an opportunity to observe youth cleaning during the annual compliance review. The program does not complete the Preventive Maintenance Checklist as they are not housed in state-operated buildings.

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

The program has a policy and procedures regarding the disposal of flammable, poisonous, and toxic items and materials. The policy states the inventory and use and disposal of such items are the responsibility of the maintenance supervisor. The program's procedures are in accordance with Occupational Safety and Health Administration (OSHA) standards. The maintenance supervisor is responsible for the disposal and has been trained on the disposal of all such items. The disposal of any hazardous waste has not occurred since the last annual compliance review. The program has a contract with a local recycling service agency to dispose of used cooking oil. The program's maintenance supervisor stated kitchen grease is kept in a small grease trap outside of the kitchen and a company empties the trap of oil, as needed. Any chemicals which need to be disposed of off-site are taken to the local waste management station. The maintenance supervisor further stated there is a mop sink for dirty mop water in all three buildings. The nurse has red bags in medical for any bodily fluids. In the event there is a chemical spill, the maintenance supervisor stated they would remove youth from the area, review Safety Data Sheets for proper disposal, and call 9-1-1. The executive director stated all flammable, toxic, caustic, and poisonous items are to be disposed of offsite at an approved county waste management station; and the disposal of such items will be logged.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

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 has a water safety plan, as well as a policy and procedures regarding participation in water-related activities. The safety plan addresses all safety issues, emergency procedures, and the rules to be followed during water-related activities. The water safety plan addresses each youth's risk level, who is participating in water activities. The program's water safety plan addresses pool and open water safety. The program's staff and youth have not participated in any water activities since the year 2018; however, the director of case management has current lifeguard certification which expires May 3, 2021. All staff are trained in emergency procedures as part of the in-service training plan. The water safety plan contains all required elements and all required swim activities are addressed in the plan, including ratio, supervision, and safety equipment. Five interviewed youth stated they have not participated in any water activities since admission to the program.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures regarding visitation and communication with youth family members. The visitation schedule is posted in the program's dormitory and the education building. The policy addresses visitation, youth correspondence (mail), and use of telephone. A

review of the program's telephone logs and correspondence logs validated youth were provided the opportunity to communicate with their families. Visitation did not during April 2020 due to the COVID-19 pandemic. The executive director (ED) stated after April 2020, the program went to a restricted schedule, which was by appointment only. This allowed for families to still see youth at structured times and to allow for social distancing. In addition, the ED stated when visitation did occur, all families had to have temperatures taken, were not allowed to bring in any outside food, only parents and guardians were permitted to visit, and visitation was limited to once a month. The visitation log was reviewed and confirmed families visited youth while the youth are in the program. The program has allowed and continues to allow alternative commination while there is a restriction on visitation, such as video calls. No youth currently in the program, or within the last six months, have had a history of human trafficking. The program was unable to provide documentation of searches of incoming or outgoing mail; however, the program did provide a list which documents all incoming and outgoing mail and who it is mailed to or from. Five youth were asked if they are able to call or send a letter to their parent or guardian and all stated yes.

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

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

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

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

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

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