STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Miami Girls Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
3300 NW 27th Ave,
Miami, Florida 33142

Review Date(s): March 3 - 6, 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:

Keith Bennis, Office of Program Accountability, Lead Reviewer (Standard 1)
Markita Andrews, Youth Opportunity Investments, LLC, Director of Case Management (Standard 2)
Rosa Flores, Office of Program Accountability, Regional Monitor (Standard 1)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 5)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Gabriel Medina, Office of Program Accountability, Regional Monitor (Standard 3)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 4)
Sharon Wong, Office of Program Accountability, Regional Monitor (Interviews)

Program Name: Miami Girls Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Miami-Dade County / Circuit 11
Review Date(s): March 3 - 6, 2020

MQI Program Code: 1138
Contract Number: 10139
Number of Beds: 30
Lead Reviewer Code: 142

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

Limited Ratings	Failed Ratings
2.17 Educational Access	1.17 Advisory Board
3.12 Suicide Precaution Observation Logs *	1.20 Recreation and Leisure Activities
5.19 Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	5.15 Outside Contractors
	5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Miami Girls Academy is a thirty-bed high risk/maximum risk program for thirteen to twenty-one-year-old females located in Miami, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides intensive mental health services and provides groups such as Thinking for a Change, Impact of Crime, Living in Balance, Toward No Drugs, Don't Let Your Emotions Run Your Life, Voices: A Program of Self-discovery and Empowerment, Seeking Safety, SAVVY Sisters, Dialectical Behavior Therapy, Impulse Control, and Teen Relationships. Additional treatment services provided includes individual, group, and family therapy which covers thought processing, group interventions, conflict resolution, emotion/anger control, healthy social skills, and social boundaries. Youth participate in art therapy with an external art teacher who provides services every Thursday at the program.

The program's administration is comprised of a facility administrator (FA), assistant facility administrator (AFA), director of case management (DCM), clinical director (CD) who serves as the program's designated mental health clinician authority (DMHCA), assistant clinical director (ACD), a registered nurse (RN) who serves as the health services administrator (HSA), physical plant manager, and an administrative assistant. Case management services are provided by three case managers and one transitional services manager. Mental health staff includes two licensed mental health counselor (LMHC) therapists, one certified behavioral analyst (CBA), two contracted behavioral analysts (Adapt and Transform Behavior), and two registered mental health counselor intern (RMHCI) therapists. Medical services are offered seven days a week, from 7:00 a.m. to 7:00 p.m. The program maintains an independent contractor agreement with a licensed medical doctor to serve as the designated health authority (DHA). The DHA is responsible for the overall delivery of healthcare services to the youth. The program currently has three full-time RNs with one serving as the HSA. In addition, the program has three pro-re-nata (PRN) RNs. Reviewed RN licenses found each was clear and active in the State of Florida.

The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The agreement was signed on December 5, 2019; however, the agreement commenced on November 21, 2019 when the previous contracted psychiatrist resigned from providing services at the program. The psychiatrist's license is clear and active with an expiration date of January 31, 2021. The previous psychiatrist also maintained a clear and active license in the State of Florida with an expiration date of January 31, 2022. Both psychiatrists have liability insurance in the State of Florida with an expiration date of February 20, 2021 for the current psychiatrist and March 3, 2020 for the previous. The psychiatrist is scheduled to be on-site each Monday. In addition to the regular duties, the psychiatrist participates in the weekly psychiatric medication management meeting with the HSA and DMHCA.

The program maintains an independent contractor agreement with a State of Florida licensed dentist located in Kendall, Florida signed on March 21, 2019 and commencing services on April 22, 2019. The dentist's license is clear and active with an expiration date of February 28, 2022. Services are provided on an as-needed basis when a youth submits a Sick Call Request or is referred through medical staff.

The program maintains an independent contractor agreement with a State of Florida licensed optometrist signed on March 28, 2019 and commencing on April 15, 2019. The optometrist' license is clear and active with an expiration date of February 28, 2021. The optometrist is

scheduled to provide on-site services approximately every two months; however, will provide services on an as-needed basis. The last on-site visit was January 10, 2020.

Educational services are provided by the Miami-Dade County School Board. The layout of the program includes an administrative building, two youth dormitories (Legacy and Journey), a maintenance garage, a multipurpose room, two medical offices, and one medication pass office. The program has a total of fifty-six operating security cameras providing coverage.

At the time of the annual compliance review, the program had twelve vacant positions which include one facility administrator position (this is a key position which became vacant February 18, 2020), one licensed mental health professional therapist position (this is a key position which became vacant November 18, 2019), one staff mentor position, six youth specialist I positions, and three youth specialist II positions.

Strengths and Innovative Approaches

- The youth participate in art therapy with an external art teacher who provides on-site services every Thursday. The objective of art therapy is to assist in reducing aggression and violence, promote non-verbal communication, promote a setting which is safe for disclosure, provide necessary diversion and emotional escape, permit the youth to express themselves in a manner acceptable to both the Department and outside culture, and reduce depression. These interventions are conducted considering the psychological diagnosis and the behavioral and interpersonal dilemmas juveniles face when in a detention setting including self-image, expressing emotions, the ability to resolve interpersonal problems, and negative cognitions. The goal is to facilitate the creative process to reestablish a sense of control and provide opportunities for the youth to reconnect with humanity. The youth are in the process of painting a mural in the courtyard which promotes change and positivity.

- The Genesis Ministry church group provides religious services to the youth once each month and the youth can interact with religious leaders from the community.

- The youth can participate in monthly program cookouts hosted by staff.

Standard 1: Management Accountability

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

The program has a written policy and procedures regarding initial background screening. Reviewed documentation confirmed the program conducts a background screening for all newly hired staff, volunteers, contracted providers, grant recipient employees, mentors, and interns with access to youth and confidential youth records prior to employment or volunteering, and every five-years of continued service thereafter. The program had twenty-four employees, four contracted staff, and seven volunteers and/or mentors hired since the program's start-up monitoring visit held in April of 2019. Reviewed documentation reflected each received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to the date of hire and/or contact with youth or access to confidential information. There was evidence in each employee's personnel record reflecting the hiring authority reviewed the Department's Central Communications Center (CCC), Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE) Automatic Training Management System (AMS) as part of the pre-employment background screening process, as confirmed with the program's human resources manager. Each newly hired staff, volunteers, and/or mentors were added to the program's Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on December 5, 2019, meeting the annual requirement. The Miami-Dade County School Board's Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on December 5, 2019, meeting the annual requirement. Each direct care staff hired after July 1, 2018 is required to complete a pre-employment assessment and receive a passing score. The program utilizes the Ergometric IMPACT for Youth Care Worker pre-employment assessment. Reviewed documentation reflected a pre-employment assessment was completed by each applicable newly hired direct-care staff and a copy of the passing score was maintained in each staff's personnel record.

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

The program has a written policy and procedures regarding five-year background rescreening for all staff, volunteers, and interns in accordance with Department requirements. The program

had three staff members and one contracted employee applicable for a five-year background rescreening. Reviewed documentation confirmed each had a rescreening completed in the Department's Clearinghouse prior to the five-year anniversary date of hire, with the information submitted to the Department's Background Screening Unit at least ten days prior to the anniversary date. There were no volunteers, mentors, or interns who were applicable for a five-year rescreening.

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 maintains a written policy and procedures which outlines an environment free of abuse and neglect where youth and staff feel safe and secure. The program maintains an employee handbook which outlines the program's code of conduct to include trauma responsive practices which recognizes and responds to the experiences of trauma in the lives of youth and families. The program's practice is to have all staff acknowledge and sign a receipt of the employee handbook and code of conduct which outlines the grievance policies and understanding of the program's code of conduct. A review of five personnel records found each record contained documentation of acknowledgement, receipt, and review of the program's code of conduct.

Observations made while touring the program reflected the Florida Abuse Hotline telephone number and the Department's Central Communications Center (CCC) telephone number were posted throughout. Youth have unimpeded access to contact the Florida Abuse Hotline or the Department's CCC. If youth report to staff they would like to make an abuse call, staff will contact a supervisor, then the supervisor will bring the youth to a private office to allow each youth to call the Florida Abuse Hotline or the CCC. All allegations of abuse, neglect, and CCC reports are logged and maintained in the program's logbook. The program had a total of thirty-seven incidents related to abuse reported since the program's startup monitoring in April of 2019. A review of all incidents, coupled with an informal interview with the assistant facility

administrator (AFA), reflected there were no incidents which involved substantiated complaints against staff, nor were there any incidents which should have been reported and were not.

Reviewed documentation confirmed the program completes a yearly Trauma Responsive and Caring Environment (TRACE) self-assessment and surveys to gauge the level of trauma informed care to youth provided within the program. Five interviewed youth reported they are aware of the abuse reporting process. Each youth reported never being denied access to contact the Florida Abuse Hotline or the Department's CCC. Four of the five youth reported they feel safe in the program while one said they did not. This youth was interviewed again regarding this question and explained the staff do not put enough effort into intervening when youth want to assault other youth. The youth reported if one youth misbehaves, then the entire program is locked down. The youth was asked if she would like to contact the Florida Abuse Hotline but declined. This information was provided to the administration. An informal interview with the AFA and regional compliance manager (RCM) confirmed this was previously called into the Florida Abuse Hotline and was investigated by a child protective investigator. The results of the investigation were found to be unsubstantiated.

Each youth was asked if they have ever heard staff use profanity when speaking to them or other youth in the program. Two of the five youth reported never hearing profanity while the remaining three reported they hear profanity often. Each youth was asked if staff are respectful when talking to them and other youth. Two of the three youth reported staff as being respectful while three reported staff are disrespectful. One youth reported staff are disrespectful and do not think about how the youth feel, another stated staff talk about youth and used profanity behind their back, while the third youth said staff are not always respectful. This information was reported to the AFA and RCM for follow-up. It was advised this would be addressed during staff meetings.

Five interviewed staff were each able to describe, in detail, the program's abuse and CCC reporting process. Each of the five staff reported they have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline, nor have they observed a co-worker using profanity, threats, intimidation, or humiliation when interacting with youth. An interview was conducted with the acting facility administrator (FA). The acting FA advised staff are expected to aspire to the highest of standards of conduct and professional performance. There are three classifications of violations of the standards of conduct, which include minor, major, and critical. The code of conduct stipulates acceptable workplace performance and behavior for all staff. Examples of violations of the code of conduct are absenteeism, tardiness, dress code, horseplay, driving infractions, arrest or conviction, violation of the Prison Rape Elimination Act (PREA) policy, and/or the introduction of contraband. The FA advised any staff involved in an abuse incident or who are a witness to an abuse incident must immediately notify their supervisor and complete an incident report. If the incident is reportable to the CCC, the administrator on duty must be notified. The FA also advised any staff can contact the CCC and all staff have a two-hour window to report all incidents to the CCC. Once reported, an internal investigation will be initiated. During the annual compliance review, the review team did not observe any physical, emotional, or psychological abuse.

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

The program maintains a written policy and procedures which address management's response to abuse allegations. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) and the Florida Abuse Hotline found the program had thirty-seven incidents concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. Reviewed documentation, coupled with an informal interview with the program's assistant facility administrator (AFA), confirmed each report was found to be unsubstantiated. Reviewed documentation of five incident reports reflected management immediately initiated an internal investigation and placed applicable staff on administrative leave and/or on no-contact status with youth until the allegation was fully investigated. Each incident was found to be unsubstantiated and applicable employees returned to work upon completion of the investigation by a child protective investigator and/or law enforcement. Reviewed training documentation confirmed staff are trained on incident reporting as part of the pre-service training plan.

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

The program has a written policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had a total of forty-six incidents reported to the CCC during the last six months, of which five were reviewed. Reviewed documentation validated each reviewed incident was reported to the CCC within the mandatory two-hour timeframe and in accordance with CCC reporting procedures. Reviewed documentation of program logbooks supported each of the reviewed incidents were documented in the logbook and were highlighted.

A review of internal incidents/grievances for the past six months determined there were no incidents which should have been reported to the CCC and were not. A comparison of reportable incidents made at Martin Girls Academy during the same timeframe last year reflected a decrease in the reportable incidents from sixty-five incidents to forty-six incidents this year. Reviewed documentation confirmed all youth are explained their rights and how to report abuse by staff during the orientation/admission to the program. Additionally, this information is found within the program's student handbook, which is provided to all youth upon orientation. An interview with the program's acting facility administrator (FA) reflected staff involved in an incident, or who witness an incident, will immediately notify their supervisor and complete an incident report. If the incident is reportable to the CCC, the administrator on duty must be notified. Any staff can contact the CCC within a two-hour time-frame of the incident occurring to report all incidents to the CCC. Once reported, an internal investigation will be initiated.

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

The program has a written policy and procedures addressing the utilization of Protective Action Response (PAR). The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. Reviewed documentation confirmed the program had forty-eight PAR reports completed within the last six months. A sample of five PAR reports was reviewed, of which all included a review by a PAR-certified instructor and were processed within the seventy-two-hour timeframe by all required parties. Reviewed documentation confirmed each participant completed a statement on the same day as when the incident occurred. Each report documented a post-PAR interview conducted within thirty minutes of the incident as well as a review of the PAR incident report by the facility administrator (FA) or designee within seventy-two hours of the incident.

Two of the reviewed reports reflected youth had injuries prior to the initiation of the reviewed PAR and none required a PAR medical review due to the actual PAR. Documentation also confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. The reviewed PAR incidents did not include the use of mechanical restraints and there were no allegations of abuse made by youth or injuries to youth or staff. The program maintains a PAR binder which contained all PAR reports and PAR Monthly Summary Reports for the year. Reviewed documentation confirmed PAR Monthly Summary Reports were submitted to the Department within two weeks of the end of each month. The program's PAR rate has increased since the last annual compliance review. The program's PAR rate during the annual compliance review period was 17.70, which is above the statewide Residential PAR rate of 2.41. An informal interview with the program's assistant facility administrator (AFA) was conducted regarding the rise in PAR rate. The AFA advised they feel the youth are escalating behavior and creating problems due to wanting to go to the detention center next door. The AFA stated the youth feel like they can get more privileges, better food, and more access to telephone calls while at the detention center. The AFA also indicated all PAR incidents are reviewed by the FA for appropriateness and discussed with the program's management team during daily management meetings. An informal interview with the clinical director confirmed after any use of PAR, youth receive a special treatment team meeting for their behavior and receive appropriate consequences determined by the management team.

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

The program has a written policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff, which was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. Pre-service training is provided through a combination of instructor-led, web-based courses, and on-the-job-training. The program provided a list of staff who are direct-care staff and are counted in the staff-to-youth ratio.

Five staff training records were reviewed for pre-service training. Each of the five records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. Each staff training record reflected documentation to support each staff exceeded the required 120 hours of pre-service training. All applicable contractually required trainings were completed for each of the five staff. Reviewed documentation reflected all trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The program has a written policy and procedures regarding in-service training. The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. The program has an annual in-service calendar which is updated as changes occur. Five applicable staff training records, inclusive of two supervisory staff's training records, were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training required. Each applicable staff had current training and/or certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, active shooter, and suicide prevention/intervention. In addition, each of the five staff had the required emergency response training, prenatal and neonatal staff education, and training in monitoring, observation, and emergency room care of pregnant females and their infants. Two supervisor training records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded the eight-hour requirement. The program's contract requires staff to receive training in the Prison Rape Elimination Act (PREA) every two years and all five training records reflected staff were trained in PREA, as required. Reviewed documentation confirmed each of the program's six licensed nursing staff had the required current certifications in CPR with AED. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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 addressing the grievance process specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. Reviewed documentation reflected these procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's procedures address each of the following phases of the youth grievance process, specifying timeframes, promoting timely feedback to youth, and rectification of situations or conditions when grievances are determined to be valid or justified. The program maintains a pre-service training which includes the grievance process and procedures. A review of five applicable pre-service staff training records reflected all staff received the required grievance process and procedures training.

The program's policy indicates if a youth requests assistance in completing the grievance form, the staff and/or other advocates can assist the youth in completing the form or complete the form for them. The program follows a three-phase grievance process to include an informal phase ("Chatty Cathy" form), a formal phase, and an appeal phase. Chatty Cathy forms allow youth to voice their objections and informally file an issue or complaint with administration prior to filing a formal grievance. Observations made while on the program tour reflected grievance forms are posted throughout the program accessible to youth. The program maintains a locked box within each dormitory near the forms for all Chatty Cathy and formal grievance forms which youth have access to several times throughout the day. If a youth is not satisfied with the resolution from the informal phase, they may submit a formal grievance form.

Program staff will respond to all informal grievances within seventy-two hours and the facility administrator (FA), or designee, will respond to all formal grievances within seventy-two hours. If the youth is not satisfied with the response from the formal grievance, the youth may appeal the decision. The FA, or designee, is also responsible for handling all grievance appeals. An interview with the program's acting FA reflected their understanding of the grievance policy and procedures. Reviewed documentation confirmed there was a total of seventy grievances filed within the last twelve months, of which seven were reviewed. A review of seven grievances revealed six were resolved at the formal level, while one was resolved at the appeal level. Five of the seven reviewed grievances reflected they were reviewed within the required seventy-two-hour time-frame, while two were reviewed late. One was reviewed two days late and the other was reviewed four days late. Each grievance documented the youth's participation, supervisory oversight, and final outcomes.

Five staff interviews were conducted in which each staff reported knowledge of the program's grievance process. Five interviewed youth stated they were aware of the program's grievance process, Chatty Cathy forms, had access to grievance forms whenever needed, and could request assistance in completing the grievance forms, if needed. An interview with the acting FA was conducted who advised grievance forms are available to the youth in each dorm in a central location. The youth can complete and submit the grievance form into the Chatty Cathy box available on the dorms. Youth can complete a Chatty Cathy form for issues which do not

rise to the level of a grievance. Grievances are reviewed at each morning management meeting and distributed for a meeting with the youth. A meeting is conducted with the youth and classification is made. Applicable staff have seventy-two hours, excluding weekends and holidays, to review the grievance. If the youth disagrees with the findings, there is an appeal process and the grievance is addressed through the chain of command.

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

The program provides delinquency interventions for each youth through evidence-based practices, promising practices, or a practice with demonstrated effectiveness. Evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Thinking for a Change (T4C), Impact of Crime (IOC), and Dialectical Behavioral Therapy (DBT) Skills Manual for Teens and Adults as interventions with each youth placed in groups according to their identified individual needs. Due to the length of stay at the program, typically all youth will participate in all intervention groups during their stay at the program. These practices were confirmed by the program's regional compliance manager and clinical director (CD) to be evidence-based, a promising practice, or a practice with demonstrated effectiveness to address the priority needs of each youth.

Interviews with the CD and the program's acting facility administrator (FA) confirmed delinquency interventions are delivered by case managers and the program's designated mental health clinician authority (DMHCA). Factors of education and work experience are considered when determining which staff will deliver life skills training or groups. It was advised the youth are matched with their therapists based on each youth's individualized therapeutic needs. A review of each of the designated staff's training records reflected each staff had the appropriate education and qualifications to be hired in their respective positions and completed the required trainings to facilitate the applicable intervention groups.

Reviewed documentation of the program's group/daily schedule reflected delinquency intervention groups are conducted throughout each week, pursuant to the program's contract, and a review of sign-in sheets confirmed this practice. Structured planned programming and activities are provided for a minimum of sixty percent of the youth's awake hours. A review of five youth individual performance plans supported four of the five had at least one delinquency intervention goal addressing an identified priority need while one did not, as the youth was recently admitted and awaiting the next group cohort to begin. A review of group sign-in sheets validated each applicable youth was participating in an intervention group.

An interview was conducted with the program's acting FA advised each staff is required to have appropriate education and experience to perform their job duties. Specialized training is provided for specialty groups. If a staff member wants to conduct groups outside of their curriculum, their experience and work history are reviewed to determine if they possess the ability to perform the task. The FA stated youth are matched to staff/counselors/case managers and intervention groups during the assessment process. A staff is identified as the best fit for each youth depending on age, prior history, and Victimization and Sexually Aggressive Behavior

(VSAB) classification. Five interviewed youth each confirmed participating in groups while at the program and provided examples of the groups they are in. The groups they reported were T4C, IOC, DBT, SAVVY Sisters, Teen Relationships, Voices: A Program of Self-discovery and Empowerment, Impulse Control, and mental health/substance abuse groups.

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

The program has a written policy and procedures regarding interventions and instructions focusing on developing life and social skill competencies to youth designed to help youth function more responsibly and successfully in everyday life situations. Youth receive life and social skill intervention services specifically addressing communication, anger management, interpersonal relationships and interactions, non-violent conflict resolution, and critical thinking to include problem-solving and decision-making. The program provides groups and curricula including Thinking for a Change (T4C), Voices: A Program of Self-discovery and Empowerment, Seeking Safety, Living in Balance, Toward No Drugs, Teen Relationships, and Don't Let Your Emotions Run Your Life. Each youth is trained in life skills such as coping with their feelings, anger management, critical thinking, impulse control, stress management, conflict resolution, and recognizing triggers by the case management staff or transition manager. Reviewed documentation of personnel records confirmed applicable program staff are trained to provide the life skills and intervention groups as well as mental health and substance abuse groups. A review of group sign-in sheets confirmed the program is providing all contractually required groups to youth according to the activity schedule. A review of five youth case management records reflected all youth are participating in life and social skills groups and trainings as required. An interview with the clinical director (CD) and assistant facility administrator (AFA) indicated youth attend delinquency and life skills groups daily and are provided an opportunity to practice these skills during their daily routine. Interviews with five youth reflected they are all currently participating in groups to include T4C, Dialectical Behavioral Therapy (DBT), SAVVY Sisters, Teen Relationships, Voices, Impulse Control, and mental health/substance abuse groups. Three of the five youth interviewed indicated they have learned behaviors in group such as to change their thinking process, consequences of actions, regulate their emotions, stop, think, and react, building better relationships with people, and uplifting each other. One of the remaining five youth reported they have learned nothing while the other remaining youth reported the lessons are all the same, as this is not her first program. Four of the five interviewed youth indicated they have been able to use the skills they have learned in their daily routine while the one youth who reported they have learned nothing. This information was provided to the CD and AFA to follow-up with the youth. Reviewed documentation coupled with an informal interview with the AFA confirmed this youth's behavior management system point level status reflected this youth has not progressed in the program due to negative behavior and unwillingness to change their behavior.

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

The program provides delinquency interventions through evidence-based principles and practices of restorative justice designed to reduce the influence of risk factors related to re-offending behavior. An informal interview with the program's clinical director (CD) confirmed the program provides Impact of Crime (IOC) groups with youth twice a week as well as group circles/daily meetings with therapists to help increase awareness and empathy for crime victims and survivors. A review of the program's activity schedule coupled with group sign-in sheets confirmed this practice. These groups are designed to assist youth with accepting responsibility for harm they have caused by their past criminal actions and challenging them to recognize and modify their irresponsible thinking such as denying, minimizing, rationalizing, and blaming victims. Reviewed documentation coupled with an informal interview with the director of case management reflected youth have participated in writing letters to at-risk youth from a local middle school to encourage them to not get involved with the juvenile justice system and avoid being a victim of crime. In addition, the youth participated in coloring pictures and writing letters for cancer patients at Nicklaus Children's Hospital. The program had an owner of multiple Wing Stop restaurants come to the program as a guest speaker to expose youth to her perspective of being a victim of burglary. An informal interview with the director of case management reflected the guest speaker provided the effects of her victimization, words of encouragement and inspiration to the youth, and spoke about her business and employment opportunities once youth are released from the program. The program engaged the youth in follow-up activities to process their reactions to the victim's accounting of how crime affected her life. A review of staff training records confirmed four staff are trained to facilitate IOC. A review of five case management records performance/treatment plans confirmed youth are receiving services to increase accountability for criminal actions and harm to others.

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

The program has a written policy and procedures which address gender-specific programming for a female population, pursuant to the contract. The program provides delinquency and treatment services which are gender-specific and targets the female population, including age, gender, special needs, and their impact on youth responsiveness to intervention or treatment. Gender-specific treatment focuses on areas including health and hygiene, physical environment, life and social skills training, substance abuse, sexual abuse, trauma, recreation and leisure activities, as well as relational and emotional topics. The program's activity schedule has specific times set aside for youth to participate in groups for SAVVY Sisters and Voices: A Program of Self-discovery and Empowerment. Reviewed documentation reflected each group is provided by the program's mental health clinicians who are trained to deliver the curriculum. A review of the curriculum and lesson plans used to educate the youth confirmed it was geared towards gender-specific issues. The clinical director, director of case management, and assistant facility administrator (AFA) were informally interviewed and validate the program provides various gender-specific programming to address the needs of the youth. Reviewed documentation confirmed the program maintains a binder with sign-in sheets reflecting the

names of youth attending the groups, the name of the facilitator, the lesson for the day, and the date/time of the groups. Five interviewed youth confirmed they participate in gender-specific groups each day.

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

The program has a written policy and procedures regarding program staff entering alerts into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. An interview with the program's assistant facility administrator (AFA) reflected the JJIS alert reports and internal alerts are reviewed daily by shift supervisors and administrative staff at the daily morning management meeting. Reviewed documentation coupled with informal interviews confirmed supervisors discuss the alerts with all working direct-care staff at each shift briefing. The program maintains an internal alert board within the multi-purpose room, the operations office, and in master control which is updated as needed by medical, clinical, and case management staff. A review of five youth records found each was applicable to having an alert entered into the program's internal and JJIS alert systems. Reviewed documentation supported each youth had the appropriate alert entered into the internal alert system and each mirrored the JJIS alert system as well. All applicable youth were removed or downgraded from alert status by appropriate medical and/or mental health staff in a timely manner. Three out of the five reviewed youth records were applicable for documentation of alerts in the logbook and each alert was found in the logbook. The AFA confirmed only medical staff can remove or downgrade a medical alert, only mental health staff are able to remove or downgrade a mental health alert, and the facility administrator, AFA, or on-site supervisor are able to remove or downgrade security alerts. It was confirmed mental health and nursing staff verify all applicable alerts ensuring they are accurate and up-to-date. An informal interview with nursing staff confirmed youth with medical grades two through five are placed on the program's medical alert system. An interview was conducted with the program's acting facility administrator (FA). The FA advised on-site health services address the individual medical needs of the youth and nursing staff review the important medical issues pertaining to the youth at the program. The program provides professional mental health services seven days a week and review/monitor the important mental health issues pertaining to the youth at the program. Additionally, a psychiatrist and psychologist professionals are on-site weekly as well. The FA confirmed internal alerts for mental health are entered by therapists and medical alerts are entered by nursing staff. Three of five interviewed staff stated they are informed of medical and mental health alerts by the internal alert board, through the logbook, and during shift briefings. One of five interviewed staff said they can look within a youth's safety binder while the remaining staff said they are informed of alerts by case managers, therapists, supervisors.

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 a written policy and procedures regarding the creation, maintenance, and storage of Individual Healthcare Records, mental health and substance abuse records, and case management records for each youth at the program. The program maintains individual, color coated, hardbound binders utilized for case management, mental health and substance abuse, and health care records. Reviewed documentation of youth records found each was labeled "confidential" and were secured in file cabinets identified as "confidential" in assigned locked offices, which are inaccessible to youth. Observations of the records reflected each youth record had the required documentation on the spine and on the front cover of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department identification number (DJJID). Reviewed records reflected all required information was maintained in chronological order within the records. Documents were organized into required sections and information was separated into designated sections with tabs for legal information, demographic and chronological information, case management and treatment team activities, correspondence, and miscellaneous.

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

The program has a formal process to promote constructive input by the youth. The program utilizes various avenues such as a youth advisory board and "Chatty Cathy" forms giving youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. The program maintains a youth advisory board comprised of youth enrolled in the program which meets at least monthly to discuss various topics. Additionally, the program utilizes youth surveys, parent/guardian surveys, daily meetings, and weekly community meetings which gives each youth an opportunity to address both positive and negative issues they may have. The program has an open floor forum during daily circle meetings where youth express issues and concerns relating to all areas of the program. Each program department sends a representative to the daily circle meetings to directly and immediately respond to any applicable youth's concerns. Reviewed documentation of youth advisory board meetings held reflected an agenda, sign-in sheets, along with meeting minutes summarizing the subject areas which were discussed. An interview was conducted with the acting facility administrator (FA) and he acknowledged the program has Chatty Cathy forms, daily meetings, and youth advocacy programs to solicit input from youth on systemic issues impacting the residential community. The FA confirmed the program has a youth advisory board which meets each month where youth can bring issues, concerns, and recommendations to the program administrators to be addressed. Two of the five interviewed youth stated they could provide feedback and input if desired while three said they could not. One youth reported they treat her like a little kid, another reported opinions or input are never asked of her, and the last youth said they do not have a process to allow youth to provide input about the program. This information was shared with the assistant facility administrator (AFA) for follow-up. During an informal interview with the AFA, it was advised youth can make suggestions to program staff and administrative staff at any time. Chatty Cathy and grievance forms were observed to be

posted throughout the program as well. Any systemic issues are addressed during weekly youth advisory board meetings.

1.17 Advisory Board	Failed 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 maintains a policy and procedures for maintaining an advisory board. Reviewed documentation reflected the program conducted one community advisory board meeting held in January of 2020. The community advisory board meeting held in January consisted of the facility administrator (FA), the lead teacher, the health services administrator, the assistant facility administrator (AFA), director of case management, the clinical director, and representative from the school board, the business community, and faith-based organizations. Reviewed documentation reflected the previous facility administrator sent emails to solicit active involvement of interested community partners. During the annual compliance review, contact was made with a board member from the January meeting to determine the level of involvement with program activities. The board member reported the first and only meeting they attended was held in January of 2020 and the community advisory board discussed various topics such as suitable community involvement activities, upcoming program events/meetings, and open floor discussion to help the program. The board member indicated the meeting ran smoothly. A review of the program's community advisory board meeting documentation confirmed the program met once in January of 2020; however, there was no other documentation to confirm any other meetings were held in 2019.

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

The program has a policy and procedures in place regarding program planning designed to establish a system of communication, facilitate staff involvement, discuss program issues, and the development of policies, procedures, and programs. Reviewed documentation reflected the program conducts monthly all-staff meetings, monthly supervisor meetings, and daily management meetings to share information with program staff and to enhance program planning. Staff can communicate input and provide feedback on the program's operations during these meetings or at any given time with program's administrative staff. A review of the program's meeting binders reflected meetings were held daily and/or monthly. Documentation of all-staff meeting minutes indicated the program reviews the Monitoring and Quality Improvement reports, any applicable major issues, medical updates, mental health updates, drill reviews, policy reviews, human resources issues, and safety and security issues with staff. A review of daily management meetings reflected the management team discussed programming issues, incident reports, grievances, Central Communications Center reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. Monthly staff meeting documentation reflected a review of the annual compliance report and the Comprehensive Accountability Report (CAR) as well. The program conducts parent/guardian surveys upon each youth's admission and discharge from the program and the feedback received from the surveys are discussed with administration and staff and is used to enhance programming. The program has a policy and procedures in place for employment recognition. An informal interview with the program's regional compliance manager (RCM) confirmed they have practices in place to minimize staff turnover. It was reported

TrueCore programs are recognized with additional monetary gifts for meeting program goals which are utilized to facilitate staff parties and boost morale. The program also utilizes a program called the TrueCore Way for staff who goes above and beyond, which allows supervisory staff to recognize staff for positive performance. During an interview with the assistant facility administrator (AFA) and RCM, it was confirmed the program holds monthly staff meetings, monthly supervisor meetings, and daily management meetings to keep staff informed of events going on in the program. The program implemented casual dress Friday to boost staff morale. In June of 2019, the program received a contract amendment to provide monetary bonuses to staff to encourage retention. The RCM advised youth and parent/guardian surveys are conducted quarterly the information collected is shared with staff and is used to improve programming. Five interviewed staff members confirmed the program holds daily, bi-weekly, and monthly staff meetings. The five interviewed staff indicated changes in policy and procedures, youth behavioral issues, youth alerts, program trends, drills, department-related topics, time and attendance, safety and security, and staff feedback are discussed during monthly staff meetings. Two out of the five staff indicated they are briefed on annual reports and parent/guardian survey results while three said they are not. Two staff reported the communication at the program is good, two reported it as fair, and one reported it as very poor. Five interviewed staff were asked to explain their ability to provide input and feedback into the program operations. Each staff reported staff can speak with administration to provide any feedback they want or suggestions they have.

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

The program maintains a policy and procedures regarding employee performance reviews. Performance evaluations are completed within ninety days for each newly hired staff and then annually thereafter for all other staff. Annual evaluations are completed to provide feedback to staff regarding their performance over the prior year to include implementation of the behavior management system and their overall specific job duties. Evaluations may include identified goals for the upcoming year. Each staff is given the opportunity to provide comments and written input regarding their evaluation. Performance evaluations address employee performance standards to include job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. Evaluations are explicit to different categories of staff positions. Each performance evaluation provides an overall numerical rating at the end of the evaluation. Reviewed documentation confirmed the program maintains position descriptions for each position title with corresponding performance standards outlining the job functions and duties required of each position inclusive of staff's implementation of the program's Positive Performance System (behavior management system) and delivery of delinquency intervention services for applicable staff. Five staff were interviewed about performance evaluations. Three staff indicated they receive performance evaluations annually, one staff stated they receive evaluations every six months, and another staff stated they receive evaluations every ninety days. An interview with the program's acting facility administrator (FA) was conducted and he advised all staff receive an annual evaluation each year completed on or before the thirty-first day of December where their progress is evaluated and any room for improvement is discussed. Reviewed documentation of five personnel records reflected each included the specific job description and an applicable performance evaluation.

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

The program maintains a policy and procedures regarding recreation and leisure activities. The program has a range of supervised and structured indoor and outdoor recreation activities available to youth. An informal interview with the clinical director and assistant facility administration confirmed the program provides activities based on the developmental level and needs of the youth in the program. A review of the program's activity schedule and logbooks verified a variety of activities are provided to the youth, including leisure and recreational activities, to promote cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Observations were made each day during the week of the annual compliance review of youth outside during recreation/leisure time, which confirmed youth participate in teamwork, healthy competition, and physical fitness. Observations confirmed staff take precautionary measures to prevent overexertion, heat stress, dehydration, and exacerbation of an existing illness or physical injury. A review of the logbook and activity schedule reflected a minimum of one hour of recreation activity/leisure time is provided daily for all youth. Reviewed documentation of five youth records reflected all youth had wellness goals and therapeutic activity on their treatment plans and updates on the progress of those plans are provided to the treatment team monthly. An informal interview with the assistant facility administrator (AFA) confirmed youth are provided an opportunity to provide input into the rules and operation of the program, including recreation/leisure time suggestions, through the youth advisory board and youth suggestion box. According to the contract, the program is to have a certified recreational therapist who shall hold a bachelor's-level degree in recreation and sports management with a track in recreational therapy and must obtain a National Council for Therapeutic Recreation Certification (NCTRC). One year of experience as a recreational therapist is preferred. The program currently has one recreational therapist in accordance with the contract. The recreational therapist has a bachelor's-level degree in recreation and sport management with approximately ten months of experience interning/volunteering as a recreational therapist. Reviewed documentation confirmed the hired recreational therapist did not pass the NCTRC certification examination taken on January 15, 2019. An informal interview with regional compliance manager indicated the recreational therapist would be retaking the NCTRC certification examination in May 2020. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. During an interview with the designated mental health clinician authority (DMHCA), it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Five staff were interviewed regarding what types of indoor and outdoor activities are provided to the youth. Each of the five staff reported youth are afforded one hour each day for recreation and leisure time. Some activities conducted include exercise, football, basketball, volleyball, kickball, dodgeball, soccer, and capture the flag. Five interviewed youth confirmed they receive at least one hour of recreation and leisure time daily.

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 written policy and procedures in place regarding the notification to the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, written notification to the youth's committing court within forty-eight hours of admission, and written notification to the assigned juvenile probation officer (JPO) and post-residential services counselor, if applicable, within five working days of admission. Five case management records were reviewed found each parent/guardian was notified by telephone within twenty-four hours of admission. Each of the five case management records indicated written notification was provided within forty-eight hours of admission to the parent/guardian. Each of the five case management records indicated the court, JPO, and post-residential services counselor, if applicable, were notified within five working days of each youth's admission to the program.

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

The program has a written policy and procedures in place to provide each youth with an orientation to the program rules, procedures, schedules, and services applicable to youth to begin on the day of their admission. A review of five case management records indicated each youth was provided an orientation within twenty-four hours of their admission to the program. Each reviewed record had a signed checklist acknowledging the youth received orientation which included all required information. A review of five youth case management records confirmed each youth received a copy of the program's youth handbook. Five interviewed youth stated they received an orientation to the program to include program rules, procedures, and schedules, within twenty-four hours of their admission.

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

The program has a written policy and procedures regarding written consent of youth who are eighteen years of age or older prior to discussing or providing the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment. Five case management records were reviewed, and none were applicable for written consent of youth eighteen years of age or older. Additional records were provided, and the program reported only one record was applicable. Reviewed documentation confirmed the applicable youth record contained the required signed consent form.

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

The program utilizes a classification system geared to promote safety and security in the program. Five reviewed case management records each contained an admission classification form. The admission classification form is used to determine the youth's living unit and room assignment based on the following: physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, suicide risk, medical risk, escape risk, and security risk. Reviewed documentation confirmed youth are reassessed and reclassified, 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. All five reviewed records reflected each youth was screened for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) prior to room assignment and was completed in the Department's Juvenile Justice Information System (JJIS). Each of the five youth records documented youth received a reassessment for activities monthly. An interview was conducted with the program's acting facility administrator (FA) indicated youth are placed in a living unit based on age group and results of their VSAB report. If a youth is vulnerable to victimization, then the youth would not be placed with a youth who is aggressive.

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 the identification and notification of youth with suspected criminal gang activity to local law enforcement. The program assesses each youth's involvement in or affiliation with gang activity when first admitted to the program. The program notifies local law enforcement and the youth's home county law enforcement of suspected gang involvement upon recognition. An alert is entered for gang members or associated gang members in the Department's Juvenile Justice Information System (JJIS). Five youth case management records were reviewed and two were applicable for youth gang involvement or association. An additional case management record with gang involvement or association was provided and reviewed. Each applicable case management record reflected local law enforcement was notified of the youth's suspected gang activity as required. The program shared the youth's gang status with the education department, the youth's juvenile probation officer, and the youth's post-residential counselor, if applicable.

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

The program has a written policy and procedures in place regarding gang member identification. Reviewed documentation confirmed the program has implemented gang prevention and intervention strategies. The program utilizes GANGS: 50+ Stories of Fractured Lives as the primary curriculum. Five youth case management records were reviewed and two were applicable. An additional case management record was requested and reviewed for gang prevention and intervention activities. Reviewed documentation confirmed the program maintains sign-in sheets to document youth participation in gang prevention and intervention activities, which was conducted at least once a month. Each of the youth's performance plans were reviewed and included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program.

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

The program has a written policy and procedures to ensure the Residential Assessment for Youth (RAY) is completed for all newly admitted youth. A review of five youth case management records each contained a RAY Assessment completed within thirty-days of the youth's admission to the program. Each of the initial assessments were maintained in the Department's Juvenile Justice Information System (JJIS). A copy of the RAY Assessment is also maintained in each youth's case management record. Two of the five reviewed records required and contained RAY Reassessments completed within ninety-days after the completion of the initial RAY Assessment. An additional case management record was requested and reviewed which contained a RAY Reassessment. The RAY Reassessment was not completed within ninety-days after the initial assessment and was completed seven days late. The program maintains all RAY Reassessment documentation in the youth's official case management record.

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

The program has a written policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is conducted within thirty days of each youth's admission into the program. A review of five youth case management records each contained a completed YNAS. Three of the

five youth's YNAS reports were completed within thirty-days of the youth's admission to the program while two were completed late. One was completed eight days late and the other was completed twenty-five days late. Reviewed documentation coupled with an informal interview with the regional compliance manager (RCM) reflected the program recognized the poor performance of the director of case management (DCM) and the DCM received formal disciplinary action and subsequently resigned from her position. The RCM advised the other case manager who completed the YNAS late received disciplinary action and has since improved. All five reviewed records reflected the YNAS being documented in Department's Juvenile Justice Information System (JJIS). The program maintains all YNAS documentation in the youth's official case management record.

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

The program has a policy and procedures for the youth's performance plan development, goals and transmittal. The program's intervention and treatment team, including the youth, meet and develop the youth's performance plan based on the initial assessments of the youth. Five youth case management records were reviewed. Three of the five performance plans were completed within the first thirty days of the youth's admission to the program, while two were late. One was completed five days late and the other was completed twenty-five days late. All five reviewed youth case management records documented each goal on the youth's performance plan specifying target dates for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal. A review of five youth case management records found four performance plans included the signature page which was signed by the youth, intervention and treatment team leader, and all parties who have significant responsibility in the goal completion while one did not contain signatures. One reviewed record reflected the youth's parent/guardian returned the signature page of the performance plan while the remaining four records documented the program attempted to receive the parent/guardian signature page; however, the parent/guardian did not send it back to the program. Four youth case management records contained a performance plan which included individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process while one reviewed record did not address the top three criminogenic needs as required. All plans contained specific delinquency interventions with measurable outcomes for the youth geared to decrease criminogenic risk factors and promote strengths, skills, and supports to reduce the likelihood of the youth reoffending. A review of each youth's court order indicated no additional court ordered sanctions were ordered by the committing court. Three of the five youth's performance plans included transition activities targeted for the last sixty days of the youth's anticipated stay. The other two

youth did not apply. All five youth records indicated within ten working days of the completion of the performance plan, the program sent a transmittal letter and a copy of the plan to the youth's the parent/guardian. Three of the five reviewed youth records indicated within ten working days of the completion of the performance plan, the program sent a transmittal letter and copy of the plan to the youth's the committing court, the youth's juvenile probation office (JPO), and the Department of Children and Families (DCF) counselor, if applicable.

Reviewed documentation coupled with an informal interview with the regional compliance manager (RCM) indicates the program recognized the poor performance of the director of case management (DCM) and the DCM received formal disciplinary action and subsequently resigned from her position. The RCM advised the other case manager involved with these plans received disciplinary action and has since improved. Five youth were interviewed and four reported they participated in the development of their performance plan, were provided a copy of their plan, and knew their current performance plan goals while one youth reported no knowledge of their plan. Reviewed documentation of this youth's case management record reflects the youth's signature on the performance plan confirming participation in the development and receipt of a copy of the plan.

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

The program has a written policy and procedures in place regarding the revision of each youth's performance plan. Revisions are based on the Residential Assessment for Youth (RAY) reassessment results, newly acquired/revealed information, and demonstrated progress or lack of progress toward completing a goal. A review of five youth case management records was conducted and reflects each youth's performance plan received applicable plan revisions as required. A review of three closed youth case management records indicated, based on the transition conference, the intervention and treatment team revised the youth's performance plan, as needed, to facilitate transition activities targeted for completion during the last sixty days of the youth stay in the program.

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

The program has a written policy and procedures in place regarding performance summaries and the transmittal of performance summaries. Five youth records were reviewed and two were applicable. An additional record was provided; the three applicable youth case management records were reviewed. Reviewed documentation reflected performance summaries were completed every ninety-days and were signed by the required parties. All performance summaries included the status on each youth's performance plan goal, the overall treatment

progress of their treatment plan, academic status, behavior, level of motivation/readiness to change, interaction with peers/staff, overall behavior adjustment to the program, and significant positive and negative events. Each of the youth were given the opportunity to review and add comments prior to signing, and each youth was provided a copy of the Performance Summary. All original summaries were maintained in the youth case management record. Each case management record documented a copy of the Performance Summary being sent to the committing court, youth's juvenile probation officer (JPO), and parent/guardian within ten working days.

Three closed case management records were reviewed and were applicable for release summaries. Reviewed documentation reflected each of the three contained the original release summary, along with justification for release sent with the Pre-Release Notification (PRN) to the JPO and each case management record contained a signed copy. The youth's committing court did not object to any of the youth being released from the program. All three closed management records provided written notification to the youth's parent/guardian of the youth's planned release once the PRN was approved and a Residential Assessment for Youth (RAY) Exit Assessment was completed. None of the reviewed case management records were applicable for the Sexually Violent Predator Program (SVPP) and none required a release letter of notification to the victim. Each of the three closed youth case management records documented the program provided the JPO with the Performance Summary, transition plan, and any psychological/psychiatric reports completed while the youth was in the program. Five youth were interviewed. Four youth reported receiving a copy of the Performance Summary sent to the court while one youth 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 encourages and facilitates involvement of the youth's parent/guardian in the case management process. The parents/guardians are invited to participate in the Residential Assessment for Youth (RAY) Assessment, development of the youth's Individualized Performance Plan, progress reviews, and applicable transition planning. Five case management records were reviewed, and each contained letters to parents/guardians for assessments, formal treatment team meetings, and transition planning. Parents/guardians are able to participate by way of telephone communication with the program staff. Five interviewed youth each confirmed their parents/guardians are involved in their case management. An interview was conducted with the program's acting facility administrator (FA) where he reported parents/guardians are invited to participate in youth treatment team meetings, weekend visits, and family activities. The program sends each family unit an input form prior to classification. The program sends a survey to parents/guardians upon each youth's admission. During Family Day events, families are encouraged to complete a family survey.

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

The program has a policy and procedures in place which addresses the members of the treatment team and the treatment team process. A review of five youth case management

records reflected treatment team included, at minimum, the youth, an administrative representative, a living unit representative, treatment staff, educational staff, the youth's juvenile probation officer (JPO), and parent/guardian. Additionally, members of treatment team included medical staff, the clinical director, and the director of case management. When applicable, a Department of Children and Families (DCF) case worker, gang prevention specialist, and transition services manager participate as well. There were no applicable youth receiving services form the Agency for Persons with Disabilities (APD). Reviewed documentation confirmed the youth's JPO, parent/guardian, and any other pertinent parities were invited and were encouraged to participate through advance notification to participate in treatment team meetings and if participation could not be arranged, allow them the opportunity to provide verbal/written input. Reviewed documentation confirmed formal treatment team meetings were conducted for each youth on a monthly basis. Observations made of a treatment team meeting during the annual compliance review confirmed active participation by all required staff and parties.

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 requiring additional treatment plan information be referenced and/or incorporated in the youth's Individualized Performance Plan. Five reviewed case management records indicated each youth's Individualized Performance Plan incorporated an academic progress monitoring plan and mental health treatment plans. There were no applicable youth requiring a Department of Children and Families (DCF) care plan nor were there any applicable youth receiving services from the Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	**Satisfactory Compliance**
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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 written policy and procedures in place regarding formal and informal treatment team meetings. Five youth case management records were reviewed. Four youth records indicated formal treatment team reviews were conducted at least every thirty days while one did not. Informal meetings were held with each youth bi-weekly to review each youth's performance. Each of the formal reviews were documented in the youth's case management record and included the youth's name, date of review, any comments from treatment team members, and brief synopsis of the youth's progress in the program. The formal review also included performance plan revisions, progress on performance plan goals, positive and negative behaviors, and behaviors resulting in physical interventions. Each youth is provided an opportunity to demonstrate skills acquired in the program and review their treatment progress. Residential Assessment for Youth (RAY) Reassessment results were also reviewed and treatment plan goals were revised when applicable. An observation of a formal treatment team was made during the annual compliance review which confirmed the youth and all required staff were present. The youth's progress on Individualized Performance Plan goals were discussed along with positive and negative behaviors and treatment progress. All members were actively

participating in the meeting and the youth was provided an opportunity to demonstrate skills acquired in the program. Each treatment plan documented the youth's anticipated release date. The Department's Juvenile Justice Information System (JJIS) reflected the anticipated release date was updated every ninety days and at the sixty-day transition conference. Five youth were interviewed. Four of the five youth indicated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program while one said they did not.

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

An interview with the program's lead educator confirmed the educational component of the program, which is under the direct supervision of the Miami-Dade County School District, is a Type 3 vocational programming which instructs accountability and behavior skills leading to appropriate work habits for employment and standards for positive living. The curriculum addresses the improvement of interpersonal communication skills, decision-making and learning skills, as well as strengthening the youth's literacy proficiency which, in turn, enables the youth to explore career choices and the skill set which is required of them. This curriculum is age appropriate for the youth who are served in the program and is appropriate for the educational abilities and length of stay of the youth. Three closed youth case management records were reviewed and reflect two of the three containing documentation of a social security card, birth certificate, and state identification card, which are essential for gaining employment. The one record did not contain the three previously mentioned documents but rather completed applications for the birth certificate, social security card, and state identification card. Each of the completed applications were signed by the youth as well as representatives from the program. Each reviewed record contained completed résumés, samples of applications for employment, as well as a post-release calendar of appointments which also detailed the location of a local Career Source Center. Each record included documentation signed by the youth's parent/guardian and juvenile probation officer signifying their awareness of the post-release vocational plan of the youth. An interview conducted with the program's lead educator and acting facility administrator (FA) confirmed this practice.

2.17 Educational Access	Limited 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's education component is under the direct supervision and management of the Miami-Dade County School District to provide educational services to the youth in the program. As such, both the school district and the program require the youth to participate in educational and career related programs for 250 days of instruction distributed over twelve months of the year for a minimum of twenty-five hours a week. A review of the program's daily academic/vocational schedule documented educational hours are from 8:00 a.m. until 11:25 a.m. and following lunch and a teacher curriculum planning period, which allows for on-site activities and testing, the classes resume from 1:00 p.m. until 2:40 p.m. A review of six randomly selected days/entries in the program's logbooks was conducted. Although the inspection revealed very minimal interruption to the education services, the entries reflected during these six days, the youth were arriving to class late. The tardiness of the youth primarily occurred during the school's first period. The lost amount of class time reflected by start times in the logbooks ranged from nine to twenty-three minutes. The program administration reported

the reason youth were late to their first period class was due to medication pass. Interviews conducted with the lead educator and acting facility administrator (FA) revealed the classes are conducted with minimal interruptions with the rarity of youth being either disruptive or combative. Five youth were interviewed. Four of the five reported there are not many interruptions during school, while one youth reported there is frequent interruptions. The one youth further explained staff walk in the classroom while it is going on and finds this disruptive.

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 purpose of the transition plan is to prepare the youth to successfully function as a member of the community post-release. Three reviewed closed records each contained a detailed transition plan. Each plan was created upon the youth's admission to the program was based upon the youth's specific goals during their stay at the program and included their post-residential goals, whether they contained a continuation of their education or goals to become employable. Each plan identified key individuals related to the transition activities which included the youth, the youth's parent/guardian, the program's educational representative, post-release staff, the youth's juvenile probation officer (JPO), and a certified school counselor from the school district of which they are returning to. Each transition plan included an exit portfolio, which contained industry certifications, a schedule of post-release appointments with identified parties such as Career Source, as well with other parties which are directly related to the youth's transitional plan goals. Included in the portfolios were a detailed educational/social review which identified post-release goals and providers to address such needs. These identified plans, which included educational/vocational records and transcripts, were transmitted to both the youth's parent/guardian and JPO upon the release from the program.

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

The program has a written policy and procedures addressing transition planning. Three closed youth case management records were reviewed. Reviewed documentation indicated a transition conference was held at least sixty days prior to each youth's targeted release date. The transition conference was attended by the youth, treatment team leader, clinical staff, medical staff, and education staff. The youth's parent/guardian and juvenile probation officer (JPO)

participated by telephone. The youth's JPO, parent/guardian, education staff, and other pertinent parties were invited to provide written input if they were unable to participate in person.

All reviewed records confirmed a review of transition activities on the youth's performance plan. Each reviewed record identified additional transition activities, target completion dates, and the person responsible for the completion of the transition goals. Reviewed documentation validated all participants in attendance signed the transition plan. A copy of the transition plan was sent to the youth's JPO. The program provided documentation reflecting the Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release. The youth and their case manager participated in the CRT meeting. A review of the probation case notebook module indicated all other required parties participated in the CRT meeting.

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

The program has a written policy and procedures in place to address the development of youth Exit Portfolios. Three reviewed closed youth case management records each contained Exit Portfolios, as required. All three records contained documentation reflecting the Exit Portfolio was discussed and started at or prior to each youth's transition conference. One Exit Portfolio contains state-issued identification card. Each of the three Exit Portfolios included a copy of the youth's transition, a calendar with all dates/times/locations of upcoming community appointments, social security card, birth certificate, educational and/or vocational certificates, school transcripts, résumé, and a sample job application. Reviewed documentation confirmed each youth's Exit Portfolio was verified upon the youth's Exit Conference and was completed and given to the youth upon their release from the program. Program staff forwarded the exit portfolio information to each youth's juvenile probation officer (JPO) and was documented in the youth's case management record. Youth were provided completed forms and clear instructions as to how to obtain the information. During the transition conference, all applicable staff were identified to assist the youth in obtaining the required information to assist with successful completion of program goals upon discharge from the program.

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

The program has a policy and procedures addressing the Exit Conference. A review of three closed youth case management records documented the Exit Conference was conducted after the program notified the youth's juvenile probation officer (JPO) of their release and was conducted within fourteen days prior to the release of each youth. Documentation in each reviewed case record included the date, signatures (names if by telephone), and a summary of any pending transition goals. The date of admission and the date of termination documented in the youth record correlated with the Department's Juvenile Justice Information System (JJIS) for each record reviewed. Participation in each Exit Conference included the program's treatment team leader, education representation, parent/guardian, JPO, youth, and other applicable parties. Each Exit Conference was held separate from the Transition and Community Re-Entry Team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program maintains a policy and procedures ensuring the provision of mental health/substance abuse services to the youth. The program has a full-time licensed mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA). The DMHCA's schedule is Monday through Friday from 9:00 a.m. to 5:30 p.m. and occasionally on Saturdays and Sundays. The DMHCA is responsible for the coordination and implementation of all the mental health and substance abuse services provided by the program including fidelity checks of group therapy, ongoing and weekly supervision of clinical staff, facilitating training, making recommendations for youth presenting with suicidal ideation, and/or crisis management. An interview was conducted with the DMHCA indicated they personally ensure group therapy, individual therapy, family therapy, and crisis interventions are completed. The DMHCA indicated they are responsible for facilitating Living in Balance substance abuse groups weekly and audits treatment records to ensure documentation is completed in a timely manner. Furthermore, the DMHCA actively participates in multidisciplinary treatment team meetings and provides clinical supervision to program therapists in a face-to-face setting on a weekly basis to ensure the program's clinical treatment programming complies with all requirements outlined within the specialty services guidelines for intensive mental health services. The DMHCA indicated the program offers intensive mental health treatment services to all youth in the program. The DMHCA confirmed being on-call twenty-four hours a day and is scheduled to be on-site Monday through Friday for a minimum of forty hours each week. A review of the DMHCA's licensure reflected a clear and active license in the State of Florida as verified on the Florida Department of Health website. The DMHCA's current license expires March 31, 2021. In addition, the DMHCA indicated they meet weekly with the psychiatrist to discuss each youth's progress, meets with the clinical staff weekly for clinical supervision, and meets daily with the clinical staff to receive ongoing debriefings related to what occurred during each day with each youth in the program.

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 maintains a policy and procedures ensuring a there is a licensed clinician on staff and the provision of mental health and substance abuse services to the youth. The program has

two full-time licensed mental health counselors (LMHCs), one of which serves as the program's designated mental health clinician authority (DMHCA). A review of the second therapist's license revealed a license expiration date of March 31, 2021. The second LMHC's schedule is Monday through Friday, 9:00 a.m. to 5:00 p.m. and covers on the weekends on an as-needed basis. In addition, the program has an independent contractor agreement with a State of Florida board-certified licensed psychiatrist. A review of the psychiatrist's license indicated a license expiration date of January 31, 2021. The program has a part-time clinical psychologist who works two hours a week, or as needed. A review of the psychologist's license revealed it expires on May 31, 2020. All licenses were found to be clear and active in the State of Florida as verified on the Florida Department of Health website. Reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. Reviewed documentation supported each licensed staff maintained a job description and/or agreement identifying the position's expectations and essential functions. The program does not currently have a Department of Children and Families (DCF) license as the building has not passed a fire inspection; however, a licensed staff is providing substance abuse services in lieu of the DCF license.

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

The program has two master's-level non-licensed mental health and substance abuse therapists at the time of the annual compliance review. One is a full-time therapist and the other is a part-time therapist. Both therapists received the required education, training, and experience to perform their assigned duties. The two non-licensed therapists conduct group therapy, individual therapy, family therapy, counseling services, assessments, and provide mental health and substance abuse services under the direct supervision of one of the two licensed clinicians. Interview with the designated mental health clinician authority (DMHCA) indicated the two licensed therapists provide substance abuse treatment services to the youth. Reviewed documentation supported each non-licensed therapist received face-to-face clinical supervision each week conducted in face-to-face setting. In addition, they participated in the treatment team meetings. The designated mental health clinician authority (DMHCA) meets with the clinical staff weekly to provide clinical supervision, discuss youth-specific clinical issues, and to ensure documentation and deadlines are met. Reviewed supervision logs contained documentation of caseload reviews including a review of case history to include specific information related to youth progress, treatment needs and goals, caseload directions, instructions, and recommendations. The program's DMHCA assures the non-licensed clinical staff works under her direct supervision and are qualified based on their education, training, and experience. A review of the program's mental health and substance abuse profile indicated the program has a new third non-licensed therapist who is currently receiving training. The program has a certified behavioral analyst (CBA) as well as a recreational therapist who works under the DMHCA's clinical supervision. Reviewed documentation found the program's behavior analyst received her behavior analyst board certification on January 31, 2011. The program does not have any psychiatric advanced practice registered nurse (APRN), volunteers, or interns for mental health or substance abuse. A review of the two non-licensed mental health therapists who conduct Assessments of Suicide Risk (ASR) confirmed each received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and

emergency mental health services. Their training included the administration of five ASRs conducted in the physical presence of a licensed mental health professional documented on the Department's Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. Each non-licensed staff's position classification descriptions were reviewed and revealed the program has an agreement with Adapt and Transform Behavior for the provision two CBAs. An interview was conducted with the CBA and reviewed documentation found each applicable referred youth had a behavior analysis services plan in place which includes reasons for the referral as well as evaluation procedures, background information, goals of intervention, replacement behaviors, skill acquisition procedures, target problem behavior procedures, and recommendations for monitoring and evaluation procedures.

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

The program has a policy and procedures to address the screening of mental health and substance abuse needs of youth admitted into the program. The policy dictates the administration of Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen youth upon admission. The MAYSI-2 is also utilized for any youth readmitted into the program. Additionally, the program policy dictates each youth is to be issued an Assessment of Suicide Risk (ASR) and Victimization and Sexually Aggressive Behavior (VSAB) screenings to gain a comprehensive understanding of each youth upon admission. The program ensures each youth's mental health and substance abuse needs are identified through the screening process which includes suicide prevention.

All youth are administered the MAYSI-2 at the time of admission to ensure the proper identification of mental health and substance abuse issues requiring immediate attention, assessment, and/or evaluation are addressed. Each MAYSI-2 is administered by a case management staff trained in the Department's Juvenile Justice Information System (JJIS). The program conducts further evaluation of each youth admitted regardless of the MAYSI-2 results. Reviewed documentation reflected the program's clinical staff reviews all available information received in each youth's commitment packet, records, reports, and other documentation regarding the youth's prior mental health and substance abuse issues, as documented on the intake chronological sheet forms found in each youth's record. The program's suicide risk screening process includes an initial evaluation of the youth upon intake utilizing the Department's ASR form. A review of five youth mental health and substance abuse records confirmed each youth received a MAYSI-2 on the day of their admission which was completed in JJIS. Each youth received an ASR and a new comprehensive mental health and substance abuse bio-psychosocial evaluation. A review of the youth's ASRs indicated each youth was placed on standard supervision. In addition to the MAYSI-2, each youth is assessed upon admission to the program utilizing the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-2), the Trauma Symptom Checklist for Children (TSCC), and clinical mental health and the substance abuse intake screening. An interview with the designated mental health clinician authority (DMHCA) confirms a classification meeting is held for each youth upon admission to the program. Within the classification meeting, the findings of the MAYSI-2, reviewed records, VSAB, ASR, and the initial interview process are reviewed. The program's nurse completes a urine drug screening as a part of the process to assist in determining the youth's substance use prior to admission to the program. In addition, a juvenile probation officer (JPO) intake

telephone call is conducted. An interview with the program's acting facility administrator (FA) found the youth are evaluated by a mental health therapist. If the therapist identifies the youth meets the criteria to be placed at a different supervision level, the applicable internal alert is updated, and the youth's level of supervision remains until removed by a licensed professional.

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

The program maintains a plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan for the delivery of mental health and substance abuse services for the youth includes the admission of a variety of assessments, youth record review, tailoring of an initial treatment plan, and the issuing of a referral for each youth to receive a comprehensive evaluation to be completed within thirty days of admission.

Due to the specialized population of youth admitted to the program, the youth automatically are referred for a comprehensive mental health and substance abuse evaluation. Following the admission process, if a youth exhibits behaviors or need an in-depth evaluation, the assigned therapist initiates a referral for assessment, which is documented on the Mental Health/Substance Abuse Referral Summary form. A comprehensive in-depth bio-psychosocial mental health and substance abuse evaluation was completed by the assigned therapist, trained to complete evaluations, working under the direct supervision of a licensed professional, with the youth, parent/guardian, Department of Children and Family (DCF) when applicable, and other parties involved in the youth's care. The assigned therapist obtains information through interviews, face-to-face sessions, and records review processes. Instead of updating evaluations, the program conducted a new evaluation for each youth within thirty-calendar days of admission. The licensed professional is responsible to review each comprehensive mental health and substance abuse evaluation and review, approve, and documented the treatment recommendations based upon the findings of the review. Each new evaluation included demographic information, reason for the evaluation, relevant background information, behavioral observations, Mental Status Examination, procedures, discussion of findings, diagnosis impressions including Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) diagnosis, and recommendations for mental health, substance abuse, psychiatric services, transition services, and any other applicable recommendations. Each reviewed mental health evaluation was inclusive of a substance abuse assessment. The program provides outpatient substance abuse assessment and treatment services. Each reviewed record contained the appropriate signed consent for release of substance abuse treatment records, youth consent for substance abuse treatment, and consent for urine collection and analysis.

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

The program has a written policy and procedures in place to establish a method in which substance abuse services are provided to all youth in the program. The program has a comprehensive plan for mental health and substance abuse services which was revised, reviewed, approved, signed and dated by the designated mental health clinician authority and the program's psychiatrist on February 24, 2020. The program provides on-site mental health and substance abuse treatment through the provision of intensive mental health treatment services. The program's treatment team is responsible for assisting in developing, reviewing, and updating the youth's initial and individualized mental health and substance abuse treatment plans. A review of five youth's mental health and substance abuse records confirmed each admitted youth is assigned to a multidisciplinary intervention and treatment team upon her arrival to the program. Reviewed treatment team documentation found the team included the youth, program administration, residential living unit, parent/guardian, when applicable, and any other staff responsible for delinquency intervention and treatment services for the youth. Each youth had an initial treatment plan completed by the treatment team on the day of their admission which identifies the youth, parent/guardian, therapist, and other treatment team members. The treatment team assists the youth's primary therapist in the development, review, and revisions of the youth's initial treatment plan as well as their individualized mental health and substance abuse treatment plan. All youth in the program received the clinical services required by the specialized intensive mental health treatment services documented in Attachment II of executed contract with the Department.

A review of five mental health and substance abuse records and five youth case management records confirmed each youth had a properly executed Authority for Evaluation and Treatment (AET) form, a signed Youth Consent for Substance Abuse Treatment form and Youth Consent for Release of Substance Abuse Treatment Records form, when applicable, and mental health/substance abuse weekly progress notes. A review of the program's Standardized Program Evaluation Protocol indicated the primary services identified for the program are the Voices: A Program of Self-discovery and Empowerment, Teen Relationships, and Thinking for a Change (T4C). Group work at the program is conducted daily for at least sixty minutes and is facilitated by the on-site therapists and licensed mental health professionals during regular programming seven days a week. A review of the program's schedules and contract coupled with an interview with the designated mental health clinician authority (DMHCA) confirmed the program consistently provided youth with the following evidence-based delinquency interventions and mental health and substance abuse treatment group sessions based on curriculums designed for juvenile offenders: Seeking Safety, Living in Balance, Voices: A Program of Self Discovery and Empowerment; SAVVY Sisters, Dialectical Behavior Therapy (DCT) Group Skills Manual for Teens and Adults, Impulse Control, Don't Let Your Emotions Run Your Life for teens, T4C, and Impact of Crime (IOC). Reviewed documentation reflected the program has not been providing the Toward No Drugs groups since the program has not had

the amount of youth applicable to conduct this group. Five staff were interviewed, each confirmed the program's therapists facilitate the mental health and substance abuse groups. Five interviewed youth each confirmed they participate in groups and received individual specialized therapies.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The program identifies the mental health and substance abuse needs of youth through a comprehensive screening process which ensures referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk. Upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by treatment staff to ensure the identification of the issues requiring immediate attention and an initial or individualized mental health or substance abuse treatment plan is completed. The program provides specialized mental health and substance abuse treatment services through the provision of intensive mental health treatment. Treatment services are provided at the program by or under the direct supervision of the licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). Upon release from the program, all youth have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for continued mental health and/or substance abuse services.

A review of five active youth mental health and substance abuse records found each youth has an initial mental health and substance abuse treatment plan which includes all the required elements. Each initial plan was developed within seven days of the onset of treatment or for youth prescribed a psychotropic medication within seven days of the initial psychiatric diagnostic interview. Each initial plan was signed by the person completing the plan, the DMHCA, and all members of the treatment team within ten days of completion. In addition to the initial plan, each reviewed youth mental health and substance abuse record contained an individualized treatment plan developed within thirty days of admission. If treatment began after admission, the plan was completed within thirty days of the initiation of treatment. Each plan was signed and dated by the mental health/substance abuse clinician completing the plan and all treatment team members who participate in the development of the plan. Each individualized plan includes psychiatric services, medication, and frequency of monitoring by the psychiatrist, when required. In addition, each reviewed youth record contained individualized treatment plan reviews conducted at a minimum of every thirty days following the development of the individualized treatment plan.

A review of the progress notes within the youth records confirmed the youth receive the services listed in the treatment plan. A review of five youth mental health and substance abuse closed records found each contained a complete discharge plan documented on the Department's

Mental Health/Substance Abuse Treatment Discharge Summary form, which was available during each youth's exit staffing. Documentation reviewed found the primary therapist is responsible for completing the mental health/substance abuse treatment discharge summary. The issues and the focus of the treatment were identified as well as the summary of the youth's progress in treatment while participating in the program. Each reviewed discharge summary documented the beginning and ending diagnosis with the presenting symptoms. There were no applicable youth released with an identified suicide risk alert. Each reviewed discharge summary contained clear recommendations for the continuation of the mental health and/or substance abuse treatment, services needed within their home along with applicable referrals for continued services, and documentation of the youth and parent/guardian's participation. The program's practice is to provide a copy of the discharge plan to the youth, parent/guardian upon release, and to the assigned juvenile probation officer.

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

The program has a policy and procedures to address the provision of mental health and substance abuse services, which includes specialized intensive mental health treatment services. A review of the program's contract and clinical program description found the program provides intensive mental health treatment services to all youth in accordance with Florida Administrative Rules 63 M-2 and 63 N-1.

Intensive mental health treatment services are provided to youth with serious to severe mental disturbance whose level of impairment and maladaptive behavior impedes their ability to function in a general offender program. All specialized intensive mental health treatment services in the program are provided by licensed and master's-level therapists. Clinical services provided by the program include mental health and substance abuse evaluations, mental health treatment planning, individual therapy at least one day a week, group therapy seven days a week, family therapy, daily mental health support services including skills training, support groups and psycho-education, mental health crisis intervention, and on-site psychiatric services with twenty-four-hour capability.

The program maintains a written comprehensive plan for mental health and substance abuse services which was revised, signed, and dated by the licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) and the psychiatrist on February 24, 2020, to establish the coordination of mental health and substance abuse services for all youth. The group therapy services provided to the youth include Thinking for a Change (T4C), Impact of Crime (IOC), Living in Balance, Towards No Drugs Abuse, Seeing Safety, Voices: A Program of Self Discovery and Empowerment, SAVVY Sisters, Impulse Control, Don't Let Your Emotions Run Your Life for Teens, and Dialectical Behavioral Therapy (DBT) Skills Manual for Teens and Adults. The program provides substance abuse prevention and education groups to all youth. Youth are encouraged to practice pro-social skills, family involvement, and effective treatment team participation. In addition, the program offers Standardized Program Evaluation Protocol (SPEP) groups. The program maintains an independent contract agreement with a part-time certified behavior analyst (CBA) to supplement mental health services. An interview completed with the DMHCA confirmed the program's practice. An interview was conducted with the program's acting facility administrator (FA) where he confirmed the program provides specialized treatment services and gender-responsive services utilizing the Girls

Matter curriculum, which is tailored to the unique needs of the population. Gender-specific treatment areas address histories of sexual abuse, substance abuse, domestic violence, trauma, and crime specific topics.

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 to regulate the provision of mental health and substance abuse services to included psychiatric services for applicable youth. The program has an independent contract agreement with a licensed psychiatrist who maintains a clear and active license with the State of Florida for the provision of psychiatric services to all applicable youth in the program. The psychiatrist is board certified in psychiatry by the American Board of Psychiatry and Neurology and is a controlled substance prescriber. The psychiatrist is on-site weekly for a total of four hours to provide psychiatric evaluations, monitor medication management, regular consultation, and emergency consultation with the facility administrator and designated mental health clinician authority (DMHCA).

The psychiatrist informed the treatment team regarding youth needs and progress while providing psycho-pharmacological therapy to the youth. A review of the psychiatrist's attendance sign-in log sheets validated the psychiatrist is attending the program as required and is on-call for consultation twenty-four hours a day, seven days a week. All youth receive an initial psychiatric evaluation and monthly comprehensive psychiatric evaluation completed on the Department's Clinical Psychotropic Progress Note (CPPN). The program's practice is to refer all youth for an initial psychiatric evaluation, regardless of their medication status. The psychiatrist documented medications prescribed as well as the medication name, dosage, frequency, diagnosis, side effects, and dosage range on each CPPN.

An interview with the psychiatrist indicated he meets with the DMHCA and the facility administrator weekly to exchange youth's clinical information, treatment, and to ensure sustainability. A review of five active youth mental health and substance abuse records found each youth was referred upon admission to the psychiatrist for an evaluation. Youth on psychotropic medications are evaluated monthly. The psychiatrist and the DMHCA meet weekly to discuss and review each youth receiving psychotropic services, their progress, and follow-up treatment. The psychiatrist contacted each youth's parents/guardians to obtain permission or discuss issues, as needed.

A review of the five youth mental health records revealed each contained a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnostic psychiatric evaluation which included the youth's medical history, mental status evaluation, treatment recommendations, prescribed medications, explanation for the need of psychotropic medication, and the frequency of monitoring their medication. Each initial diagnostic evaluation was documented on the CPPN, contained page number three of the CPPN, and clearly documented treatment plan discussion with the youth and their parent/guardian. Four of the five youth entered the program with psychotropic medications; however, they did not require any changes to their medication after admission. Each of these four youth received an initial psychiatric

interview within fourteen days following the youth's admission. Reviewed documentation reflected each of the applicable youth were seen by the psychiatrist at a minimum of every thirty days. An interview with the psychiatrist confirmed this practice. The program does not use the assistance of a psychiatric advanced practice registered nurse (APRN). Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications.

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

The program maintains a written policy and procedures regarding the suicide prevention plan to establish the method in which suicide prevention services shall be provided to all youth at the program. The program has a suicide prevention plan which details their suicide prevention procedure. The plan is reviewed annually and was last updated, signed, reviewed, and approved by a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) on April 25, 2019. The program's written plan details suicide prevention procedures and includes identification, assessment, suicide precautions, levels of supervision, procedures for use of Precautionary Observation, procedures for use of Secure Observation, serious suicide attempt or serious self-inflicted injury review, and mortality review, as outlined in Florida Administrative Code 63N-1. An interview with the DMHCA indicated the program provides suicide prevention training throughout the year and conducts monthly mock emergency mental health drills to include emergency response to suicide attempts and/or self-inflicted injury.

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

The program has a policy and procedures to address the provision of mental health and substance abuse services which includes suicide prevention services. All program staff receive training on suicide prevention which consists of a thorough review of the program's suicide prevention plan and includes techniques, behavioral cues, and recommended responses. All required monitoring protocols are explained in detail with ample cases and practices developed within the training sessions including rapid identification, referral, screening, and assessment of youth having suicide risk factors upon their intake to the program.

The program assesses each youth utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Assessment of Suicide Risk (ASR). Youth identified with an elevated suicide risk are placed on Precautionary Observation (PO) until they are evaluated by

the licensed designated mental health clinician authority (DMHCA) or the other program's licensed clinician. Reviewed documentation confirmed each youth placed on PO remained on constant supervision until a Follow-Up ASR was completed and the youth was stepped down to close supervision. A Mental Status Examination was conducted prior to stepping each youth down to standard supervision. Mental health therapists provided supportive counseling as documented on the suicide PO logs. A review of five youth mental health and substance abuse records supported one was applicable for Secure Observation (SO). The program provided three additional applicable youth records for review to meet the minimum sample size. A review of four applicable youth records supported prior to placement on SO, the placement was authorized by the facility administrator/designee and the DMHCA.

The secure room was designated in writing and a Health Status Checklist was completed prior to placement. The program documented a staff member of the same gender conducted a visual check of the youth to determine if there were any observable injuring which would make placement in the SO inappropriate. Reviewed documentation supported the SO room was inspected prior to the youth's placement ensuring it was safe and secure. Each youth was maintained on constant supervision. Suicide Precaution Observation Logs were maintained for each youth during their stay and were completed in full. A Follow-Up ASR was completed for each youth within eight hours of placement in SO and all four youth were removed within twenty-four hours of placement after consultation with the DMHCA and the facility administrator. Documented practice supported mental health staff provided supportive counseling to each youth during their placement in SO. Each completed ASR and Follow-Up ASR was reviewed by the DMHCA. Discontinuation of suicide precautions and step-down supervision was documented as required.

The program has an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization, medical treatment, and a mortality review for a complete suicide. The program maintains three complete suicide response kits located in master control, operations office, and the multi-purpose conference room office. Each kit is secured and inaccessible to youth. Each kit was observed and contained the knife-for-life, wire cutters, needle nose pliers, one-way cardiopulmonary resuscitation (CPR) mask, face shield, and non-latex gloves. Reviewed training records for the non-licensed therapists validated each completed the required twenty hours of training and five supervised ASRs completed under the direct clinical supervision and presence of one of the two licensed mental health clinicians. Five staff members were interviewed and indicated if a youth expresses suicidal thoughts, the direct care staff is responsible to notify a mental health staff, search the youth and room for sharp objects, place youth on sight and sound supervision, and document the supervision. Each of the interviewed staff was aware of the locations of the suicide response kits throughout the program.

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

The program maintains a written comprehensive plan for mental health and substance abuse services as well as a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risks of suicide in the least restrictive means possible. Reviewed documentation confirmed the program has a Precautionary Observation (PO)/Secure

Observation (SO), mental health alert, and Baker Act tracking system in place which was signed and dated by the designated mental health clinician authority (DMHCA) and the facility administrator (FA) in February of 2020. A review of five applicable youth mental health and substance abuse records found all were applicable for PO. The reviewed Suicide Precaution Observation Logs found each was maintained for the duration the youth was on suicide precautions; however, the logs were inconsistent in the identification of safe housing areas on the program logs for youth on PO and were inconsistent in the use of real time for the documentation of the observation of youth behavior on the PO logs reviewed. Each shift supervisor and mental health staff signed the logs daily, as required. Two youth who were on suicide precautions, at the time of the annual compliance review, were interviewed and both reported they were never left alone while on PO.

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.	

Reviewed training documentation confirmed all staff receive training on suicide prevention. The training consists of a thorough review of the program's suicide prevention plan and includes detection techniques, behavioral cues, and recommended responses. A review of five mental health staff training records and mock suicide drills showed each mental health staff completed the required six hours of annual suicide prevention training and participated in mock suicide drills at least quarterly. All completed drills included the use of life saving measures including the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED). A review of the program's mock suicide and mental health drills supported all were conducted on each shift quarterly, as required. Each reviewed drill documented a description of the incident, a synopsis of the response, involved staff, and any applicable deficiencies and/or corrective action. An interview was conducted with the acting facility administrator (FA) and indicated the program completes drills once a month 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 maintains a written policy and procedures regarding the crisis intervention plan to establish the method of crisis intervention services which will be provided to all youth. The program has a written crisis intervention plan which was approved, signed, and dated by the program's designated mental health clinician authority on April 25, 2019 and is reviewed annually. The plan details crisis intervention procedures to include a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review process. The program's practice is to submit a mental health/substance abuse referral summary to the mental health staff for any youth demonstrating acute emotional or psychological distress and/or self-injurious behavioral issues to receive crisis assessment, intervention, and counseling.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the 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.	

A review of five youth mental health and substance abuse records revealed three were determined to be in crisis and each confirmed the mental health clinicians conducted a Crisis Assessment on the youth each day. A mental health referral is generated and the Department's Juvenile Justice Information System (JJIS) is updated at this time. Once the youth has been determined to not be in crisis, the JJIS alert is closed. Each conducted Crisis Assessment included all the required elements. Each youth was transitioned to close supervision and standard supervision as required and the JJIS alert was closed. Each completed Crisis Assessment included the reason for the assessment, Mental Status Examination and interview, determination of danger to self/others, initial clinical impressions, supervision recommendations, and treatment recommendations. In addition, each Crisis Assessment documented recommendations for follow-up and notification to the youth's parent/guardian of follow-up treatment. In two of the three cases, the youth were alleged victims in a Prison Rape Elimination Act (PREA) event and were offered ongoing mental health treatment services consistent with the prescribed level of care. The crisis assessments were conducted immediately for all three youth and the Department's Central Communications Center was notified within the required timeframe for both applicable PREA events. These investigations were ongoing during the annual compliance review.

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 maintains written policy and procedures regarding an emergency care plan to establish a method in which emergency mental health and substance abuse services will be provided to all youth. The program has a written emergency mental health and substance use services plan which was last revised, signed, and approved by the designated mental health clinician authority (DMHCA) on April 25, 2019. The program's emergency plan included procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health and substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 (Marchman Act), documentation, training, and review. The plan contained all the elements required by Florida Administrative Code 63E-7 and 63N-1. All the program staff are required to be certified in first aid, cardiopulmonary resuscitation (CPR), and automated external

defibrillator (AED). All program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. An interview conducted with the program's DMHCA revealed the program utilizes Jackson Memorial Hospital for crisis stabilization.

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

The program has a policy and procedures regarding youth who require Baker or Marchman Act services while in the program. Reviewed documentation confirmed the program has a Precautionary Observation/Secure Observation, mental health alert, and Baker Act tracking system in place signed and dated by the designated mental health clinician authority (DMHCA) and the facility administrator (FA) in February of 2020. A review of five youth mental health and substance abuse records found none were applicable for Baker Act in the scope of this annual compliance review. Three additional records were provided and reviewed. Three closed youth mental health and substance abuse records applicable to Baker Act indicated each youth was placed on supervision for the entire time since the discovery, each youth was placed on one-to-one supervision, mental health staff were involved, and each youth was taken out of the program by the DMHCA. Upon return to the program, each youth was placed on constant supervision and a Mental Status Examination (MSE) was conducted. In addition, an Assessment of Suicide Risk was completed by a licensed mental health professional and each youth was maintained on constant supervision until properly transitioned to a lower level of supervision. None of the youth's supervision levels were lowered until the required assessment was conducted by one of the licensed clinicians and the mental health staff confers with the FA or designee. There were no youth in the program applicable to Marchman Acts during the scope of this annual compliance review.

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 maintains a written policy and procedures ensuring the designated health authority (DHA) is responsible for the overall administrative and appropriate clinical healthcare services provided to youth. The program maintains a current independent contractor agreement with the DHA, signed March 12, 2019 and commencing on April 15, 2019, and shall automatically be renewed from year to year, unless terminated in accordance as outlined in the agreement. The current DHA is a licensed medical doctor (MD). A review of the license confirmed it was clear and active in the State of Florida with an expiration date of January 31, 2022. The DHA's education and specialty background is in pediatrics. The program maintains an independent contractor agreement with a licensed MD to serve as a back-up in the event the DHA is on scheduled leave. A review of their license confirmed it was clear and active in the State of Florida with an expiration date of January 31, 2022. The back-up MD's education and specialty background are in pediatrics and surgery and a member of the American Board of Pediatrics. Both the DHA and back-up MD maintain liability insurance in the State of Florida with an expiration date of May 16, 2020 for the DHA and April 1, 2020 for the back-up DHA. Reviewed documentation from Florida's Department of Health found neither had any disciplinary cases or public complaints on record. The DHA does not designate services to a physician assistant or advanced practice registered nurse (APRN). The DHA works in conjunction with the contracted psychiatrist to remain informed of the youth's psychiatric issues. The DHA is scheduled to be on-site two hours each week and is on-call twenty-four hours a day, seven days a week for consultation for acute medical concerns, emergency care, and coordination of off-site care. The program's policy and procedures outline specific duties of the DHA to include conducting Comprehensive Physical Assessments, conducting Sick Call and/or conducting medical evaluations and treatments based on referrals either through the program's Sick Call process or episodic care. The DHA assesses and treats youth episodic care conditions and/or chronic health conditions. The DHA is responsible for reviews of currently prescribed medication(s), orders new prescription medication(s), and monitors for effectiveness and side-effects. The DHA is scheduled to be on-site a minimum of two hours on Tuesdays. A review of the Physician Weekly Clinic List and sign-in logs for the past six months validated the DHA was on-site weekly with the exception of two dates where they were on-site for one and one-half hours. An interview with nursing staff and reviewed documentation supported the DHA examined two youth on each of these two dates.

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

The program maintains Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized. The facility administrator (FA) ensures all healthcare professionals receive an orientation to the program and Department requirements as well as communication within the healthcare system and with program staff. The FA and the program's assigned designated health authority (DHA) conduct an annual compliance review of all health-related policies, procedures, and protocols. In conjunction with the FA and the DHA, the contracted psychiatrist is responsible for the development, review, and approval of any FOP and protocol

related to psychiatric services. Reviewed documentation supported the DHA, FA, and psychiatrist each reviewed and signed all healthcare policies and procedures three different times during the annual compliance review period, with the latest revisions dated October 30, 2019. The program has three full-time registered nurses (RN) and three pro-re-nata (PRN) RNs. One RN serves as the health services administrator (HSA). Reviewed documentation and interviewed staff indicated all nursing staff reviewed, signed, and dated a cover page indicating their review of the FOPs, treatment protocols, and other procedures in July of 2019, October of 2019, and February of 2020. The program has procedures in place ensuring all newly employed healthcare staff receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, provided by the HSA.

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

The program maintains a written policy and procedures ensuring each youth's parent/guardian is afforded the right to give or withhold consent regarding the healthcare provided to youth at the program. A review of five youth Individual Healthcare Records (IHCR) were reviewed for the presence of the Department's Authority for Evaluation and Treatment (AET) form. Reviewed documentation supported the original AET was filed in one youth IHCR and a copy was filed in four youth IHCRs. Each copy was clearly marked as such. No youth was over the age of eighteen and the program only had one youth eighteen years of age. The one applicable record was reviewed, and documentation supported the youth signed a Release of Information Authorization Form for Youth Eighteen Years of Age or Older. An interview with the health services administrator (HSA) indicated once the youth turns eighteen years of age, the youth is responsible for authorizing their own physical and mental health care. No reviewed IHCR was applicable for a court order being filed in the record due to the youth being in the care of the Florida Department of Children and Families (DCF). Each reviewed IHCR contained parental notifications behind the AET in the appropriate section of the record. An interview with the program's HSA reported when a youth is not admitted with a properly signed AET, the nursing staff immediately notifies the facility administrator, who will then contact the youth's assigned juvenile probation officer or juvenile probation officer supervisor for assistance in obtaining the signed AET. The facility administrator and/or case manager will then contact the youth's assigned juvenile probation officer for assistance in obtaining a valid AET for the youth. An interview with the HSA also reported when youth turn eighteen the AET becomes invalid and the program practice is to have the youth sign a Release of Information Authorization Form for youth eighteen years of age or older.

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

The program maintains a written policy and procedures ensuring, to the fullest extent possible, parents and/or guardians are afforded the right to give or withhold consent with regard to the healthcare provided to their children. Additional informed consent is obtained for special circumstances where care is not authorized through the Department's Authority for Evaluation and Treatment (AET) form. A review of five youth Individual Healthcare Records (IHCR) validated each maintained documented practice of parental/guardian notification. Each reviewed IHCR indicated the youth required additional vaccinations/immunizations and the

parent/guardian was notified for approval prior to administration. One youth had a change in medication and another youth had a discontinuation of medication and the parent/guardian was notified as required. One youth was taken to the emergency room and reviewed documentation supported the parent/guardian was notified as required. Three youth were taken off-site for outside medical care and reviewed documentation supported parental notification and consent was obtained. The program maintains a policy and procedures for obtaining consent for all discontinuations, significant changes, and newly prescribed psychotropic medications. All five reviewed youth IHCRs supported whenever a psychotropic medication was initially prescribed, discontinued, or drug dosage significantly changed, parent/guardian verbal consent was obtained and documented on page three of the Department's Clinical Psychotropic Progress Note (CPPN) and a copy was mailed to the parent/guardian for their signature requesting the form be returned to the program. There were no applicable youth in the custody of the Department of Children and Families (DCF). The program's practice is for all youth to receive a comprehensive psychiatric evaluation within fourteen days of admission. The program's practice is to complete page three of the CPPN regardless of prescribed medications. Each reviewed record contained documentation of a completed psychiatric evaluation and page three of the CPPN sent to the parent/guardian. Each documented a staff member witnessed all telephone call conversations on the third page of the CPPN where treatment recommendations, applicable prescriptions, and diagnostic information was discussed with the parent/guardian. Reviewed documentation showed each CPPN was sent to the parent/guardian with a corresponding cover letter. The program maintains a policy and procedures to ensure relevant information regarding a youth's vaccination/immunization history is obtained and youth receive proper vaccinations/immunizations. Five youth IHCRs were reviewed, and each was applicable for vaccinations being verified within thirty days of admission. Each record documented receipt of the youth's vaccination history on the day of admission. Each reviewed record supported a copy of the Department's Immunization Tracking Record and a copy of the Florida Shots immunizations record. No reviewed records were applicable for a Religious Exemption from Immunization. The program does have a policy and procedures in place in cases where the parent/guardian does not authorize vaccinations/immunizations at the time the AET is signed. No records were applicable for a parent/guardian refusing to consent to vaccinations/immunizations. The program documents vaccination/immunization consent by way of the Department's Parental Notification of Health-Related Care Vaccinations/Immunizations form. An interview with the program's health services administrator confirmed each youth's vaccination/immunization record not documented in the youth's IHCR upon admission, will be obtained through the Florida Shots web-site on the day of admission.

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

The program maintains a written policy and procedures ensuring each youth shall be screened upon admission to determine if the youth has an acute injury, illness, chronic medical condition, physical impairment, mental disability, or developmental disability requiring a medical or mental health evaluation and treatment and/or if medication needs to be met. Youth are not placed in the general population until any identified healthcare needs do not require immediate medical attention and/or a referral for further assessment. Each youth is rescreened whenever physical custody changes and the youth is returned or readmitted into the program. A review of five youth Individual Healthcare Records (IHCR) supported the Department's Facility Entry Physical Health Screening (FEPHS) form was completed by a registered nurse (RN) on the date of

admission. The RN then notifies the designated health authority (DHA) of the admission and initial screening results. In addition, the DHA maintains routine admission orders to ensure each youth's screening includes vital signs, urine drug screen, urine sexually transmitted disease screening, and urine pregnancy test. An interview with the program's health services administrator (HSA) reported all newly admitted youth are seen during the admission screening process in order to complete the initial healthcare assessment. Three of five reviewed youth IHCRs supported there has been a change in physical custody during the youth's stay. Two youth had one change in custody and one youth had four changes in custody. Reviewed documented practice supported a new FEPHS re-screening was completed by the RN for each returning date after a change in custody occurred. An interview with the program's HSA reported any time there is a physical custody change a new FEPHS screening is completed.

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 maintains a written policy and procedures ensuring all youth admitted shall be oriented upon admission, or during the next available opportunity, to the healthcare system. The orientation health education shall be provided by the healthcare staff, in writing and during an individual session with the youth, to ensure youth with identified disabilities can understand the information provided. If applicable, the orientation and health education will be provided in Spanish as well as any other language a youth utilizes as their primary language. The Miami-Dade County School District personnel shall provide information as to how to present this information to youth who are deemed impaired or have cognitive deficits. The program maintains a written policy and procedures ensuring all youth are provided gender-specific and trauma informed services to include gynecological care and obstetrical services. A review of five youth Individual Healthcare Records (IHCR) supported each youth received a general care orientation upon their admission to the program conducted by a registered nurse (RN). Each healthcare orientation was documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for female adolescents. Reviewed documentation in each IHCR validated a health education packet was provided and discussed with the youth. As part of the healthcare orientation and health education, each youth received training on environmental and exercise precautions to ensure the prevention of heat stress injuries through adherence to accepted heat stress and exercise tolerance guidelines, as well as addressing cold weather and environmental stressors. In addition to the admission health orientation, each youth received health education throughout their stay which was documented in each IHCR on the Health Education Record form. The program's policy outlines health education is provided through one-on-one teaching between the youth and healthcare staff, through classes conducted by the Miami-Dade County School District, classes conducted by the Miami-Dade Health Department, or in a group session conducted by the program's healthcare staff. Informal interviews with youth validated this practice.

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

The program maintains a written policy and procedures regarding notifying the designated health authority (DHA) telephonically or verbally of all new admissions, regardless of any

identified medical conditions, on the same day of admission. The program's procedures outline healthcare staff will provide the DHA with a comprehensive overview of all applicable admission orders, medication orders, preliminary laboratory studies, applicable diet orders, activity restrictions, and specific treatment orders for all youth with an identified health related condition. The DHA has approved routine admission and standing physician orders to include urine testing, routine over-the-counter medications for minor complaints, and Epinephrine Auto Injector, if applicable, for anaphylactic shock prevention. A review of five youth Individual Healthcare Records (IHCR) validated the DHA was notified on each youth's date of admission. The program's practice is to document the telephone call on the program's DHA Notification of Admission form as well as on the Nursing Chronological/Notification Progress Note – Female Admission. Five IHCRs were reviewed for DHA admission notification. Each youth's IHCR documented the DHA notification was made by telephone on the day of admission. In addition, youth admitted on prescribed psychotropic medications documented the psychiatrist was notified of each youth's admission. Each youth was identified with a known or suspected chronic condition and four youth were admitted with prescribed psychotropic medications. The nursing staff updated the Chronic Conditions Log after the notification was completed. None of the reviewed IHCRs reflected the youth were in need of an emergency response. An interview with the program's health services administrator reported the admitting nurse notifies the DHA and the psychiatrist the same day of the youth's admission by telephone to make them aware of the youth's health condition and to obtain orders to continue medications when applicable.

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.	

The program maintains a written policy and procedures ensuring each youth admitted shall receive and/or shall have a completed Health-Related History (HRH) prior to the completion of the Comprehensive Physical Assessment and prior to any participation in sports, exercise, or any other strenuous activity. The program utilizes the Department's HRH form, which is a standardized, comprehensive, medical and health-related history of the youth. The program's practice is to complete a new HRH at admission in order to report any significant medical changes since the previous HRH was conducted. A review of five youth Individual Healthcare Records supported a HRH was completed by the registered nursing staff on the day of the youth's admission. Each completed HRH was then reviewed and signed by the designated health authority (DHA) prior to the completion of the CPA. The program's practice is to complete a new HRH and CPA annually.

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 maintains a written policy and procedures ensuring each youth admitted shall receive and/or shall have on record a current Comprehensive Physical Assessment (CPA) and Health-Related History (HRH) prior to any participation in sports, exercise, or any other strenuous activity. The CPA is the standardized physical assessment of a youth, conducted by the designated health authority (DHA). When a youth is admitted into the program with a current CPA, the registered nursing (RN) staff reviews the CPA and documents the findings in the admission note. The RN documents the date and results of the most recent tuberculosis skin test (TST). Program practice is for the DHA to review the previous CPA while examining the

youth and completes a new CPA no later than seven days from admission and prior to the youth engaging in strenuous exercises and extreme outdoor weather conditions. A review of five youth Individual Healthcare Records (IHCR) validated the program utilizes the Department's CPA form. All CPAs were completed by the DHA. All sections of the CPA were completed in full utilizing "O" with no applicable "X" markings. In each reviewed CPA, sections nineteen through twenty-two were left blank and documented, "deferred by clinician, not medically indicated." One youth was transported to the emergency room the day prior to the CPA being conducted and the DHA documented the date of the gynecological examination conducted at the hospital. Reviewed documentation of practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. The program maintains a written policy and procedures ensuring each youth shall receive routine healthcare screenings and evaluations upon their admission for latent or active tuberculosis (TB), as well as environmental controls for the program. Youth are not to be placed into the general population until their healthcare needs are identified and are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. Upon admission and re-entry, all youth are screened for Tier I TB utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. When the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the DHA and transferred to Jackson Memorial Hospital in Miami, Florida for evaluation. The program does not have an airborne infections isolation room. As a result, the youth wait outside in the open air until transported to the hospital for evaluation. A review of five youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to TB. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. An interview with the program's health service administrator (HSA) reported youth are assessed at the time of admission with the FEPHS. Additionally, PPDs are administered annually, and if deemed applicable, at the time of admission for all youth. There were no current youth with symptoms suggestive of active TB and no youth on anti-TB medications.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide, based on the screening tool and medical evaluation, to order testing for STIs. A review of five youth Individual Healthcare Records (IHCR) indicated each youth was identified as sexually active and was clinically screened and evaluated for STIs. The program utilizes the Department's Sexually Transmitted Infections Screening form. Each youth was determined to receive further evaluation and was referred to the DHA. Testing was ordered and was generally conducted on the same day or within two days of the order. Test results were filed in the lab section of the youth's IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or requiring a rescreening due to presenting symptoms. An interview with the program's health service administrator (HSA) reported youth are screened for STIs and offered testing at the time of admission. All youth have the opportunity to be tested upon request any time they are in the program. Each youth shall be tested when requested at any time. Testing shall also take place when indicated based on risks and with informed consent from the youth.

The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. A review of five youth IHCRs validated each youth was provided the opportunity to receive counseling, testing, and treatment for HIV. The program utilizes the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent Form. Two youth consented and three did not. An additional applicable IHCR was reviewed in order to meet the required minimum sample size of three. The program's DHA and back-up physician both carry a medical doctor license and are authorized to provide pre-counseling, testing, and post-counseling. Each of the three records applicable for HIV testing contained results placed in a sealed business envelope marked "confidential," including the youth's name and date of testing. An interview with the program's HSA reported if a youth consents to HIV testing, they are pre-counseled by the DHA. The nursing staff then draw blood and send to LabCorp in Miami, Florida. Once the test results are returned to the program, post-HIV counseling is then completed by the DHA. Completed HIV education, counseling, and testing was documented on each youth's Health Education Record form and in the nursing chronological notes. In addition, the nursing staff document each youth receiving HIV testing on the monthly HIV Testing Tracking Log to include the youth's name, Department identification number, dated tested or refused testing, pre-HIV counseling and testing date, post-HIV counseling date, and DHA signature. The program does not document any youth's HIV status in their internal alert system. Youth who are HIV positive shall have an initial evaluation by the DHA. There is no automatic "need to know" by virtue of the HIV status of the youth. Program policy indicates there must be a clearly delineated "need to know" to divulge this information and the youth must be counseled first about the reason and to whom the information will be divulged to. Five interviewed youth each indicated they can request HIV testing at the program.

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 maintains a written policy and procedures ensuring there is a system in place to respond to the complaints of a youth illness or injury of a non-emergent nature. Sick Call care, including dental complaints, shall be available to all youth. Sick Call care shall be provided by licensed healthcare staff, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). Emergency dental care services shall be provided by the contracted/licensed dentist and/or the youth will be transported to the emergency room. Youth admitted to the program are assessed by the healthcare staff upon admission. Through an interview with the health services administrator (HSA) and a review of the youth's previous medical and dental history, the healthcare staff note any identified medical and/or dental issues on the Department's Facility Entry Physical Health Screening (FEPHS) form. All youth shall be able to make Sick Call requests and have their complaints treated appropriately through an established Sick Call system. The program identifies Sick Call as the official method for a youth to request healthcare services for an illness or injury. Sick call is provided twice a day, Monday through Friday from 11:40 a.m. to 12:40 p.m. and 2:30 p.m. to 3:00 p.m. In addition, Sick Call is provided on Saturday and Sunday from 12:30 p.m. to 1:00 p.m. and 4:30 p.m. to 5:00 p.m. Only a licensed healthcare staff may conduct Sick Call and all Sick Call encounters are conducted in the medical clinic to ensure youth privacy. The youth complete a Sick Call Request form and place it in the mounted/designated Sick Call box in the

dormitory and nursing staff check the Sick Call box every two hours. The program maintains DHA approved nursing protocols and DHA approved protocols for non-licensed staff to deal with healthcare situations. The protocols clearly indicate no substitutions are permitted without the authorization of the DHA. Completed Sick Call Request forms are filed in chronological order in the nurse's chronological note section in the youth's healthcare record. In addition, all Sick Calls are documented on the Department's Sick Call Index and on the Sick Call Referral Log. Observations found the Sick Call forms were located on the wall and a deposit box was accessible to all youth in both dormitories. A review of five youth healthcare records reflected four youth completed a Sick Call Request form at least once during their stay. One youth submitted two separate Sick Call Request forms and three youth submitted three separate Sick Call Request forms. No youth presented a similar Sick Call complaint three or more times within a two-week period. The program's procedures reflect healthcare staff will automatically refer all youth submitting a Sick Call Request to the DHA or dentist for an evaluation and treatment. In each instance, the registered nurse (RN) documented the treatment and/or services provided to the youth during the Sick Call event on the Sick Call Request form. Reviewed youth records indicated each Sick Call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed in the nursing chronological notes section of each healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the shift supervisor for review. The supervisor is required to review the Sick Call complaint promptly, but no longer than two hours after the request was submitted. The supervisor will then determine if the Sick Call requires immediate attention. The DHA and/or designee as well as the HSA are on-call and available for consultation twenty-four hours a day, seven days a week to determine if the Sick Call requires immediate attention and/or instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar with and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. An interview with the HSA reported all supervisors are trained on the Sick Call process in pre-service training and refresher training is provided annually. During the annual compliance review week, a Sick Call event was observed. The youth was escorted to the medical clinic by a Protective Action Response (PAR) certified youth care worker. The youth provided verbal consent for annual compliance review team member to observe the Sick Call process. The youth was seen within the medical clinic on an examination table ensuring the youth's privacy. All aspects of the Sick Call process were observed to be thorough and informative. The program's RN identified why the youth was there and asked the youth to initial the Sick Call form. The RN was knowledgeable of the youth's condition and offered an ice pack, which was in compliance with the DHA-approved nursing protocols. The youth was educated on procedures, the youth's allergies were confirmed, and the nursing chronological notes were updated. Five interviewed staff indicated nursing staff conduct Sick Call. Five interviewed youth were interviewed and found one indicated they can be seen immediately once they submit a Sick Call Request form while four indicated they can be seen within one day.

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 maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed, in response to unexpected illnesses, accidents, or conditions requiring immediate attention or an immediate professional assessment to determine the severity. Twenty-four-hour emergency medical, mental health, and dental care shall be available to youth. The designated

health authority (DHA), in consultation with the health services administrator (HSA), shall ensure the provision of emergency care with the appropriate local healthcare provider. All staff who have direct contact with or provide supervision of youth, including transportation, shall be trained in Sick Call complaints to include emergency complaints and immediate transfer of youth who require emergency medical, mental health, and dental care services. The facility administrator is required to ensure all telephones within the program have access to outside lines to ensure unimpeded access to the emergency use of 9-1-1. An interview with the HSA confirmed all program telephones have access to call 9-1-1. A review of five youth healthcare records supported each had at least two or more encounters of episodic care provided on-site by the registered nursing (RN) staff. The program was able to provide one example of when nursing staff were not on-site, and a non-licensed staff provided episodic care. The youth complained of a headache and the on-call HSA was notified and instructed the staff mentor to provide the youth with two Ibuprofen tablets. The incident was documented on the Report of On-Site Healthcare by Non-Healthcare Staff form, which the RN reviewed the next day, signed the form, and conducted a follow-up assessment of the youth. The other four youth were assessed by the RNs and documented their findings in problem-oriented SOAP (subjective, objective, assessment, plan) elements. Nursing staff maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). The program maintains six first aid kits throughout the facility. Four kits were located in main master control, medical clinic, operations office, and in the multi-purpose conference room. The program has two kits which are designated for the program's transportation vans and are maintained in master control. The first aid kits and emergency equipment are approved by the DHA. The DHA has designated the RNs to inspect the contents of the first aid kits weekly and to inspect the emergency equipment each month. Items are to be replenished as needed. Weekly checks are documented on the program's Weekly First Aid Kit Inspections form. The DHA approved the contents the first aid kits are required to contain and a review of three random kits supported each contained all required elements. The program maintains a written policy and procedures ensuring the program-based automated external defibrillators (AEDs) are properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains three AEDs located in the operations office, master control, and in the multi-purpose conference room. Reviewed documentation supported nursing staff conduct a monthly check on each AED and document the findings on the Emergency Equipment Monthly Inspection Log. All staff, volunteers, and interns are authorized to provide assistance to victims of sudden cardiac arrest, if they have been trained in the use of the AED, as documented in their respective training record. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. Additionally, all nursing staff maintained current certifications in CPR and AED. A review of five youth Individual Healthcare Records (IHCR) found two youth required episodic and/or first aid care during their stay in the program. One additional IHCR was requested and reviewed for a sample size of three. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Care Log. The AED procedures were observed as audio instructions and each AED was demonstrated by the nursing staff during the week of the annual compliance review. Reviewed AED batteries indicated the operations office AED expires in April of 2023 and the multi-purpose conference room AED expires in April of 2022. Reviewed AED pads found the one in the operations office expires in November of 2020 and the one in the multipurpose conference room expires in

October of 2021. The operations office AED had the original pads and have not been changed as of this annual compliance review and the multi-purpose conference room AED pads were last changed in March of 2018. The program maintains three complete suicide response kits located in main master control, operations office, and the multi-purpose conference room office. The program places a knife-for-life within each of the program's six first aid kits. The AEDs and suicide response kits are inventoried monthly by nursing staff to ensure they are fully stocked and operational. A review of the program's mock emergency medical drills reflected a drill was conducted on each shift monthly for the last twelve months. The demonstration of CPR and use of AED was conducted each quarter. Observations made during the tour of the facility found postings throughout informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in main master control, operations office, multi-purpose conference room office, medical clinic, therapist's offices, and case manager's offices. Reviewed training records supported all supervisory staff have been trained in the administration of the Epinephrine Auto Injector. Five interviewed youth indicated they can see a dentist in the event they have tooth pain and/or doctor if needed while at the program. Five interviewed staff reported they could personally call 9-1-1 or have master control staff call 9-1-1 when a youth has been identified with a medical emergency. In addition, the HSA and supervisor would be contacted.

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.	

The program maintains a written policy and procedures for the provisions of off-site emergency and non-emergency referrals for medical care and treatment. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth Individual Healthcare Records found three youth requiring off-site care and/or emergency care. One youth had one off-site care event and two youth each had three off-site care events. Reviewed documentation supported the parent/guardian was notified as required. The Department's Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the IHCR. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care form and discharge paperwork as evidenced by signature and date. One youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses (RNs) track follow-up testing, referrals, and appointments on the Monthly Periodic Tracking form and as a follow-up on a monthly appointment desk calendar. The RNs set aside all off-site care findings, instructions, and information for the DHA to review and document their signature. The applicable healthcare records contained the completed Summary of Off-Site Care form and applicable follow-up and discharge paperwork. The DHA documented their review of the off-site care findings, instructions, and information. An interview with the program's health service administrator (HSA) reported the program calls the DHA after all off-site visits are completed and the RN receives telephone orders from the provider. All youth with off-site emergency room visits are scheduled to see the DHA upon the next on-site visit.

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

The program maintains a written policy and procedures to provide guidance to health services personnel in the areas of chronic illness monitoring and clinical establishment guidelines. The program defines a chronic medical condition as an illness, disability, or condition which is permanent or persists longer than six months, except for allergies, hearing/speech/visual impairment, developmental disability, or mental deficiencies. Youth identified with chronic medical conditions shall have treatment plans and/or physician progress notes specifying a youth's course of therapy identifying the role of the qualified health professional in carrying it out and is updated as needed. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth Individual Healthcare Records (IHCR) indicated all were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All youth were classified with a medical grade of two through five. All youth were taking prescribed medication on an ongoing basis and there was one youth currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program has had no pregnant youth in the last twelve months and there were no youth prescribed anti-tuberculosis medication at the time of the annual compliance review. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether the youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations as required. An interview with the designated health authority (DHA) and the health services administrator (HSA) indicated chronic conditions are monitored and evaluated every sixty days and are documented in the DHA Physician Order Log. An interview with the program's HSA reported youth identified with a chronic condition are placed on the appointment calendar, on the Monthly Periodic Tracker, and on the Chronic Conditions List to ensure the DHA follows-up with each applicable youth. The psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations in each reviewed record. All on-site evaluations were maintained in the chronological progress notes and treatment orders were clearly written. The Department's Problem List was updated for each youth as changes occurred.

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

The program maintains a written policy and procedures ensuring there is no lapse in a youth's medication regimen ensuring all prescriptions shall be expeditiously purchased and procured in a timely manner. Parental notification shall be made, except in emergency situations. Prescribed medications shall never be delayed or withheld for funding reasons. All prescribed medications shall be obtained from a licensed vendor, according to a contractual agreement. Emergency prescriptions may be obtained from a local pharmacy. A review of five youth Individual Healthcare Records (IHCR) indicated each youth was admitted on prescribed medications. Reviewed nursing admission notes and Facility Entry Physical Health Screenings

(FEPHS) documented the youth's current medications in each instance. Reviewed documentation supported the registered nursing (RN) staff completed a Nursing Chronological/Notification Progress Note – Female Admission documenting the designated health authority (DHA) and the psychiatrist were notified by telephone of the youth's admission providing a history, obtaining admission orders, and to continue the prescribed medications. In addition, the RN staff completed the DHA Notification of Admission form documenting current medications, applicable chronic conditions, allergies, and medical grade. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the continuation of medications. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The RN staff complete the Prescription Medication Verification Checklist and Medication Receipt, Transfer, and Disposition form when youth are admitted with current prescribed medications ensuring all medications have a current and valid order and are given pursuant to a current prescription. The program maintains a written policy and procedures ensuring all authorized prescribers, including consultants, shall utilize the formulary when providing appropriate healthcare to youth. Deviations, additions, and deletions from the formulary shall be completed following appropriate procedures. The program maintains a pharmacy provider agreement with a 1st Choice Pharmacy signed April 15, 2019 and maintains a current Class II Type B pharmacy license through the Department of Health with an expiration date of February 21, 2021. The program may obtain emergency prescriptions from a local Walgreens pharmacy, when necessary. A review of five youth IHCRs validated each youth was applicable for prescribed medication. Each reviewed IHCR documented a current and valid prescription order. Each IHCR was applicable for the youth being admitted on medications, a change to medications, or a new medication being ordered. In each instance, the physician's order sheet clearly documented the medication and dosage. The program maintains a written policy and procedures ensuring medications shall be provided pursuant to a physician's order written in the IHCR. Oral prescription medications shall be administered according to instructions. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. Psychotropic, tranquilizing, or stimulating medications shall never be administered for the purposes of program management and control, nor be used for the purposes of experimentation and research. All five reviewed youth IHCRs supported each contained a standard Department Medication Administration Record (MAR) outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. Each medication was administered in accordance with the approved nursing protocols and physician's order. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All five reviewed youth IHCRs indicated each youth was taking prescribed medications upon admission. The initial MAR for each record matched the medication(s) listed. Observations found the medications are procured through the 1st Choice Pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. The program maintains a written policy and procedures ensuring the provision of psychiatric services for youth with diagnosed Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) mental disorder including psychiatric evaluations, psychiatric consultations, and medication management. Procedures outlined psychotropic medications shall be provided pursuant to a physician's order written in the youth's IHCR. The program maintains a weekly Psychiatric List identifying the youth's prescribed psychotropic medications. An interview with the health services administrator (HSA) indicated they participate with the psychiatrist and DHA in a weekly meeting to discuss psychotropic medication management. Reviewed documentation supported the psychiatrist was on-site weekly as required. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventories of controlled medications are

conducted by two RNs. Each reviewed MAR supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed nursing staff initialed the MAR for each administered medication entry. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. There were no indications of lapses and/or errors in the medication administration of the sample size reviewed. A review of the Department's Central Communications Center (CCC) reports validated there was one substantiated incident of missed medications on September 29, 2019 and September 30, 2019 where a youth did not receive their 6:00 p.m. prescribed medications. The RN staff maintain a locked emergency box located in the medication administration room with OTC medications listed on the AET form for the seven trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on-site. There was one youth prescribed with an Epinephrine Auto Injector and this is placed in the locked emergency box each night in the event staff need to access. The RN staff maintain a Monthly Access to Medications roster identifying the appropriately trained non-licensed staff who have access to routine medications. Program policy only permit the nursing staff to have access to and administration of controlled substances and narcotics. Three of five reviewed IHCRs documented refusal of medications at least one time on the reviewed MARs. In addition, RN staff complete a Refusal of Treatment form and place it in the nursing chronological notes section of the IHCR. Observation of one medication administration by nursing staff during the annual compliance review week validated the medication cart was secured when not in use. Observations of the medication administration room and medication cart were found clean and organized and all medications were separated in the medication cart as required. Observation of medication administration during sick call conducted by the RN validated the Six Rights of Medication Delivery/Administration was maintained for the youth. The program maintains a secured refrigerator located in the medical clinic utilized for medications. At the time of the annual compliance review, the program had no current prescribed medications stored in the refrigerator. The only medications were bulk supply of vaccinations. Nursing staff maintain a Daily Temperature Log for the refrigerator. According to the HSA, the program has no other bulk supply of medications stored. The program's practice is to order youth-specific thirty-day supplies when prescribed. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program had no controlled medications on-site during the annual compliance review week, and observations showed medications would be stored behind two locks and inventoried as required. Five interviewed youth confirmed four indicate nursing staff provide medication to youth while one youth indicates they do not take medication. Five staff were interviewed regarding the administration of medication at the program and all reported the nurse administers medications.

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

The program maintains a written policy and procedures ensuring the health services administrator (HSA) shall be responsible for all chemical products, drug and medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Unused and expired medications shall be returned to the pharmacy for proper disposal, credit, and/or replacement. All medications shall be inaccessible to youth. The program

maintains a Florida Department of Health, Division of Medical Quality Assurance, Class II Type B license with an expiration date of February 28, 2021. Observations found all medications securely stored in the medical clinic and in the secured medication administration room are inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter (OTC) medications were placed in the emergency locked box on the wall of the medication administration room. Observations validated oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There were no medications requiring refrigeration during the annual compliance review week. The program stored a bulk supply of vaccinations and documented the daily temperature of the refrigerator on the Temperature Log for Vaccines form. Reviewed documentation supported the checks were conducted daily each month. The program securely stored sharps and syringes separate from medications. Syringes and sharps are counted through a perpetual inventory and are verified weekly. All controlled substances are maintained in the locked box within the locked medication cart located in the secure medication administration room. The keys to the medication cart and emergency key box are secured in a mounted combination locked box within the medication administration room. At the time of the annual compliance review, the program had no controlled medications or narcotics on-site. Reviewed documentation and nursing interviews confirmed all OTC medications are inventoried perpetually and weekly. The program's medications are procured through a pharmacy provider agreement with 1st Choice Pharmacy. The medications are in blister packs documenting the number of pills in each prescription order. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist's license expires December 31, 2020. Reviewed documentation supported the consultant pharmacist was on-site at least one day each month during the review period. The HSA reported the consultant pharmacist is on-site monthly for inspection and attends quarterly meetings at the program. The HSA reported the consultant pharmacist assists in checking all nursing units, medication carts, OTC medications, controlled substances, sharps containers, count sheets, refrigerators, and emergency kits. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator, designated health authority (DHA), and registered nursing staff. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained supervisory staff. Non-licensed staff shall provide self-administration medication only when there is no licensed healthcare staff on-site. A review of training logs indicated seven non-licensed staff members received training for youth self-administration of medications by the program's licensed HSA. All prescribed youth medications are administered by nursing staff when they are on-site. Reviewed and documented practice supported each applicable youth's Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventories are conducted by two registered nurses. The program had no applicable youth prescribed a controlled medication or narcotic during the annual compliance review week. Observations conducted during the annual compliance review week supported three youth's prescribed medication inventories were accurate. Three OTC medications and three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with inventory counts. The program maintains a current agreement with Stericycle, Inc. for biomedical waste treatment with an operating permit with the State of Florida, Department of Health with an expiration date of September 30, 2020. Stericycle, Inc. picks up medical waste monthly.

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 maintains a written policy and procedures ensuring there is an approved plan for infection control and exposure control to ensure staff, youth, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The plan was reviewed and approved by the facility administrator on April 25, 2019 and again on February 18, 2020. The designated health authority (DHA) documented a review on April 25, 2019 and again on October 25, 2019. The corporate office documented a review on April 22, 2019. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. The plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV), as well as infectious diseases caused by blood-borne pathogens. The plan includes procedures for other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly to include pediculosis and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), food-borne illnesses such as those caused by Escherichia Coli (E. Coli), and bio-terrorist agents. The program's plan outlines procedures regarding chemical exposures and universal precautions. The program provides all staff with the opportunity for Hepatitis B immunizations and access to protective equipment. An interview with the health service administrator (HSA) reported there have been no instances in which the local health department, Centers for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified for an infectious disease. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator (FA) has a process in place to establish a separate record containing all documents for youth and staff who have experienced a facility or occupational exposure. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the program's acting FA explained the program's Exposure Control Plan/Infection Control Plan is located in the medical office, the FA's office, and on the program's K-drive for all staff to have access. The FA indicated the Exposure Control Plan/Infection Control Plan is reviewed with all staff during new hire training and all staff receive semi-annual training conducted by the registered nursing staff. An interview with the program's HSA coupled with a review of records supported all youth receive infection control training upon their admission and annually.

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

The program has a policy and procedures ensuring all youth are provided gender-specific and trauma informed primary services, gynecological care, and obstetrical services. The designated health authority (DHA) is notified of each youth's admission. As part of the DHA-approved admission orders, a urine pregnancy test is conducted on each youth upon their verbal consent. When a pregnant youth is admitted, the DHA initiates prenatal care immediately. The program maintains nursing protocols and treatment plans developed by the DHA for pregnant youth. At a minimum, prenatal vitamins, activity restrictions, and sexually transmitted infection (STI) testing are given to pregnant youth. All pregnant youth will have a human immunodeficiency virus (HIV) test unless the youth refuses after counseling by the DHA as to the risks of transmission of HIV to the fetus. The pregnant youth signs a Release of Information form, is encouraged to allow parental notification when medical issues arise, and sign a disclosure giving consent prior to the parental notification. The healthcare staff provide routine monitoring of the pregnant youth's nutritional and weight status during the course of their pregnancy. When applicable, the youth will receive vaccinations in accordance with the Florida Department of Health and the Center for Disease Control and Prevention (CDC), following the DHA's orders. Interviews with nursing staff and reviewed procedures indicated each applicable youth receives education on alcohol and drug usage, smoking, nutrition, STIs, contraception, prenatal care, birthing process, postpartum care, and basic baby care. Each youth receives a documented plan of care through post-birth to include psychological, physical care, and if applicable, adoption procedures and rights. An interview with nursing staff validated this practice. The program ensures all non-healthcare staff involved in the supervision or treatment of pregnant youth receive appropriate healthcare education. A review of five youth training records supported each youth received healthcare education in the daily monitoring and observation for indications of danger signs related to pregnancy. A review of five staff training records supported each received training in labor and delivery and post-partum care of youth. Reviewed documentation supported the training was entered in the Department's Learning Management System (SkillPro). The program had no applicable pregnant youth in the last twelve months.

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 maintains a written policy and procedures requiring all program staff to promote safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, and consistently applying the program's Positive Performance System (behavior management system). The program has a daily youth activity schedule which was posted throughout the program. Program staff are required to account for the whereabouts of youth under their supervision and ensure staff-to-youth ratios are compliant with contract requirements. The program's contract requires staff-to-youth ratios during the day time to not exceed one-to-five during awake hours and one-to-six during sleep hours. The ratio for off-site activities, visitation, or when youth are separated from the population is one staff to five youth; however, observations found two staff participated in the transportation of one youth.

Observations of staff supervision for four days during the annual compliance review week included classroom activities, line movement, transportation off-site, groups, and outdoor activities. The observations revealed staff accounted for youth under their supervision at all times and validated staff-to-youth ratios were maintained as required. The program conducts formal head counts each hour and informal head counts at least twice during each shift as well prior to youth movement. Counts are also conducted during power outages. A review of facility logbooks for the previous six months validated head counts and movements are conducted and documented by master control.

During outdoor activities and/or movement, observations showed staff were strategically positioned to ensure proper supervision of youth and to ensure there were no physical obstructions in their view of the youth. Observations of interactions between program staff and youth reflected the interactions were positive and consistent with the program's behavior management system. Informal interviews were conducted throughout the annual compliance review week and confirmed staff understood the procedures for any discrepancy in youth counts. Five formally interviewed staff explained the procedures included stopping all movement, performing a recount, performing an emergency count, notifying program administration and supervisory staff, securing youth, and conducting perimeter and facility program searches.

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

The program maintains a clearly written policy and procedures regarding their Positive Performance System (behavior management system) (BMS), which is a system of rewards, privileges, and consequences based upon the principles of the Social Learning Theory whereby the youth learn by observing and imitating others and model the behaviors and attitudes through rewards and consequence. The program utilizes Girls 4 Success: Growth and Change System, which is a trauma informed, gender-responsive, reinforcement system which supports the modeling of appropriate skills and voicing of personal needs through healthy avenues. A written description of the BMS is provided to each youth in the program's youth handbook during orientation. The handbook outlines the program's rules governing conduct, as well as the positive and negative consequences for behavior. The youth handbook includes a list of behavioral infractions for demonstrating negative behavior and rewards youth can earn for demonstrating positive behavior.

The BMS is a point based five-tiered level system which is designed to decrease unwanted behaviors and increase desired behaviors through reinforcements while fostering accountability for behavior and compliance with the residential community's rules and expectations. Each youth accrues points by meeting or partially meeting expectations at each activity throughout the day which provides for immediate reward and gratification as well as ongoing feedback. Earned points for each day and week translate into opportunities to advance through the five progressive BMS system levels. The five levels include Level One: Foundation, Level Two: Radiance, Level Three: Harmony, Level Four: Elegance, and Level Five: Grace. The BMS outlines daily, weekly, and monthly incentives as well as responsibilities, expectations, privileges of each level, rewards for meeting behavioral expectations, and the process for level advancement.

A review of five youth case management records confirmed all were oriented upon admission to the program through the program's youth handbook. The program's annual in-service and pre-service training plans include training on the BMS for all staff. A review of five pre-service and five in-service training records confirmed each staff was trained in the BMS utilized at the program, as required. Observations made during the program tour revealed the program has postings of the BMS incentives. Rewards include participation in daily, weekly, and monthly incentives, purchasing items from the program's boutique, participating in community presentations, a youth advisory board, and community outings, if permissible. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited.

Five interviewed youth each confirmed they were aware of the BMS and provided information on the BMS within their youth handbook. All five youth indicated they are never allowed to punish other youth. Two youth rated the BMS as poor, one rated it as fair, and two rated it as good. Five interviewed staff each confirmed they were trained in the BMS and able to explain their understanding of the BMS which reflected the program's policy. The interviewed staff

confirmed reward incentives may include things such as extra snacks, earning the use of an MP3 player, and planned daily/weekly incentives. The acting facility administrator (FA) was interviewed and confirmed the program utilizes a BMS tracker/level system and consequences are monitored through special and monthly treatment team meetings.

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 maintains a written behavior management system (BMS) which requires positive and negative consequences in a ratio which exceeds four-to-one positive-to-negative consequences. The BMS is designed to maintain order and security, provide constructive discipline, and provide positive and negative consequences to encourage youth to meet behavior expectations. The program's BMS requires all staff to be responsible for monitoring and addressing behavior. Consequences for violation of rules are to be applied logically and consistently and are directly related in severity to the seriousness of the inappropriate behavior exhibited. Consequences and sanctions are applied individually, and group punishment is never allowed. Youth are not denied basic rights including increased length of stay, meals, clothing, sleep, physical health services, mental health services, education services, exercise, correspondence privileges, or contact with parent/guardians, their attorney of record, juvenile probation officer, Department of Children and Families case worker, and clergy. Interviews with five youth and five staff validated this practice.

The youth handbook informs each youth of the program's responsibility to the youth as well as the youth's responsibility and expectations to the program. Observations of youth and staff interactions during the annual compliance review week reflected the exchange of open communication between youth and staff in relation to youth actions and behavior. The BMS allows staff to explain to the youth the reason for any imposed sanctions, for youth to explain their behavior to staff, as well as the opportunity for discussion of the youth's behavior impacting others. Discussions may include reasonable reparations for harm caused to others, and alternative acceptable behaviors. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and consistently imposed. The program utilizes "Chatty Cathy" forms where the youth may submit a Chatty Cathy form to informally voice any concerns or requests with staff prior to filing a formal grievance.

The program does not utilize room restrictions as a form of imposing sanctions for inappropriate behavior. Five staff and five youth were interviewed and confirmed staff discuss imposed sanctions, consequences, and alternative acceptable behaviors with the youth. Each of the interviewed youth were aware of the BMS, aware it is posted throughout the program, and were provided information on the BMS within the youth handbook. Four of the five interviewed staff stated they received feedback from supervisors or the recreational therapist regarding their

implementation of the BMS, while one stated they did not receive feedback. Each staff was able to describe different types of rewards provided to youth. An interview with the acting facility administrator (FA) was conducted and he addressed how the implementation of the BMS is monitored to ensure it is administered fairly and consistently among all staff. The FA advised all staff receive training on the BMS and the point cards to ensure fair treatment across the board. Additionally, all staff complete additional training and refreshers by the training academy 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 a written policy and procedures to ensure staff observe youth at least every ten minutes anytime youth are in the sleeping quarters. It is the program's practice for master control to call for a count every ten-minutes, as indicated by the clock on the program's video surveillance system, and for staff to document room checks every five minutes on the Room Check and Common Area Search form when youth are in the sleeping quarters. Staff ensure flesh, or a body part, is visible to confirm the youth's presence and do not enter a youth's room unless there is either a safety and/or a security issue observed. Staff document the actual time of the room check and initial on the room check sheets. Each check is initialed by the staff completing the room check. If a youth is not in their room, an "X" is marked in the box for the time of the room check. The room check forms identify the name and room number of each youth. A review of randomly selected one-hour periods on six different dates, inclusive of checks on two different shifts, was conducted in comparison to the video recordings for the corresponding dates, times, and locations. The review indicated checks were consistently conducted every five minutes and were documented in real time. Five staff were interviewed. Four of the five stated room checks are conducted every five minutes when youth are placed in their room for sleeping or non-punishment reasons, while one staff indicated room checks are conducted every ten minutes.

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

The program maintains a written policy and procedures to ensure youth are always accounted through a system of physically counting youth at various times throughout each day. The program is to conduct and document formal resident counts at six specified times each day, in addition to ongoing informal counts. Emergency counts are conducted if a youth is suspected to be hiding or missing and following a disturbance or unusual incident, such as power outages. Observations found the program maintained a chronological record of events, incidents, and activities in a facility logbook maintained by master control. Youth were accounted for by a physical count and through random head counts throughout each day when youth moved from one activity to the next. Observations made during the annual compliance review week indicated it is the program's practice to conduct hourly formal counts. Observations validated youth were queued and each counted prior to movement. Observations included counts conducted in the classrooms, dormitories, and outdoor activities. The daily census is documented in the facility logbook at the start of each shift.

A review of randomly selected dates and times in the facility logbooks for the previous six months reflected youth counts were completed at the beginning of each shift, after outdoor activities, and after movements from one area of the program to another. The counts were not documented after conducting drills when exiting the building. All formal and informal counts documented in the logbook included the time of the count and number of youth at each location. Five staff were interviewed, and each was aware of the program's policy and procedures on adequate supervision of youth as well as procedures if there are discrepancies in youth counts, including emergency counts. In the event of a discrepancy, staff reported all movement is stopped and a recount is conducted. If the count remains out of compliance, a code green would be called, administration would be notified, other youth would be secured, and a search would be initiated.

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

The program maintains a written policy and procedures to ensure the maintenance of a chronological record of events, incidents, and activities in a central logbook. The program ensures direct care staff, including each supervisor, are briefed when coming on duty. The program maintains a spiral-bound logbook with numbered pages for each month. Observations and review of logbooks for the previous six months found logbook entries were documented in ink with no erasures or white-out areas. Errors were typically struck through with a single line, dated, and initialed by the person correcting the error. Observations found very few errors were written over. Reviewed documentation of randomly selected days within the logbooks reflected each entry included the date and time of the event, the name of the staff and youth involved, as well as a brief description, the name, and signature of the staff making the entry. Admissions and releases were documented as well as transports away from the program. It is the program's practice to utilize written shift reports to document the events, activities, and incidents occurring on each shift, which is reviewed with incoming staff. Each staff signs the shift briefing sign in sheet to acknowledge receiving the information. Reviewed logbooks reflected they consistently documented internal incidents reported to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC).

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

The program maintains a written policy and procedures for key control and security which includes assignment, inventory, tracking, and storage of keys. The system includes key assignment with restrictions on usage, inventory and tracking of keys, secure storage, and procedures for addressing and reporting missing and/or damaged keys. The physical plant manager has overall responsibility for key control management. Observations made throughout the annual compliance review week found all staff and visitors surrendered their personal keys to master control in the administration building. Staff's personal keys are collected upon the staff entering the program and stored in a locked cabinet in master control. The master control operator is responsible for the control, issuance, and return of all keys and documents each key transaction on one of the two Key Control Logs for administration staff or operations staff. All key rings are tagged to record the ring number, keys assigned, and number of keys on the ring. All key rings and keys on them are recorded on the Key Log. A random review of three staff and their assigned keys matched the Key Log. The locked key cabinet was organized into separate sections by department for education, clinical, case management, staff mentors, and direct-care youth specialists with each key hook labelled with the assigned staff's name and a separate section for visitor keys. The keys to the key storage cabinet were kept on the wrist of the on-shift

master control operator. The program reported not having any lost keys in the past year. Restricted medical keys are maintained in a wall mounted/padlocked box in master control, for which only medical staff have the lock combination. Interviews with five staff confirmed each was knowledgeable of the key control process including how keys are assigned as well as the process for missing or lost keys, damaged keys, and restricted keys.

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

The program maintains a written policy and procedures which delineate items and materials considered to be contraband when found in the possession of youth in the program. The program maintains a system to prevent the introduction of contraband and to identify contraband items and materials through searches of the physical plant, grounds, visitors, vendors, staff, and youth. The program's youth handbook includes a list of contraband items and informs youth of the consequences if found with contraband. Each youth is provided with a written copy of the youth handbook upon admission into the program and each are oriented to the program rules including the list of items considered to be contraband. The program's policy and youth handbook included all items considered contraband as outlined in Florida Administrative Code. The list of contraband items included personal cellular telephones and/or equipment or electronic devices capable of taking pictures or video recordings, as well as smart watches, which are prohibited. The program's policy specifies the manner in which any unauthorized or contraband item is to be disposed, to include return to the sender, mailed to the youth's home, returned to the youth upon release, or in the case of illegal contraband, turned over to law enforcement. Unannounced room searches are conducted at least weekly at irregular and unpredictable times and common area searches are conducted daily. A review of shift reports, the master control logbook, Visitation Documentation Summary forms, and Common Area Search forms validated the program's practice of consistently monitoring areas of the facility, grounds, and youth rooms for contraband. The program's policy requires case managers to inspect all outgoing and incoming correspondence in the presence of the youth for unauthorized items, contraband, or information which may breach the security of the program. Interviews with five staff validated the program's practice. The program's policy and procedures, coupled with orientation training provided to all new staff by the assistant facility administrator (AFA), stipulates staff found in possession of contraband will be subject to disciplinary action up

to and including dismissal. All instances involving confiscation of illegal contraband require the program to turn the item over to local law enforcement authorities and file a criminal report.

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

The program maintains a written policy and procedures to ensure searches, and full body visual searches, are conducted according to Florida Administrative Code (FAC) at the time of admission, after off-campus activities, and visitation. Searches are conducted by two staff of the same gender as the youth being searched and conducted in a private area. Parents/guardians are notified of searches during visitation by way of the parent/guardian intake letter, which is sent at the time of each youth's admission. Youth are searched after school, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus activities and/or appointments, suspected of contraband, or are a security risk are searched, as validated by a review of program search forms. Observations made throughout the annual compliance review week validated youth are provided instruction regarding the search, youth searches were conducted by staff of the same gender as the youth, were conducted in a manner so as not to degrade the youth and were based on the Protective Action Response (PAR) training manual. Searches observed during the annual compliance review week included those conducted after youth exited the assigned sleeping room, after outdoor recreation, upon departing educational classes, prior to off-site transportation, and when youth moved from one area to another. Staff were observed conducting a full body visual search of one youth after the youth returned from an off-site transport. Five staff were interviewed, and each stated youth are searched after every movement and at any occasion when a youth is suspected of possessing contraband. Five youth were interviewed and all indicated searches occur after outdoor activities, when items are missing, and after visitation. Four youth indicated searches occur when returning from off-site activities.

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

The program has two operable vans, both equipped with safety screens separating the front seats from the rear passenger compartment, which are utilized for the transportation of youth. Both vehicles were examined and were found to be equipped with an up-to-date fire extinguisher, first aid kit, seatbelt cutter, window punch, and operable seatbelts for each passenger. First aid kits are not left in the vehicles when they are not in use and are maintained in master control. A review of annual vehicle inspections validated annual safety inspections were last completed on January 13, 2020. Reviewed maintenance repair invoices reflected repairs were completed when needed. The rear and side doors of the vans are unable to be opened from the interior of the vehicle. Observations of a youth transport indicated staff inspected the interior and exterior of the program van prior to the youth entering the vehicle and both staff and the youth were observed wearing seatbelts. A random check of twenty-one

personal and facility vehicles located in the parking lot within the program's fenced perimeter found all vehicles were securely locked.

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 maintains a written policy and procedures to ensure vehicles used to transport youth are properly maintained and contain safety and emergency equipment to ensure they are operated in a safe manner. Each vehicle utilized for the transportation of youth is required to pass an annual safety inspection. The program has two operable passenger vans and examination of the vans validated each had an up-to-date and fully-charged fire extinguisher, an approved first aid kit, a seatbelt cutter, and window punch. First aid kits remain in the master control area until ready for use. Rear passenger doors were unable to be opened from the vehicle's interior. The program maintains a list of twenty-four eligible staff who are approved as drivers for the program. The program assigns a ratio of one staff to five youth during transport, not including the driver.

Observations of a transport verified the youth was not unsupervised at any time, the appropriate staff-to-youth ratio was within the contractual requirements, and the driver was in possession of the program issued cellular telephone and a current driver's license. Inspection of twenty-one randomly selected personal vehicles in the employee parking lot found all doors were secured. Five staff were interviewed specific to what type of communication device staff are provided with during transport and four responded either the program's cellular telephone and/or their personal cellular telephones. One staff indicated two-way radios are issued as the transport communication device. All five staff confirmed they are not allowed to use personal vehicles to transport youth.

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

The program maintains a written policy and procedures requiring a safe and secure physical plant, grounds, and perimeter to be maintained and for weekly safety and security audits to be conducted. The program's assistant facility administrator (AFA) serves as the physical plant manager and is responsible for conducting weekly safety and security audits and submitting them to the Department. Identified deficiencies were documented on the reports including the status and due date of any needed corrective action and were added to the program's tracker.

A review of reports for the previous six months and an informal interview with the AFA revealed a weekly safety and security audit was not conducted in three of the previous twenty-six weeks; one was not completed by the previous facility administrator (FA) and the others reflected the program conducted two audits in one week in an attempt to have the second audit conducted in the one week count as the following week's audit. When corrected, issues were removed from subsequent reports while corrective actions still in process were updated on the reports for subsequent weeks. A review of security video surveillance footage during the annual compliance review indicated the digital video recording (DVR) device maintains recordings for at least thirty days or longer. An informal interview with the acting FA indicated the process in identifying and tracking safety and security deficiencies is through the weekly safety and security audits as well as through the program's tracker for remaining issues.

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 maintains a written policy and procedures to ensure youth do not use tools or equipment as weapons or for security breaches. The policy addresses storing and inventory of tools, as well as class type. Maintenance tools are kept in the maintenance shop which is a secure area inaccessible to youth. All tools classified as A-list tools by the program are prohibited for use and/or handling by youth at any time. A tool inventory is kept for each tool. A review of the inventory matched the tools maintained in the secure area without exception. The program's tools were numerically marked and securely stored when not in use. Tools are to be inventoried at least monthly; however, the program did not maintain any inventory of tools prior to January of 2020 due to the physical plant manager position remaining vacant until mid-December of 2019.

At the time of the annual compliance review, the program had one full-time and one part-time facility maintenance staff, in addition to the assistant facility administrator (AFA) assuming the role of physical plant manager. The maintenance staff are responsible for conducting the inventories and securely maintaining all tools and equipment. The maintenance staff complete a Daily Tool Log Inventory List which documents checks each day of each tool inventory item. All maintenance tools were inaccessible to youth and were observed to be secured in the maintenance shop. All tools are inventoried daily by the maintenance manager.

Observations of the daily inventory was conducted. Tools were primarily stored using a shadow-board system in a locked area within the locked maintenance shop and were marked for easy identification. There were some larger tools securely stored in the maintenance manager's office and these were inventoried as required. The maintenance staff utilizes a wheeled maintenance cart in which a variety of tools are used to complete each project. This cart would be maintained within the secured area when in use. The cart is stored in the locked maintenance shop when not in use. Observations of the tool storage area found it was well organized. Class B tools, including mops, brooms, and buckets are maintained in a locked closet in the multipurpose room which is accessible by all direct-care staff keys. The items are used by staff and youth when performing daily cleanup activities. Staff are required to complete a sign-out and sign-in log when items are taken and are returned to the designated storage closet.

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 maintains a written policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries. The program staff-to-youth ratio during a work project is no less than one staff to five youth. Interviews with staff indicated the program does not institute disciplinary work assignments and does not participate in vocational work activities involving on-site tool usage. A review of five staff training records and five youth case management records indicated staff and youth are trained in the use of class B tools only. Five youth were interviewed, and all responded they use mops and brooms while two youth indicated they also use scrub brushes. One youth stated they complete the laundry. Five staff were interviewed, and all responded youth are permitted to use mops and brooms, while four of the

five clarified only youth who are assessed and certified by case management to use class B tools are permitted to use the mops and brooms. One staff indicated youth are also allowed to use scrub brushes. Observations made during the annual compliance review found youth utilizing brooms for clean-up activities with staff providing direct supervision.

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

The program maintains a written policy and procedures specific to outside contractors entering the program areas with tools and equipment. The program is to restrict tools to those necessary, check tools upon the worker's arrival and departure, restrict youth access to the work area, ensure immediate reporting of any tool the worker cannot locate, and follow up if any tool is missing. The Vendor/Outside Contractor Tool Inventory List is used to document a description of each tool and the number of each tool brought on-site. The program revised the form in early December of 2019 to include the initials of both the staff and vendor at the time of entrance to and at the time of exit from the program.

A review of completed forms indicated the documentation did not consistently record the number of tools brought into or removed from the program. Additionally, the forms consistently failed to document the initials of the maintenance staff and vendor at both entrance and exit. Although each form included the signature of the physical plant manager to indicate their administrative review of the form within twenty-four hours of completed contractor work, each review failed to address missing items such as the number of tools brought into the program and staff and/or vendor initials, which were missing from the forms. The maintenance staff is to meet with all outside contractors upon their arrival to discuss the program's guidelines and restrictions. Reviewed documentation supported the forms were signed by the outside contractors and witnessed by the maintenance staff. An interview with the maintenance staff indicated they shadow the outside contractors during the entire time they are on-site. A review of three vendor project invoices in comparison to the program's contractor binder revealed the program did not maintain a contractor sign-in sheet, a Prison Rape Elimination Act (PREA) acknowledgement, nor a Vendor/Outside Contractor Tool Inventory List for each outside repairman or worker who entered the program to perform a work project requiring the use of tools.

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 maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on April 29, 2019, and a written policy and procedures to ensure drills are consistent with the program's COOP. The COOP requires the program to conduct unannounced fire drills once every month for each shift. Reviewed documentation validated fire drills were conducted on all three shifts each month, as required. The program additionally conducted monthly emergency drills on each shift ensuring fire, severe weather, disturbances, bomb threats, hostage situations, chemical spills, flooding, and terrorist threats/acts were covered on a rotating basis. Drill documentation included the type of drill, date and time, participants, a brief scenario description, deficiencies identified during the drill, and applicable corrective actions.

The program does not currently have a cleared fire inspection. The program received an Intermediate Construction Inspection from the Division of State Fire Marshal on November 7, 2019 and violations noted were regarding the fire sprinkler system, fire alarm system, improper storage of flammables and gasoline powered equipment, fire rated doors, as well as open electrical boxes in need of repair/replacement. The Department's Facility Management Services is overseeing and directing corrections of the noted violations which are being completed by the Department's contracted vendors. An informal interview with the program's regional compliance manager reflected the next fire safety inspection is not scheduled and it was unknown as to when they would conduct the next inspection.

Five interviewed staff all reported they had participated in a fire drill in the previous twelve months. Three staff indicated their participation in drills related to major disturbance, bomb threat, chemical spills, flooding, and escapes. Two staff reported taking part in drills related to weather, hostage situation, and/or terrorism scenarios. Three of the five interviewed youth responded they had participated in fire drills and have been instructed as to what to do in the event of a fire, while two reported they had not. Follow up questions with the two negatively responding youth revealed the youth's response was to indicate the fire drills did not occur "often" and the program had not had a fire drill "lately;" however, the youth knew what to do in case of a fire. Documentation indicated fire drills were last conducted at the program on February 11, 2020, February 25, 2020, and February 29, 2020. An interview conducted with the acting facility administrator (FA) confirmed fire and COOP drills are conducted once each month on each shift.

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

The program maintains a Department approved Disaster and Continuity of Operations Plan (COOP) available for all staff to review. The acting facility administrator (FA) was interviewed and indicated the COOP is available to all staff and is located in the administration building and in the medical department. The plan was approved by the Department on April 29, 2019 and provides for basic care and custody of youth in the event of an emergency or disaster. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery.

The COOP addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing has been identified should the program require evacuation due to an emergency or disaster. Reviewed documentation confirmed the program maintains critical identifying information in hardcopy binders including case management, mental health, and medical. All binders are easily accessible and mobile in the event of an emergency resulting in the program

relocating quickly or in the event needed information cannot be accessed electronically for all youth in the program. A review of five binders found each contained all required elements.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Failed 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 maintains a written policy and procedures specific to the storage and inventory of flammable, poisonous, and toxic items and materials which requires a perpetual inventory system to be maintained and current at all times. Youth are prohibited from locations where toxic items and chemicals are stored. The program did not maintain any inventories of chemicals prior to January of 2020. Beginning January 1, 2020, hazardous chemicals were recorded on the Master Daily Chemical Inventory form. Chemicals included on the Master Daily Chemical Inventory were those stored in a locked metal cabinet within the locked maintenance shop, which is inaccessible to youth.

Reviewed documentation reflected the Master Daily Chemical Inventory inconsistently identified each item. Some chemicals were fully identified while others only list a brand name with no other identity/identification for the chemical. The program corrected this during the annual compliance review to list the brand and full name of each chemical on the Master Daily Chemical Inventory. The program's Master Daily Chemical Inventory included two items (one sixty-seven-point six-ounce hand sanitizer and a sixty-gallon Sand Mix) for which no Safety Data Sheets (SDS) were included in the SDS binder. The program corrected this during the annual compliance review to remove the Sand Mix from the inventory and added an SDS for the hand sanitizer within the SDS binder. One chemical was included in the SDS binder but was not included on the program's Master Daily Chemical Inventory.

A locked closet in the program's multipurpose room is utilized to store class "B" tools and cleaning items, including liquid hand soap, spray cleaners, disinfectant, and cleaner/degreaser. The program's two maintenance staff, the assistant facility administrator (AFA), and all direct-care staff have keys to the class "B" storage closet. The program did not maintain an inventory of non-toxic chemicals stored in the class "B" tool closet with the size and quantity of each chemical at the start of each month. A handwritten Weekly Chemical Inventory form specific to the class "B" tool closet did record the quantity but not the size of each chemical item present in the closet on the date the contents were "inventoried," thereby not allowing the program to determine whether or when a chemical was missing. The form inventoried two bottles of soap on March 1, 2020 and one bottle of soap was in the closet on March 4, 2020 with no indication of items being signed out on the Chemical "B" Sign Out Logs for February or March. A bottle of bleach spray cleaner was found to have been returned to the class "B" closet during the annual compliance review week; however, this item was not included on any chemical inventory. Additionally, the dates on the handwritten Weekly Chemical Inventory indicated the form was not completed weekly with seven of the nine weeks documented since it was initiated on January 3, 2020. When completed, the program's Weekly Chemical Inventory form recorded the number of each chemical container; however, the inventory did not document the quantity of each chemical at the start of the month nor did the form document any reduction in the inventory number when a chemical was depleted and/or disposed of. Staff did not consistently complete the Chemical "B" Sign-Out Log when removing cleaning chemicals from the closet. During the annual compliance review week, a one-gallon bottle of soap was removed from a locked closet, depleted, and the bottle was thrown away without having been signed-out on the log or the

depletion of the soap documented on the inventory. Staff were also inconsistently not completing the Chemical "B" Sign-Out Log to indicate the amount/number of the chemical being returned and secured. One chemical cleaning product was included in the SDS binder but was not on the program's Weekly "B" Chemical Inventory nor shown to be depleted on the Chemical "B" Sign Out Log. Additionally, observations of the program's laundry room revealed the presence of a third one-gallon bottle of soap, while inventories accounted for two bottles, and three fifty-pound boxes of powdered laundry detergent which were not included on any of the program's inventory forms. Furthermore, SDSs for the laundry soap were not included in the SDS binder. A review of the Fire Safety Inspection Report, dated November 7, 2019, noted violations related to the maintenance shop are improperly storing flammables and gasoline powered equipment.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	**Limited 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 maintains a policy and procedures prohibiting youth from handling any flammable, poisonous, and/or toxic items or materials. Youth are not to clean, handle, or dispose of any toxic, bio-hazardous bodily fluids, or human waste. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. Five youth were interviewed and four of the five responded they are permitted to use paint under the direct supervision of staff, while another youth responded they were permitted to use a window cleaner. The area was behind two locked doors and a locked chain-linked fence stored in a locked metal cabinet. Most chemicals were found to be stored in areas inaccessible to youth; however, three fifty-pound boxes of powdered laundry detergent were observed in the laundry room on the Journey dormitory as well as one empty powdered laundry detergent box which was used as a wastebasket for dryer lint.

Observations noted of youth cleaning during the week of annual compliance review and demonstrated staff spraying the cleaning chemical and youth wiping to clean the area. Five youth were interviewed and four reported not using any chemical or cleaning products while one youth reported using laundry soap. An informal interview with the youth indicated the youth handled powered laundry detergent the previous week in the Journey dormitory laundry room as part of community service hours assigned by staff as a behavioral consequence. A review of video surveillance footage from the date and time indicated by the youth confirmed the youth did directly handle laundry detergent powder while under the direct supervision of a staff. Additionally, a reviewed controlled observation report documented a youth was in group, became upset, and ran into the laundry room within the program's Journey dormitory on

January 31, 2020, indicating the door was unlocked. The youth was able to pour powdered laundry detergent all over the laundry room floor before staff intervened. The program maintains a service agreement with Gregory Pest Solutions for periodic pest control services.

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 maintains a written policy and procedures for the disposal of toxic and/or hazardous materials. The policy requires adherence to procedures in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 Code of Federal Regulations. An interview with the maintenance staff and the assistant facility administrator (AFA) indicated the program did not dispose of any hazardous materials or toxic chemicals since the program moved into the current facility; however, the program utilizes Waste Management for the disposal of such items.

Food items are not prepared on-site as the meals are prepared for the program off-site and delivered to the program. As a result, there are no kitchen waste products to dispose. The maintenance staff who are responsible for the disposal process received training on how to manage and who to contact regarding the proper disposal of hazardous and toxic materials. Interviews with the maintenance staff and the AFA indicated coupled with observations of the multipurpose room area indicated there is a designated/locked storage room for mops, buckets, and brooms. A utility sink and/or floor drain is used to dispose of liquid waste resulting from janitorial work. An interview with the AFA validated the maintenance staff's practice. An interview with the program's acting facility administrator (FA) reflected all flammable, toxic, caustic, and poisonous items are disposed of off-property through Waste Management.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures to ensure youth are provided the opportunity to receive visitation and communication. Upon admission, each youth is oriented and provided with the program's visitation policy and guidelines. The program's visitation policy indicated consideration for requests of alternative visitation arrangements with parents/guardians, if needed. The program conducts visitation for all youth on Saturdays and Sundays from 12:00 p.m. to 3:00 p.m.; however, visitation was not included as part of the program's posted daily schedule.

Five reviewed youth case management records documented each youth signed for receiving information concerning visitation, telephone, and mail procedures upon admission. The program

posted visitation schedule and rules at the front of the facility outside the administration building. Interviews with program staff indicated the program encourages visitation and communication between youth and their family. A review of five youth case management records documented each contained a completed Approved Correspondence/Visitation/Telephone log. Additionally, Visitation Sign-In/Sign-Out Logs were reviewed and validated the program's practice. Each youth receives a youth handbook which outlines youth rights and includes the right to visitation, telephone, and mail access. Five interviewed youth each reported they have been provided opportunities to communicate with their family members by mail, telephone, and/or at visitation.

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

The program maintains a written policy and procedures for the use of controlled observations. The program has a two main controlled observation rooms located in the hallway between the Legacy and Journey dormitories across from the operations office. There is an additional room within each dormitory which the program may utilize for controlled observation if the two main rooms are in use. All rooms were observed to meet the size and construction requirements required by Florida Administrative Code. Searches are to be conducted and documented on the Controlled Observation Report form within the narrative report section.

Reviewed documentation confirmed the program utilized controlled observation seventy-two times within the previous six months. Eight randomly selected Controlled Observation Reports were reviewed, and one did not document the controlled observation room was inspected prior to placing the youth in the room or leaving the youth alone in the room. Documentation indicated a staff member of the same gender as the youth completed each search of the youth before the youth was left alone in the controlled observation room.

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

The program maintains a written policy and procedures for the use of controlled observation. Reviewed documentation reflected the program utilized controlled observation seventy-two times within the previous six months. Reviewed documentation reflected controlled observation was authorized by a supervisor prior to use to determine if it would further jeopardize the safety and security of the youth and others. Each youth placed in controlled observation was either deemed to be an imminent risk of physically harming self, staff, others, or the youth was engaged in major property destruction and was likely to compromise the security of the program or jeopardize the youth's safety or the safety of others.

Reviewed documentation of eight randomly selected Controlled Observation Safety Check forms confirmed the program conducted safety checks every ten minutes for each youth, which exceeded the fifteen-minute requirement. Each controlled observation report contained a Health Status Checklist form completed by a healthcare professional or staff of the same gender as the youth. Two of the eight reviewed placements lasted longer than two hours and each included required documentation of extensions granted every two hours by the facility administrator or designee; however, one indicated the justification for continuing controlled observation beyond

two hours was obtained one hour late, three hours and two minutes after the controlled observation began.

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

The program maintains a written policy and procedures for the use of controlled observation safety checks and for releasing youth from controlled observation. The policy requires safety checks to be completed every fifteen minutes on all youth placed in controlled observation. A review of eight Controlled Observation Safety Check forms was conducted and found all observations were completed every ten minutes, exceeding the requirement. Each entry indicated the time, code explaining youth's behavior while observed in controlled observation, and the staff's initials of who observed the youth. A youth may be released from controlled observation when it is determined the youth is no longer an imminent threat to self or others.

A review of each controlled observation report reflected the facility administrator (FA) or supervisor staff member authorized each youth's release from controlled observation based on the youth's verbal and physical behavior indicating the youth was no longer an imminent threat of harm to self or others and an in-house alert was entered for each applicable youth. Six of the eight reviewed reports were reviewed and approved by the FA or assistant facility administrator (AFA) within fourteen days of the youth's release from controlled observation to determine if placement was warranted and handled appropriately and two did not include documentation of a review by the FA or AFA occurring at all.

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

A review of five youth case management records was conducted specific to the safety planning process for each youth. Reviewed documentation reflected the program developed a program-specific Safety Plan form which identifies stimuli which included positive and negative effects on the youth. The program's Safety Plan form included an initial planning process and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth's admission to the program and all of the reviewed plans met the fourteen-day intake requirement. The safety plans are to be jointly prepared by the youth, parent/guardian or family member, case manager, and clinical staff. There was no indication the parent/guardian of the five-youth participated in the development of the plan; however, documentation revealed a copy of each youth's Safety Plan was mailed to the respective parent/guardian. The plans are reviewed and signed by all staff involved and the youth. The youth's safety plans are to be updated every thirty-days to include signatures and the date of the youth and staff. The program's Safety Plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences.

Five safety plans were reviewed and required a total of twenty-one plan updates. All plans were updated each month and each plan update for three youth was completed within thirty days as required; however, the plan for one youth had seven updates, one of which was updated

twenty-six days late rather than within thirty days as required. The plan for another youth was updated four times, two of which were more than thirty days after the previous plan/update was completed. The first update was completed six days late and the most recent update was completed four days late. Each plan followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. All five youth's safety plans incorporated recommendations of previous and current clinical assessments as required. Each youth's safety plan was maintained in the youth's mental health records as well as in the operations office, which is easily accessible to all staff. Additionally, each youth's safety plan was maintained in the youth's assigned sleeping room. Five staff were interviewed, although one staff did not respond to the question related to safety plans. All four responding staff knew where to locate each youth's safety plan and were able to explain the process for reviewing the plans. Five interviewed youth each confirmed they were involved in the development of their safety plan.