STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Miami Girls Academy

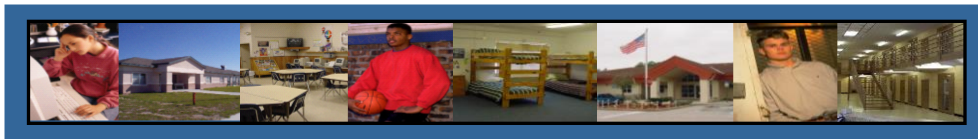
TrueCore Behavioral Solutions, LLC

(Contract Provider)

3300 NW 27th Avenue,

Miami, Florida 333142

Review Date(s): September 15-18, 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:

Rosa Flores, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Camelia Daley, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Paula Friedrich, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Patrick Morse, Office of Accountability and Program Support, South Regional Supervisor (Standard 3)

Program Name: Miami Girls Academy	QI Program Code: 1451
Provider Name: TrueCore Behavioral Solutions, LLC	Contract Number: 10139
Location: Miami-Dade County / Circuit 11	Number of Beds: 30
Review Date(s): September 15-18, 2020	Lead Reviewer Code: 182

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.20 Recreation and Leisure Activities	1.03 Provision of an Abuse-Free Environment *
2.05 Gang Identification: Notification of Law Enforcement	1.10 Delinquency Intervention and Facilitator Training
2.11 Performance Summaries and Transmittals	3.02 Licensed Mental Health and Substance Abuse Clinical Staff *
2.17 Educational Access	3.08 Specialized Treatment Services*
5.02 Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	5.01 Youth Supervision *
5.03 Behavior Management System Infractions and System Monitoring	
5.24 Controlled Observation	

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 *	Failed
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	Failed
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Limited

* 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	Limited
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	Limited
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
2.22	Safety Planning Process for Youth	Satisfactory

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

Standard 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 *	Failed
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*	Failed
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Satisfactory

* 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 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
4.19	Licensed Medical Staff*	Satisfactory

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

Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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

Program Overview

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 at the program; however, due to the outbreak of the COVID-19 pandemic and the Centers for Disease Control and Prevention (CDC) guidelines, this service was suspended effective March of 2020.

The program’s administration is comprised of a facility administrator (FA), assistant facility administrator (AFA), director of case management (DCM), a clinical director (CD) who serves as the program’s designated mental health clinician authority (DMHCA), an assistant clinical director (ACD), a registered nurse (RN) who serves as the health services administrator (HSA), physical plant manager, a human resource manager, and an administrative assistant. Case management services are provided by two case managers and one transitional services manager. Mental health staff includes two licensed mental health counselor (LMHC) therapists, one non-licensed therapist and one certified behavioral analyst (CBA).

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 two 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 psychiatrist is scheduled to be on-site each Monday. In addition to the regular duties, the psychiatrist participates in the weekly psychiatric medication management meetings with the HSA and DMHCA. The program also maintains independent contractor agreements with a State of Florida Licensed dentist and optometrist. 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-two security cameras providing coverage; however, at the time of the annual compliance review, two cameras were pending repair. At the time of the annual compliance review, the program had eleven vacant positions which included one licensed mental health professional therapist position (this is a key position which became vacant July 6, 2020), two staff mentor positions, four youth specialist I positions, three youth specialist II positions, and one master control operator.

Strengths and Innovative Approaches

Youth are provided the opportunity to have approved MP3 players for their dormitory rooms once they achieve Level Radiance or higher and not on precautions. Youth considered for this must to be assessed by clinical staff to ensure they can handle the responsibility of a MP3 player. The youth can then earn songs or buy songs from the program's boutique as incentives.

.

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 completed upon hire, as well as the submission of an Annual Affidavit of Compliance with Level 2 Screening Standards. The program conducts a background screening for all newly hired staff, volunteers, contracted providers, mentors, and interns with access to youth and confidential youth records prior to employment or volunteering. Since the last annual compliance review, the program hired thirteen new staff, who were all applicable for an initial background screening. The program did not have any new volunteers or mentors since the last annual compliance review.

A reviewed of documentation for the thirteen newly hired staff 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. The reviewed documentation confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, and the Florida Department of Law Enforcement's (FDLE) Automated Training Management System (ATMS). Each newly hired staff was 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 Berke System for youth care worker pre-employment assessment. The 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 the 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 two staff applicable for a five-year background rescreening. The reviewed documentation confirmed each had a rescreening completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to the five-year anniversary date of hire, with the information submitted to the BSU at least ten days prior to each 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)	Failed 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 for abuse reporting and for providing an abuse-free environment. The policy reflects youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. The program maintains an employee handbook which outlines the program's code of conduct. The program's practice is for all staff to acknowledge the 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 contained documentation of acknowledgement, receipt, and review of the program's code of conduct. Observations during the program tour reflected the

Florida Abuse Hotline telephone number and the Department's Central Communications Center (CCC) telephone number were posted throughout the facility. At the time of the annual compliance review, the program was under an outcome-based corrective action plan with the Department due to utilizing alternative programming. According to the alternative programming plan, upon admission to the program youth are placed in their rooms for an extended period of time with minimal items. The program has since installed two separate telephones with direct access to the Florida Abuse Hotline. The telephones were installed on both dormitories to allow the youth enhanced unimpeded access to the Florida Abuse Hotline. Youth now have unhindered access to contact the Florida Abuse Hotline or the Department's CCC. If a youth reports to staff they would like to make an abuse call, staff will contact a supervisor, the supervisor will bring the youth to a private office to allow the 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 eighty-two CCC reports and forty-five incidents were related to abuse reported since the last annual compliance review. A review of eight CCC reports, coupled with an informal interview with the facility administrator (FA), reflected there was one incident which involved a substantiated complaint against a staff, there were no additional 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 of the interviewed youth reported never being denied access to contact the Florida Abuse Hotline or the Department's Central Communication Center (CCC). Each of the youth reported they feel safe in the program. Each youth was questioned if staff are respectful when talking to them and other youth. Each of the five youth reported staff are respectful; however, three youth reported it can depend on certain staff. Each youth was questioned 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, two youth reported having heard profanity occasionally, and one youth reported hearing profanity often. This was addressed with the program's FA and will be addressed with staff.

Five staff were interviewed regarding the program's abuse and CCC reporting process. Five staff reported they never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. One staff stated they observed a co-worker using profanity when interacting with youth. This information was addressed with the FA, who advised this would be discussed with program staff. An interview was conducted with the FA, who stated the code of conduct includes the overall expectations for ethical and professional behavior for both youth and staff. If a staff is found in violation of abuse, staff shall be held accountable which can lead to termination. Physical abuse, threats, and/or profanity towards the youth are all considered critical violations of the code of conduct. Critical violations are subject to progressive discipline to include termination. The FA advised, the youth are knowledgeable with the reporting process of contacting the Florida Abuse Hotline and/or CCC. Furthermore, youth receive the youth handbook during new intake orientation, which describes the reporting process and the Florida Abuse Hotline and CCC telephone numbers posted throughout the facility. Staff are provided training in the reporting process as it is part of the new hire training and the reporting process is also discussed during the all staff meetings. During the annual compliance review, there were no observations made by the review team regarding any physical, emotional, or psychological

abuse; however, a CCC report was generated by an anonymous caller alleging improper conduct use of unnecessary force.

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 of physical, psychological, and emotional abuse. Five staff training records were reviewed and documented receipt of training on child abuse reporting requirements. Documentation within the last six months was reviewed for allegations of abuse to the Florida Abuse Hotline or the Department's Central Communications Center (CCC). A review of internal incidents and reports made to the CCC and the Florida Abuse Hotline found the program had twenty-two 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, confirmed each report was found to be unsubstantiated. Reviewed documentation of eight 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. The 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 maintains a written policy and procedures to address reporting incidents occurring at the program to the Department's Central Communications Center (CCC), in accordance with the Florida Administrative Code. The program had a total of eighty-two incidents reported to the CCC during the last six months, of which eight were reviewed. Reviewed documentation validated each reviewed incident was reported to the CCC within the required two-hour time frame of the program being made aware of the incident. Reviewed documentation of program logbooks supported each of the reviewed incidents were documented and were highlighted. A review of internal incidents and grievances for the past six months determined there were no incidents which should have been reported to the CCC and were not. Reviewed documentation confirmed all youth are explained their rights and how to report abuse by staff during the orientation and admission to the program. Additionally, each youth is educated on the grievance process during orientation and the process is outlined in the youth handbook, which is provided to all youth upon orientation. An interview with the program's facility administrator reflected staff involved in an incident or who witness an incident, are to complete an incident report and follow the reporting requirements as outlined within the policy. Staff are to contact the CCC and the Florida Abuse Hotline within a two-hour time frame of the incident occurring to report all incidents.

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 regarding Protective Action Response (PAR) techniques. 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 twenty-nine PAR reports completed within the last six months. A sample of five PAR reports were reviewed. Each of the reviewed PAR reports included a review by a PAR-certified instructor and was reviewed within the seventy-two hour time frame by all required parties. Reviewed documentation confirmed each participant completed a statement on the same day as the incident occurrence. 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. Four of the five reviewed PARs contained the completed post-PAR, medical review, and one of the reviewed reports reflected a PAR required medical review was not conducted. During the annual compliance review, the program director confirmed a medical review was not conducted for the one PAR report. 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. Four of the five reviewed PAR incidents included 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 the 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 18.73, which is above the statewide Residential PAR rate of 2.23. An informal interview with the program's regional compliance manager (RCM) was conducted regarding the rise in PAR rate. The RCM advised the program has had an increase in transfers of highly aggressive youth and indicate the majority of the programs PAR's were attributable to the same youth who have continued to exhibit the most aggressive behaviors towards staff in the program.

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 and approved on September 15, 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 of the staff training records reflected documentation to support each staff met or 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 and approved on September 18, 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.

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 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 phase of the youth grievance process, specifying time frames, 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 calendar 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 follows a three-phase grievance process to include an informal phase which utilized the “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 during the annual compliance review week reflected grievance forms were posted throughout the program and accessible to youth. The program maintains a locked box within each dormitory near the “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. 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 FA reflected their understanding of the grievance policy and procedures. Reviewed documentation confirmed there was a total of thirty-two grievances filed within the last six months, of which five were reviewed. A review of the five grievances revealed four were resolved at the informal phase, while one was resolved during the appeal phase. Each of the five reviewed grievances reflected they were reviewed within the required seventy-two hour time frame. 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 with the grievance forms, if needed. An interview with the FA was conducted who advised grievance forms are available to the youth in each dorm or if they request to speak to a staff member. The FA informed the process has an informal phase, a formal phase, and an appeal phase.

1.10 Interventions and Facilitator Training	Failed 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 clinical director to be evidence-based, a promising practice, or a practice with demonstrated effectiveness to address

the priority needs of each youth. Interviews with the program's clinical director and the program's 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. 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.

During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming. According to the alternative programming plan, youth were not able to participate in groups with their peers and were instead provided worksheets, during weeks one, two, and three. During weeks four, five, and six youth were able to participate in groups for one hour each day. A review of five youth individual performance plans supported each record 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 cohort to begin. A review of group sign-in sheets validated each applicable youth had or was currently participating in an intervention group. Specialized training is provided for specialty groups. If a staff 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. 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, Sisters Attracting Value Vision and You (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. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing

alternative programming which impacted the youth schedule; however, the reviewed documentation provided by the program supported youth did receive their life skills training while they were restricted to their room for a period of time. A review of five youth case management records reflected all youth are currently participating in life and social skills groups and trainings as required. Interviews with five youth reflected they are all currently participating in groups to include T4C, Sisters Attracting Value Vision and You (SAVVY) Sisters, Teen Relationships, Voices, Impulse Control, and mental health/substance abuse groups. Each of the five interviewed youth indicated they have learned behaviors in group such as to interacting with others, communication skills, regulate their emotions, and they get to role play with each other.

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 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 facility administrator (FA) reflected youth participate in writing apology letters. In addition, the youth participated in coloring pictures and writing letters for hospital patients at Nicklaus Children's Hospital. A review of staff training records confirmed four staff are trained to facilitate IOC. A review of five individual performance plans confirmed each youth was 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 Sisters Attracting Value Vision and You (SAVVY) Sisters and Voices: A Program of Self-discovery and Empowerment. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming which impacted the schedule; however, the program provided documentation supporting youth did receive gender-specific services while they were restricted to their room for a period of time. Reviewed documentation reflected groups

are currently being 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 facility administrator was informally interviewed and confirmed the program provides 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. Each of the reviewed youth records were applicable for documentation of alerts in the logbook and each alert was found in the logbook. It was 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 (FA), 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 FA. The FA confirmed internal alerts for mental health, substance abuse are entered by therapists and medical alerts are entered by nursing staff. Each of the five interviewed staff stated they are informed of medical and mental health alerts by the internal alert board, updates provided by the staff, and during daily shift briefings.

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

The program maintains 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 of Juvenile Justice 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 for the past six months reflected an agenda, sign-in sheets, along with meeting minutes summarizing the subject areas which were discussed. An interview was conducted with the facility administrator (FA) and they 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. "Chatty Cathy" and grievance forms were observed to be posted throughout the program as well. 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. Each of the five youth interviewed were knowledgeable with the process of providing youth input in the program. Three of the five youth do not believe the youth advisory council is effective and two believe it is either effective or somewhat effective. Any systemic issues are addressed during youth advisory board meetings.

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

The program maintains a policy and procedures for maintaining a community advisory board. Reviewed documentation of the previous two quarters reflected the program conducted two community advisory board meetings which were held for April and July 2020. The last annual compliance review was held in March of 2020; therefore, only the last two quarters were reviewed. The community advisory board meeting held in July 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, representative from the school board, other business community, and faith-based organizations. Reviewed documentation reflected the 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 July meeting to determine the level of involvement with program activities. The board member reported the only meeting having attended was held in July 2020 through a Zoom meeting or conference call and the community advisory board discussed various topics such as suitable community involvement activities and upcoming program events/meetings. The board member indicated the meeting was very informative. A review of the program's community advisory board meeting documentation confirmed the program met once in March and July 2020. The next expected quarterly meeting will be scheduled in October 2020.

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, the Department's 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 to help and minimize staff turnover. It was reported TrueCore programs are recognized with gift cards or are provided lunches for meeting program goals which are utilized to facilitate staff parties and boost morale. During an interview with the assistant facility administrator (AFA), 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. 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. Three of the five staff indicated they are briefed on annual reports and parent/guardian survey results while two said they are not. One staff reported the communication at the program is fair, three reported it as poor, and one reported it as very poor. Five interviewed staff were able 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, and one indicated suggestions can be made but not always accepted.

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. 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. Four staff indicated they receive performance evaluations annually, and one staff stated they receive evaluations every six months. An interview with the program's facility administrator (FA) was conducted and advised all staff receive an annual evaluation, which is scored and discussed and signed by the staff. Reviewed documentation of five personnel records reflected each included the specific job description and an applicable performance evaluation.

1.20 Recreation and Leisure Activities	Limited 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 the youth. An informal interview with the clinical director and 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 which 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. Observations confirmed staff take precautionary measures to prevent overexertion, heat stress, dehydration, and exacerbation of an existing illness or physical injury. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming which negatively impacted recreation and leisure activities as the youth were restricted to their room for a period of time.

A review of the logbook and activity schedule reflected a minimum of one hour of recreation activity or leisure time 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. 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 concentration 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's recreational therapist vacancy position was filled on August 10, 2020 and the program has an active full-time recreational therapist in accordance with the contract. The recreational therapist has a bachelor's-level degree in recreation and sport management with experience interning/volunteering as a recreational therapist. Reviewed documentation confirmed the newly hired recreational therapist has the NCTRC certification.

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 indoor/outdoor recreation and/or a large muscle activity each day. 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, soccer, yoga, board games, and water balloon games.

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 maintains a written policy and procedures requiring a notification to the parent/guardian and the youth's committing court upon each youth's admission. Five reviewed youth case management records found each parent/guardian was notified of the youth's admission by telephone and in writing within twenty-four hours of admission to the program. None of the reviewed records were for youth under the supervision of the Department of Children and Families. Each of the five reviewed records confirmed youth were provided a telephone call to their parent/guardian at the time of admission. Additionally, each record documented an admission letter was sent to the parent/guardian within forty-eight hours of each youth's admission. All five reviewed case management records validated the program's practice of sending a notification letter to the committing court(s) and to each assigned juvenile probation officer within five working days of each youth's admission.

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

The program maintains a written policy and procedures addressing youth orientation to the program. A review of five youth case management records indicated each youth completed program orientation within twenty-four hours of admission. Each reviewed record included a signed orientation checklist and written acknowledgement of receiving a copy of the program's youth handbook which includes information on the services available to the youth in the program, the program's daily schedule, expectations and youth responsibilities, how to access medical and mental health services, access to the Florida Abuse Hotline and the Department's Central Communications Center, the zero-tolerance policy regarding sexual misconduct, behavioral management system, items considered to be contraband, dress code and hygiene procedures, community access, individual performance planning, expectations for release from the program, visitation, mail, the use of the telephone, grievance procedures, emergency procedures, and assigned living units. Five youth were interviewed and each reported their orientation was conducted on the day they were admitted to the program and included program rules, procedures, schedules, and other pertinent information. There were no youth admissions during the week of the annual compliance review.

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 maintains a written policy and procedures which requires the program to obtain the written consent of any youth age eighteen years or older before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment. Five youth case management records were reviewed and two were applicable for youth over the age of eighteen years; therefore, an additional applicable record was selected for review. Each of the three applicable records validated the youth's written consent was obtained, as required.

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 maintains a written policy and procedures to detailing requirements for a classification process which promotes safety and security, as well as effective delivery of treatment services. Initial classification is used for the purpose of assigning each newly admitted youth to a living unit and sleeping room. The policy outlines the effective delivery of treatment services are to be based upon the determination of each youth's individual needs and risk factors. The program's policy addresses when reassessments are warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and behavioral concerns.

A review of five youth case management records confirmed each youth had an admission classification completed for the purposes of assigning the youth to a dormitory, sleeping room, therapist, and case manager. All five reviewed admission classification forms were completed on the date of admission for each youth. Classification meetings are conducted with the youth by the treatment team which includes the treatment director, case manager, therapist, medical staff, a living unit representative, the youth's parent/guardian, and juvenile probation officer. Admission classification forms were reviewed in five youth case management records and none were found to be applicable for requiring an alert to be entered into the Department's Juvenile Justice Information System (JJIS) at the time of admission.

The program maintains an internal alert system which is a component of the classification system to alert staff when mental health, substance abuse, physical health, security risk factors, or special needs related to newly admitted youth are identified during or subsequent to the classification process. The admission classification for one youth indicated a security status for the youth; however, JJIS did not indicate the alert was entered on the youth's date of admission.

The program's policy and procedures allow for youth to be reassessed and reclassified throughout their stay as the program learns more about the youth. Reclassification is to occur when youth are reassigned to a living unit, youth group, when assigned work projects or other activities involving tools, when a youth is anticipated to participate in off-campus activities, when privileges change, or at the request of the facility administrator. However, the majority of reviewed reclassifications were completed due to a change in sleeping room assignment. Each reviewed record documented the completion of a reassessment which included review of the program's policy and procedures, the youth's individual performance plan, treatment team notes, performance summaries, and reassessment results were discussed at treatment team meetings.

2.05 Gang Identification: Notification of Law Enforcement	Limited 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 maintains a written policy and procedures to address gang identification and the notification of gang information to law enforcement. The program assesses each youth at admission for suspected gang involvement. Alerts are placed in the Department's Juvenile Justice Information System for any youth identified as a gang member or gang associate and a letter is sent to local law enforcement agency's gang coordinator. Five active youth case management records were reviewed and four were found to be applicable for gang involvement or association. Documentation indicated local law enforcement was notified of the suspected gang activity in all four records. Three of the four applicable records were for youth whose program placement was outside of the youth's home county; however, the program had no documentation to indicate a law enforcement agency in any of the three youth's home counties were notified of the youth's suspected gang activity. During the week of the annual compliance review, notification was made to a home county law enforcement agency in each of the three applicable instances.

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 maintains a written policy and procedures to address gang prevention and intervention strategies. Reviewed documentation confirmed the program has implemented gang prevention and intervention strategies, utilizing GANGS: 50+ Stories of Fractured Lives as the primary curriculum. The Impact of Crime curricula is also used. Five youth case management records were reviewed, four of which were applicable. Reviewed documentation confirmed the program maintains sign-in sheets to document at least monthly youth participation in gang prevention and intervention activities. Each of the youth's performance plans were reviewed and found to include 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 Re-Assessments	Satisfactory Compliance
The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS. The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record.	

The program maintains a written policy and procedures requiring the completion of the Residential Assessment for Youth (RAY) with all newly admitted youth. A review of five youth case management records revealed 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. A copy of the RAY Assessment was also maintained in each youth's case management record. Three of the five reviewed records required and contained RAY Reassessments completed within ninety-days after the completion of the initial RAY Assessment. Two records indicated the RAY Reassessment was not completed within ninety days after the initial assessment, with one completed two days late and the other seven days late. One youth's case management record was missing a RAY Reassessment which was completed on July 17, 2020; however, the program was able to print a copy of the reassessment and placed it into the youth's record during the week of the annual compliance review.

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 maintains a written policy and procedures requiring the completion of Youth Needs Assessment Summary (YNAS) for each youth within thirty days of admission. Five youth case management records were reviewed and each contained a YNAS completed within thirty days of the youth's admission to the program. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in each youth's official case management record. A review of JJIS revealed one youth's YNAS was created on November 25, 2019 and was printed on November 26, 2019 due to the YNAS being left open in JJIS and the YNAS was not completed and closed until April 14, 2020.

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 maintains a written policy and procedures outlining the requirements for developing individual performance plans. The treatment team is to develop an individualized performance plan (IPP) within thirty days of each youth's admission to establish the goals each youth must achieve prior to release from the program, which are based upon the findings of the youth's initial Youth Needs Assessment Summary (YNAS). The treatment team members participating in the development of the IPP for each youth are to include the youth, a representative of program administration, case management and the youth's living unit, mental health treatment staff, and education staff as confirmed by each member's dated signature on the IPP. The goals are to be measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, including delinquency interventions, targeted court-ordered sanctions, and planned transition activities.

Four of the five reviewed youth records validated the performance plans were developed within thirty days. The initial performance plan for one youth was developed four days late on August 22, 2019 and not signed until sixty-two days later on October 23, 2019. Another performance plan was dated one day prior to the date of the youth's initial assessment. Each of the five reviewed IPPs addressed the top three criminogenic needs of the youth and all goals included specific measurable interventions, responsibilities of the youth and staff, and projected target completion dates. All five reviewed records indicated each youth was enrolled in education and career programing. The IPPs are to be signed within ten working days of completion by each youth and treatment team leader, as well as all parties with a significant goal responsibility. Two of the five reviewed IPPs were signed by the youth, treatment team leader, and all significant parties responsible for the goal completion. Three youth IPPs did not document the participation of an education representative, which the program indicated was owed to educational staff not having been on-campus due to the COVID-19 pandemic. The program was unable to document any remote review of IPPs by educational staff while off-site due to the COVID-19 pandemic. Once signed, the program is to send a transmittal letter and a copy of the IPP to the committing court, as well as each youth's juvenile probation officer (JPO) and parent/guardian. Four of the five reviewed youth records indicated a transmittal letter and a copy of the performance plan was sent within ten working days to the committing judge, JPO, parent/guardian. However, the record with the IPP signed sixty-two days after it was developed did not contain documentation to evidence the plan was sent to the committing court, the parent/guardian, or the JPO within ten days of being completed. Five interviewed youth confirmed they participated in the

development of their IPP and were familiar with their IPP goals, were able to explain the treatment process and confirmed they received a copy of their 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 maintains a written policy and procedures to ensure each youth's performance plan is revised, as needed to ensure the youth's successful completion of the program. A review of five youth case management records documented each performance plan had revisions based either on the Residential Assessment for Youth (RAY) Reassessment results or newly acquired information which warranted a change. Reviewed practice indicated the multidisciplinary treatment team met formally approximately every thirty days to discuss each youth's performance plan and documented the youth's demonstrated progress towards completion of each goal. Discussion of any youth with demonstrated lack of progress toward completing a goal would be discussed by the team during a special treatment team meeting and modifications would be made accordingly to the youth's performance plan. Two of the five reviewed records were applicable for youth with less than sixty days from transitioning from the program. Therefore, one additional closed record was selected to achieve the minimum sample size. All three applicable youth records documented revisions made to the individualized performance plans during the last sixty days of the youth's stay in the program, to ensure the youth's successful completion of the identified goals prior to discharge.

2.11 Performance Summaries and Transmittals	Limited 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 maintains a written policy and procedures addressing performance plan summary and transmittal requirements. Five youth case management records were reviewed and each was applicable for requiring performance summaries. Documentation validated four of the five reviewed records included performance summaries completed every ninety-days following the signing of the initial performance plan. One record had one performance summary which was due by July 19, 2020; however, it was completed thirty-two days late on August 20, 2020. A total of eleven performance summaries were completed for the five reviewed youth. Seven of the eleven performance summaries were original signed documents which included comments and were filed in the youth's case management record. Four summaries were completed in the Department's Juvenile Justice Information System; however, the four signed originals were not maintained in the youth records; therefore, it could not be determined if the youth read and commented on or signed the four summaries. All performance summaries included the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peer and staff, the status of each goal, and significant positive or negative events. One of the reviewed youth case management records was for a youth anticipating

discharge from the program on October 16, 2020. Documentation supported a release summary was completed on August 20, 2020 and forwarded to the assigned juvenile probation officer (JPO) at least ninety-days prior to the youth's planned release. Three closed records were reviewed and documentation supported a release summary was completed and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least ninety-days prior to each youth's planned release. Once approved, the program provided written notification to the youth's parent/guardian or when applicable, the Department of Children and Families. All three closed records indicated the program completed a Residential Assessment for Youth RAY exit assessment. None of the reviewed closed records were for Sexually Violent Predator Program (SVPP) eligible youth.

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 maintains a written policy and procedures to address the encouragement of parent/guardian involvement in case management services. Five youth case management records were reviewed for documentation of parental involvement. Documentation in the five reviewed records indicated the program facilitated parent/guardian involvement by mailing an admission letter within forty-eight hours of admission which included the dates of upcoming treatment team meetings. Each youth record documented the parent/guardian was encouraged to participate in the assessment, performance plan development, progress reviews, formal treatment team meeting, and transition planning for their youth. Parent/guardians are invited to participate in the youth's formal treatment team meetings by telephone. Documentation in the five reviewed records indicated the parent/guardian either participated by telephone or had the opportunity to provide verbal/written input on the program's Parent/Guardian Input form. Observation of the program's treatment team meeting during the week of the annual compliance review demonstrated parent/guardian participation and indicated the program's case management staff maintained regular communication with the parent/guardians. Five interviewed youth each confirmed their parent/guardians are involved in their case management services.

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 maintains a written policy and procedures to address treatment team and its members. At a minimum, treatment team includes the youth, representative from the program's administration, living unit and education, and others responsible for providing or overseeing the provision of intervention and treatment services. Five youth case management records were reviewed and each contained an initial individual performance plan signed by all required members of treatment team inclusive of each youth's case manager, a representative from administration, a living unit representative, educational staff, mental health staff, medical staff, the program's recreation therapist, the assigned juvenile probation officer (JPO), and the youth's parent/guardian or Department of Children and Families, when applicable. All required staff provided information to the treatment team meetings verbally in person or those not in attendance provided written input which was read to the team during the meeting. Reviewed documentation confirmed the youth's JPO, parent/guardian, and other pertinent parties were

invited in advance and encouraged to participate in treatment team meetings. For youth currently involved or having past/potential involvement in human trafficking, program staff will attempt to secure participation from the youth's current human trafficking service provider or one such provider in the community to also participate in treatment activities. The program is looking to establish a relationship with a local provider with which to work in the future.

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 maintains a policy and procedures stipulating for youth identified with a mental health, substance abuse, or physical health need, the youth's performance plan must reference or incorporate the youth's treatment or care plan. When a youth has a current behavior support plan or case plan through the Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD), the program coordinates the youth's performance plan with the youth's DCF/APD care plan for related issues. Five youth case management records were reviewed. All five youth had separate academic and mental health treatment plans which were incorporated into the performance plan. The DCF and/or APD behavior support plan was not applicable for any of the youth records reviewed.

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 maintains a written policy and procedures pertaining to formal and informal treatment team meetings. Five youth case management records were reviewed, and documentation supported formal treatment team meetings were conducted once every thirty days for all five youth. A review of the youth's formal performance plans demonstrated each plan contained the youth's name, date of review, any comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, and progress on performance plan goals. The formal review also included discussion of positive and negative behaviors, and behaviors resulting in physical interventions. Each meeting includes discussion of the youth's treatment progress and the Residential Assessment for Youth (RAY) Reassessment results. Each youth's informal performance review is conducted biweekly and documented in the case records. Documentation included the youth's name, date of review, a brief synopsis of the youth's positive and negative behaviors, progress in the program and on performance plan goals, performance plan revisions, and behaviors resulting in physical interventions as well as comments from treatment team members. Each youth is provided an opportunity to demonstrate skills acquired in the program. It is the program's practice to utilize the identical Performance Plan Review form for both informal and formal treatment team reviews, while clearly indicating at the top of the form whether each review was formal or informal. Five youth were interviewed and indicated they are provided the opportunity during treatment team meetings to demonstrate any skills learned in the program. All five youth confirmed the staff review their performance plan including progress made on performance plan goals, positive and negative behavior, and overall treatment progress.

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

An interview with the program's lead educator as well as with the on-site facility's administrator confirmed the educational component of the program which is under the direct guidance and supervision of the Miami-Dade County School District. The program offers a Type 3 vocational programming which instructs accountability and behavior skills leading to appropriate post-residential employment and values for positive living. The curriculum addresses the improvement of interpersonal communication skills, decision-making learning competences as well as reinforcing the youth's literacy proficiency which in turn enables the students to explore career choices within the Hospitality Industry and the basic skill set this trade requires. 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 management records were reviewed and all three contained the minimum essential documents for employment. Two of the three records contained a social security card, birth certificate, and identification card. One of the three records documented missing an identification card due to judicial denial due to lack of documentation. Two of the three records contained a completed employment application and two of the three records contained a résumé created by the youth which summarized their education, work experience, and/or career training. All three records contained a post-release Plan for Success which detailed the location of a local Career Source Center and a specific date for the youth's introductory appointment. 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.

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. Both the school district and the program requires the students to participate in educational and career related programming and expect the students to participate in the educational and vocational programming for 250-days of instruction distributed over twelve months of the year for a minimum of twenty-five hours a week. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming. During the use of the alternative programming plan, youth did not meet the required 300 minutes of educational instruction each day. A review of the of the current daily academic schedule and an interview with both the facility administrator and the program's lead educator verified the 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. Classes resume from 1:00 p.m. until 2:40 p.m. as well as attesting to educational and vocational classes occurring. The program's current logbook was reviewed for the program's educational access in regard to any documented delay or interruptions of instruction and confirmed the program currently has minimal educational interruptions.

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 educational transition plan is to formulate and provide to the youth services and interventions which are based on the student's assessed educational needs and post-release education plans. A review of three closed records each contained a transitional plan which incorporated elements of post residential educational planning and developed with the youth, the program, input from the program's education and aftercare staff and was based solely upon the youth's individual assessed needs, performance as well as their post release goals whether they be a continuation of education or employment. Additionally, each plan contained key monitoring responsibilities by individuals who are responsible for the re-integration and coordination of the provision of support services for the youth upon release from the program. 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. The identified plans included educational/vocational records and transcripts were transmitted to both the youth's parent/guardian and JPO upon the youth's 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 maintains a written policy and procedures to address transition planning, transition conferences, and Community Re-Entry Team (CRT) meetings. Three closed youth case management records were reviewed for transition planning conferences and a CRT meetings. Documentation indicated each transition conference was conducted at least sixty days prior to the youth's release date. All pertinent parties were invited to attend the transition conference in advance and if unable to attend, encouraged to provide written input to the team leader prior to the conference. Reviewed documentation in all three transition conferences supported the youth, case manager who also acted as the treatment team leader, the program director or designee, mental health staff, and medical staff participated in person, and educational staff, the parent/guardian, and the assigned juvenile probation officer participated by telephone. Each transition conference included a discussion of all transition activities, the person(s) responsible for completing each activity, and targeted completion dates. Case notes in each of the reviewed

three closed records validated a CRT meeting was conducted. A review of each closed record supported the program received an invitation to participate 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 is to assemble an exit portfolio for each youth to assist the youth upon release back into the community. A review of three closed youth case management records found the exit portfolios were discussed and signed by each youth during the exit conference. All three reviewed exit portfolios included a copy of the transition plan, a calendar with dates/times/locations of follow-up appointments in the community, a social security card or certification of social security number, birth certificate, vocational certificates, school transcripts, and a résumé. One closed record contained all required items. Two of the three closed records contained a State of Florida Identification card. The program explained the youth was unable to obtain a state of Florida Identification card due to the judge not responding to the program's request to take the youth off-campus for the purpose of obtaining the identification. Two of the three closed records included a completed sample employment application. Reviewed documentation confirmed program staff sent a copy to the juvenile probation officer for each of the three reviewed youth and each youth was given a copy of the exit portfolio upon release. One of the three closed records was for a secure maximum risk youth, whose record validated the youth was provided with completed forms and clear instructions on how to obtain relevant information. A plan was put in place to assist the youth in obtaining the required information and the staff responsible for assisting the youth to successfully complete all goals were identified during the transition conference.

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 maintains a written policy and procedures pertaining to exit conference requirements. The program is to conduct a conference at least fourteen days prior to each youth's targeted release date. The conference is to include the youth, residential program staff, the youth's juvenile probation officer, parent/guardian, and other relevant parties to review the status of the youth's transitional activities and finalize plans for the youth's release and re-entry into their home community. Three closed youth case management records were examined for completion of the exit conference. Reviewed documentation indicated each exit conference was conducted within the required time frame was conducted separate from the Community Re-Entry Team meeting and documented all the participants dated signatures upon the conference form. When applicable, the program staff noted on the signature line those who participated telephonically. The date of admission and release within all three closed records correlated with the dates entered into the Department's Juvenile Justice Information System. The case manager, parent/guardian, education staff, assigned juvenile probation officer, youth, and other pertinent parties participated in the exit conference either in person or by telephone. The status of transition activities was discussed in each of the three conferences.

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

The program maintains a written policy and procedures to address the safety planning process for youth. The program maintains a safety plan for each youth in their individual mental health record. Copies of the youth safety plans are maintained in a binder in master control, which is accessible to all staff. Five interviewed staff were able to identify the location of all safety plans. A review of five youth case management records supported all five safety plans were completed within fourteen days of the youth's admission and were jointly prepared by the youth, parent/guardian, and clinical staff. All five interviewed youth confirmed they contributed to their own safety plan. All three reviewed youth case management records documented safety plan updates were made every thirty-days. Four of the five interviewed staff confirmed clinical staff provide updates to the safety plans. One interviewed staff indicated they had last reviewed the safety plans upon youth admission, one indicated they had last reviewed the safety plans during the last treatment team meeting, and three staff indicating having reviewed safety plans either today, yesterday, or two days ago. One staff specified the most recent review took place during a stabilization session and another indicated the safety plans are discussed in clinical supervision.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) and as the clinical director. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:30 p.m. and provides weekend coverage on the third weekend of the month. In addition, between the other LMHC who serves as the assistant clinical director and the non-licensed master's-level therapist, the second weekend coverage of the month is split amongst the three. The assistant clinical director is scheduled to work the first weekend of the month and the non-licensed therapist works the fourth weekend of the month. The program does not maintain a sign-in log for the DMHCA since they are a full-time employee. The program's contract outlines the position requirements of the DMHCA to be accountable for ensuring appropriate coordination, implementation and oversight of mental health and substance abuse services in the program. The DMHCA supervises two non-licensed master's-level therapists; however, at the time of the annual compliance review there was one therapist vacancy. A review of the program's contract amendment, number thirteen; found the program will reduce the two non-licensed master's-level therapist positions to one due to the three percent cut in budget. The reduction will take place starting October 1, 2020 and will expire on June 30, 2021. In addition, the DMHCA supervises the certified behavior analyst and one recreational therapist. At the time of the annual compliance review, the DMCHA carried a caseload of four youth in the program. The DMHCA is responsible for providing weekly face-to-face clinical supervision to the program's non-licensed therapists. A review of the DMHCA position description indicates they provide oversight of the mental health and substance abuse clinical staff and shall provide at least one hour of weekly on-site, face-to-face supervision to each non-licensed therapist. The DMHCA serves as the mental health and substance abuse authority and is responsible for ensuring compliance with the contractual intensive mental health services, behavior modification, cognitive behavioral therapy, individual and group services, assessments, and diagnostic services. An interview with the DMHCA indicated they provide oversight in the clinical department. The DMHCA assures each youth is receiving their individual therapy, groups, and family therapy services as planned. The DMHCA conducts mental health and substance abuse record audits every month to ensure quality assurance. The DMHCA indicated they provide assistance in the de-escalation of crisis situations and ensures maintaining the overall well-being of the youth. Additional responsibilities also include oversight of Assessments of Suicide Risk, crisis intervention, diagnostic assessments, interview and examinations, and administration and interpretation of psychological and psychiatric testing. The DMHCA position requires the availability for consultation twenty-four hours a day, seven days a week. The program conducts daily management meetings in which the DMHCA attends and provides

updates regarding the youth and also participates in weekly meetings with the psychiatrist to discuss each youth receiving services. The DMHCA also indicated communication amongst the clinical staff and the rest of the program staff is paramount and the usual communication is daily through electronic mail (e-mail). A review of the DMHCA's position description validates the services provided and serving as the program's mental health and substance abuse authority.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	**Failed 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 is contracted to have one full-time designated mental health clinician authority (DMHCA) who also serves as the clinical director. In addition, the contract requires a licensed therapist to serve as the assistant clinical director. At the time of the annual compliance review, the program had a key licensed therapist position vacant since July 6, 2020. The program's contract also requires a psychologist position to be on-site weekly for approximately two hours. The psychologist is required to complete assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and meet weekly with the DMHCA to discuss youth tested and their results, and forward testing materials and results to the DMHCA for filing. The psychologist is also required to participate in weekly group supervision to provide input into case reviews, and/or provide training as need on various topics. According to interviews with the DMHCA, facility administrator (FA), and regional compliance manager; the psychologist has not been on-site or provided services in the last twelve months. The assistant clinical director's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The assistant clinical director is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:30 p.m. and provides weekend coverage on the first weekend of the month and shares the second weekend of the month coverage amongst the DMHCA and the non-licensed therapist.

At the time of the annual compliance review, the assistant clinical director carried a caseload of six youth in the program. The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment; therefore, the required services are provided only by one of the two licensed mental health counselors. The program maintains a comprehensive plan for mental health and substance abuse services. The procedures documented a review by the FA on July 6, 2020. The program maintains an agreement for professional services with a State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist who is scheduled to be on-site weekly. A review of the license reflected the psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2021. The FA verified both the psychiatrist and DMHCA are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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 is required to have two master's-level non-licensed therapists; however, at the time of the annual compliance review the program had one vacant position since July 6, 2020. A review of the program's contract amendment, number thirteen, found the program will reduce the two non-licensed master's-level therapist positions to one due to the three percent cut in budget. The reduction will take place starting October 1, 2020 and will expire on June 30, 2021. The master's-level therapist's degree was in social work and is currently a registered social worker intern in the State of Florida with an expiration date of May 19, 2024.

At the time of the annual compliance review, the program had seventeen youth in their population. The non-licensed master's-level therapist carried a caseload of seven youth, the designated mental health clinician authority (DMHCA) carried a caseload of four youth, and the assistant clinical director carried a caseload of six youth. The reviewed caseload assignments reflected each was below one therapist to twelve youth ratio requirements. The program also has a full-time board-certified behavior analyst (CBA) with an expiration date of January 31, 2021. The CBA is on-site Monday through Friday from 10:00 a.m. to 6:30 p.m. The program's therapists provide mental health and substance abuse treatment under the direct supervision of DMHCA. The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment; therefore, all applicable services are provided by one of the licensed mental health counselors.

The program's DMHCA is responsible for providing clinical supervision to the non-licensed clinical staff. Reviewed Clinical Supervision Logs found the DMHCA conducted the required weekly face-to-face supervision with each non-licensed clinical staff member. Reviewed documentation supported the weekly supervision was documented on a form which included all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The reviewed documentation found the completed Clinical Supervision Logs included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training.

The program hired the non-licensed therapist on July 27, 2020; therefore, the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services was not completed as of the annual compliance review. Reviewed documentation supported it will be part of the pre-service training plan. Reviewed mental health records and documented practice supported the applicable Assessment of Suicide Risk and Crisis Assessments were completed by a licensed mental health counselor or by one of the trained previous non-licensed therapists.

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 ensures mental health and substance abuse services are available to all youth who are determined to meet clinical criteria and certified to receive such services. Mental health and substance abuse treatment is provided on-site through the provision of intensive mental health treatment services. The program has a policy and procedures to ensure each youth's mental health and substance abuse needs are identified through a comprehensive screening process which ensures referrals are made when youth have identified mental health and/or substance needs or are identified as a possible suicide risk. Immediately, upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team staff to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation.

The screening process is designed to gather information on the youth prior to the youth entering the general population. As a key component of the initial intake process, following the completion of the Facility Entry Physical Health Screening form conducted by nursing staff, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) is administered by a trained staff member in the Department's Juvenile Justice Information System (JJIS). A review of five youth mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for each youth. The program provided training documentation for all applicable staff who completed the MAYSI-2 for each youth. Each reviewed MAYSI-2 reflected the screening was completed in full in the Department's JJIS.

Following the MAYSI-2 screening, the clinical therapist reviews all available information to include the youth's commitment packet information, pre-dispositional reports, previous psychological and/or psychiatric evaluations for information regarding suicide risk, mental health or substance abuse issues to include inpatient and/or outpatient mental health and substance abuse treatment. The review also includes youth history of drug, alcohol, emotional instability, significant trauma, mental illness in the family, and any suicide risk factors. The review is documented on the program's Records Review form. All reviewed MAYSI-2's resulted in the youth requiring a referral for further evaluation. Program practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results. Therefore, no additional referrals were generated during the intake process.

There was one instance where a staff member believed the youth needed further evaluation contrary to the MAYSI-2 results or where a need for a crisis intervention or emergency service as a result of the screening. This individual youth had hits for suicide ideation and was immediately screened for suicide utilizing the Department's Assessment of Suicide Risk (ASR). Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an ASR regardless of MAYSI-2 screening results. The program's facility administrator reported upon intake the program completes the MAYSI-2, ASR, and the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB).

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

The program maintains a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the process by which all youth, regardless of identified needs are referred for the completion of a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. The non-licensed therapist is responsible for completion of the evaluation, make recommendations, and to provide a provisional diagnosis. The program's licensed clinical staff is then responsible for reviewing each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and indicating a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review.

A review of five youth mental health and substance abuse records and an interview with the designated mental health clinician authority (DMHCA) supported the practice. Reviewed practice also supported the program assesses each youth utilizing the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Juvenile Assessment and Intervention System (JAIS), Trauma Symptoms Children's checklist (TSCC – Youth Sixteen and Under), Trauma Symptom Inventory (TSI – Youth Seventeen and Older), and the American Society of Addiction Medicine (ASAM). Three of the five reviewed youth mental health and substance abuse records contained an evaluation completed within thirty days of admission by a non-licensed therapist and two were completed by the licensed mental health counselor (LMHC).

Reviewed practice supported the licensed clinical therapist reviewed and signed the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation within the required ten calendar days for the three applicable evaluations. Each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, recommendations, and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use. Program practice is to conduct a re-evaluation and a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation every twelve months.

One of the five reviewed youth records was applicable for a re-evaluation which was completed as required. The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. Therefore, all substance abuse treatment services were provided by the LMHC. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each youth record contained a signed Youth Consent for Substance Abuse Treatment form and a signed Youth Consent for Release of Substance Abuse Treatment Records form. In addition, each youth signed a client rights and responsibilities form, consent for urine collection and analysis, and signed for a list of telephone numbers which included the Florida Abuse Hotline, Department's Central Communications Center, and the Department of Children and Families.

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

The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. Each youth's mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. Each assigned primary therapist develops the youth's individualized treatment plan based on identified needs, and treatment is provided by staff trained to perform the services provided.

A review of five youth mental health and substance abuse records documented each youth was assigned to a treatment team upon arrival to the program. Each youth record contained an Admission Card and an Initial Mental Health and Substance Abuse Treatment Plan created on the day of admission. The program's Admission Card identifies the case manager and the primary therapist and not all other multidisciplinary treatment team members. An interview with the regional compliance manager indicated during the admission classification meeting, which the program considers to be the first treatment team meeting, all parties participate in the development of the admission classification.

Reviewed practice did not support the education staff were part of the treatment team. Interviews with program staff indicated during the review period, education staff have not been on-site due to the COVID-19 pandemic. All education has been provided virtually. When questioned why the education staff could not participate virtually, the program staff indicated the admission classification usually was conducted after school hours and education staff were not available. A review of case notes for all five youth for the past six months supported mental health and substance abuse groups were being provided daily as scheduled. A review of services for each youth for a six-month period documented participation in group therapy, individual therapy, and family therapy sessions. A review of mental health and substance abuse group sign-in sheets supported groups were provided daily to youth.

The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. Therefore, all substance abuse treatment services were provided by the licensed mental health counselor (LMHC). Five youth were interviewed regarding participation in individual and family therapy. Each youth reported participating by telephone with their parent/guardian. Five program staff were interviewed regarding mental health and substance abuse groups at the program. Each interviewed staff reported the clinical therapists facilitate groups; however, some trained staff facility delinquency intervention groups. An interview with the assistant facility administrator and the director of treatment services confirmed the program offers intensive mental health treatment services.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse (MHSA) services. All MHSA treatment services are provided through the provision of intensive mental health treatment services. Treatment services conducted at the program are provided by or under the direct supervision of the licensed mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA). Youth determined to have a mental health and/or substance abuse Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, shall have an Initial MHSA Treatment Plan and an Individualized MHSA Treatment Plan. Upon release from the program, all youth 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.

Five youth mental health and substance abuse records were reviewed for an initial treatment plan. Each reviewed youth record contained an initial mental health substance abuse treatment plan on the Department's Initial MHSA Treatment Plan form documenting development on the day of admission. Each reviewed initial plan included signatures of the master's-level non-licensed therapist, licensed therapist, youth, and other treatment team members. However, each was missing an education signature and one was missing a living unit representative. All five reviewed youth mental health and substance abuse records were applicable for the youth being admitted on prescribed psychotropic medication and each initial plan included the youth's psychiatric needs. All five reviewed youth mental health and substance abuse records contained a completed Individualized MHSA Treatment Plan. All five individualized plans were developed within thirty days of each youth's admission. Each completed individualized plan was documented on the program's form containing all the elements of the Department's Individualized MHSA Treatment Plan form and outlined prescribed services including individual, group, family therapy, and psychiatric services. All five reviewed plans were signed by the non-licensed therapist creating the plan. The licensed therapist reviewed and signed the plan on the same day as the non-licensed therapist. All five reviewed plans documented signature of treatment team members who participated in the development of the plan; however, the education staff did not document their participation in the development of the plan as each reviewed plan was missing an education staff signature.

Interviews with program staff indicated during the review period, education staff have not been on-site due to the COVID-19 pandemic. Four reviewed plans were applicable of having parent/guardian input and signatures; however, none of the reviewed applicable plans documented the parent/guardian participated in plan development. Three of the five reviewed plans were applicable and included the provision for psychiatric services as two youth were discontinued from the medications they were prescribed prior to admission. Each plan

documented the prescribed services to include individual therapy one time each week, group therapy one time daily, and family therapy one time each month. Reviewed weekly progress notes validated each youth received the prescribed services as outlined on the individualized plan. All five reviewed youth mental health and substance abuse records documented the multi-disciplinary treatment team conducted a treatment plan review at least every thirty days. An interview with the DMHCA validated the practice and also indicated the treatment plan is updated annually or revised as warranted.

Three closed youth records were reviewed for the completion of a mental health and substance abuse discharge summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/ Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth being released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference as required. The program's practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

3.08 Specialized Treatment Services (Critical)	**Failed 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 maintains a policy and procedures ensuring mental health and substance abuse treatment services are provided through the intensive mental health treatment services programming. Youth with a Diagnostic and Statistical Manual of Mental Disorders (DSM–5) who demonstrate serious symptoms of the disorder and impairment in social, emotional, and/or adaptive functioning of substantial degree and duration. 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 treatment services are provided by licensed or master's-level therapists. Clinical services include mental health and substance abuse evaluations, intensive 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 psychiatric and pharmacological services. Treatment services is guided by an individualized mental health and substance abuse treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment is provided by a licensed mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA) and also provided by the other LMHC who serves as the assistant clinical director and the non-licensed master's-level therapist. Each youth is assessed upon admission utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming

which impacted the youth from receiving their treatment services as outlined in their treatment plan. Additionally, Clinical Services were not delivered in accordance with training and fidelity.

At the time of the annual compliance review, the program had seventeen youth in the census. The program provides each youth with group therapy services seven days a week. The program's contract outlines services provided include Seeking Safety, Living in Balance, Project Toward No Drug Abuse (TNB), Voices: A Program of Self Discovery and Empowerment, Teen Relationship, Sisters Attracting Value Vision and You (SAVVY) Sisters, Dialectic Behavioral Therapy (DBT) Skills Manual for Teens and Adults, Impulse Control, and Don't Let Youth Emotions Run Your Life for Teens: DBT. The program provided all services with the exception of TNB. According to interviews with the DMHCA, the TNB curriculum has not been initiated due to the lack of satisfying the recommended group size guidelines, which identify a minimum of five participants.

According to the DMHCA, the program had a maximum of two to the three youth qualified to participate at any given time in TNB. The program also has a full-time board-certified behavior analyst (CBA) with an expiration date of January 31, 2021. The CBA is on-site Monday through Friday from 10:00 a.m. to 6:30 p.m. The program's contract requires the program to have a licensed psychologist available to provide services as needed. The program indicated the psychologist has not provided services for the last twelve months. Interview with the DMHCA indicated the youth are provided individual therapy sessions weekly, group daily, and family therapy monthly. Services are reviewed in weekly face-to-face clinical supervision. Based upon the findings of the comprehensive evaluation, youth shall have an individualized mental health and substance abuse treatment plan developed, which includes service provisions for all identified treatment needs. Treatment interventions and frequency are specified on each plan. Youth identified with substance abuse treatment need, services shall be specified on the individualized treatment plan and provided on a weekly basis.

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 maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's procedures outline the role of a contracted psychiatrist for the management and oversight of psychiatric care. The program's psychiatrist supervises the treatment team and provides psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical and psychiatric follow-up visits are conducted on an individualized basis.

The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist, board certified in psychiatry as well as child and adolescent psychiatry to provide services to the youth at the program. A review of the license verified the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the program's contract with the psychiatrist

revealed the psychiatrist is to be on-site weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave; however, no back-up coverage was provided since the last annual compliance review. A review of the back-up psychiatrist's license confirmed it was a clear and active MD licensure in the State of Florida with an expiration date of January 31, 2021. The program submitted an Alternative Method of Service Delivery for TrueCore's Contract # 10139, Miami Girls Academy to the Department and it was approved for the program to provide telepsychiatry and telehealth.

A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist provided telepsychiatry weekly for approximately two to three hours, as required. Additional reviewed documentation supported the psychiatrist participated in the weekly clinical treatment team meetings with the program's designated mental health clinician authority (DMHCA) and the mental health therapists. The Psychiatrist/Treatment Team meeting minutes included a review of each referred youth, current medication, diagnosis, rationale for any applicable changes, and discussion and meeting outcome between the psychiatrist and clinical team. The program's policy and practice are to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission.

A review of five youth mental health and substance abuse records indicated three youth were admitted on prescribed psychotropic medications. However, program practice is to complete a psychiatric initial diagnostic interview completed within seven days of admission on all youth. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. Each reviewed record documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form and each contained page number three of the CPPN. All three applicable youth were assessed by the psychiatrist at least every thirty days. The review was documented on the program's Medication Management form and page three of the Department's CPPN was attached to each form completed in full. There were no documented lapses in psychiatrist services for the records reviewed. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported participation in weekly treatment team meetings and weekly on-site visits. The psychiatrist meets with the clinical treatment team members and the DMHCA every week to review youth in the program, usually on Mondays.

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 suicide prevention plan. The suicide prevention plan was last updated and approved by the program's administration on February 18, 2020. The plan outlines the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. An informal interview with the designated mental health clinician authority (DMHCA) indicated the program provides suicide prevention training throughout the year and conducts 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 maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services. The program maintains six complete suicide response kits located in the operations office, multi-purpose room office, master-control, medical, and one in each of the two vans. Interviews with the medical staff and observations during the annual compliance review confirmed the kits contain a knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct the Department's Assessment of Suicide Risk (ASR) on each youth during the admission screening process.

A review of five youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All five reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The program was able to provide three examples of youth who placed on precautionary observation (PO) within the last twelve months. One youth was placed on PO twice and the other youth was placed on PO once. The youth were placed on PO each time due to expressing suicidal ideations to staff. A review of the three applicable ASRs found the forms were completed by two non-licensed clinical staff and one by the licensed mental health counselor (LMHC). Each youth was referred and assessed on the same day determined to be at risk and was placed and maintained on a constant supervision status. The program documented the referral on the Department's Mental Health and Substance Abuse Referral Summary form.

Reviewed documentation supported the authorization of precautionary observation status, the completion of a suicide precautions observation log, and received supportive services from the mental health clinical staff. Reviewed training documentation supported the non-licensed staff received the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Reviewed practice supported the completion of a Follow-Up ASR the day after the ASR was completed. Upon completion of the Follow-Up ASR, the youth was transitioned to close supervision and remained on this level for twenty-four hours prior to being assessed by completion of a mental status examination and transitioned to standard supervision. Each transition to a lower supervision level documented a discussion between the LMHC and the facility administrator (FA). In addition, there was telephone contact with the youth's juvenile probation officer and parent/guardian regarding the

youth's potential suicide risk. A review of the Department's Juvenile Justice Information System documented an alert was initiated and removed as required for the applicable youth.

A review of the program's shift reports and logbooks documented clear updates regarding youth on PO status. A review of three applicable youth mental health and substance abuse records indicated each youth was placed in secure observation during the review period. Placement was authorized by the FA and designated mental health clinician authority (DMHCA). Reviewed documentation supported the secure room was designated in writing and a Health Status Checklist was completed prior to placement. A staff member of the same gender conducted a visual check of the youth to determine if there were any observable injuries. The secure observation room was inspected prior to the youth's placement to ensure it is safe and secure. Suicide Precaution Observation Logs were completed in full while each youth was in secure observation. All three youth were removed from secure observation within twenty-four hours. Each reviewed record documented written consent for continuation by the DMHCA. Each youth was provided supportive counseling services while in secure observation. Documentation validated the DMHCA and the FA concurred with the removal of suicide precautions for each youth. The FA has approved an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide.

The multidisciplinary review includes all required elements to include the circumstance surrounding the event, program procedures relevant to the incident, relevant training, pertinent medical and mental health services involving the victim, precipitating factors, and recommendations. The program utilizes Jackson Behavioral Health Hospital in Miami, Florida for crisis stabilization (Baker Act and for Marchman Act). Five interviewed staff each indicated when a youth expresses suicidal thoughts staff would talk to the youth, notify the mental health staff, search the youth and their room, place the youth on constant sight and sound, and document supervision.

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

The program maintains a written suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO) status. A review of five youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All five reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The program was able to provide three examples of youth who placed on precautionary observation (PO) within the last twelve months. One youth was placed on PO twice and the other youth was placed on PO once. The youth were placed on PO each time due to expressing suicidal ideations to staff. Three applicable PO records and Suicide Precaution Observation (SPO) Logs were reviewed.

The program's practice is to complete the Department's SPO Log form. The reviewed SPO Logs and Close Supervision Visual Checks (CSCV) Log were documented in real time and were conducted by the direct-care staff. The SPO Logs documented visual checks at least every thirty minutes and the CSCV Logs documented visual checks every five minutes. All three reviewed logs documented behavioral warning signs while the youth was placed on PO. Each reviewed SPO Logs documented the shift supervisor's signature and the clinical mental health

staff signature. The three youth placed on PO were interviewed and each indicated while they were on PO staff were with them at all times. Two of the three youth also indicated they were never left alone for any period of time. One youth indicated they were left alone one time when an incident occurred with another youth in the dormitory destroying property and hurting self. The youth indicated the staff came back shortly after the youth was in control and was not left alone again.

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

A review of five staff training records supported each staff received training on suicide prevention and implementation of suicide precautions. The training consists of a thorough review of the program's suicide prevention plan and includes detection techniques, behavioral cues, and recommended responses. Reviewed records supported each staff received two hours of computer-based training in the Department's Learning Management System (SkillPro) and four hours of instructor-led. A review of mock suicide drills confirmed each staff participated in mock suicide drills at least quarterly. There were forty-three staff in total; however, eleven were new hires. All thirty-two applicable staff each participated in at least one mock suicide drill semi-annually. Reviewed drills included the use of life saving measures including the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED).

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. An interview with the FA validated the program provides training or mock drills for staff, which includes emergency response to suicide attempts or self-inflicted injury. The FA also indicated all staff are notified when a youth is potentially suicidal by utilizing the program's alert board and through electronic mail (e-mail). Of the five interviewed staff, two indicated mock drills are conducted monthly and three indicated drills are conducted quarterly. According to staff interviews, staff members who were not present during the mock drill do have the opportunity to review each drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury.

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 crisis intervention plan. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process. The program maintains a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The program also maintains a written crisis intervention plan. The plan was reviewed and approved by program administration on July 6, 2020. The program's crisis

intervention plan included a process for notification and alert system, means of referral, communication, supervision, documentation, and review ensuring the safety and security of youth and staff.

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

The program maintains a written crisis intervention plan, which includes provisions for the completion of crisis assessments. A review of five youth mental health and substance abuse records found two instances requiring the completion of a Crisis Assessment. The program was able to provide an additional Crisis Assessment to meet the review sample size. A review of the three applicable Crisis Assessments found the program utilized the Department's Crisis Assessment form. Each Crisis Assessment documented completion immediately following the determination a youth may be in crisis. A Mental Health and Substance Abuse Referral Summary was completed by the clinical staff as well as a mental status examination. The Crisis Assessments was completed in full by the licensed mental health counselor (LMHC). The reviewed records documented the completion of a mental status examination prior to transitioning the youth to standard supervision. The program had no alleged Prison Rape Elimination Act (PREA) events during the annual compliance review period.

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

The program maintains a written emergency mental health and substance abuse services plan, which was last revised and approved by program administration on July 6, 2020. The plan included procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act and Marchman Act to Jackson Behavioral Health Hospital in Miami, Florida. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. Five interviewed staff indicated all program staff have the ability to call 9-1-1 in the event of an emergency.

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 maintains a written policy and procedures for ensuring emergency mental health and substance abuse services are provided to all youth. The program's emergency care plan outlines the process for Marchman Act and Baker Act proceedings. An interview with the designated mental health clinician authority (DMHCA) indicated the program had four youth requiring Baker Act and no applicable youth requiring Marchman Act during the review period. A review of three Baker Acts and the applicable youth mental health and substance abuse records found the licensed mental health counselor (LMHC) completed the required Certificate of Professional Initiating Involuntary Examination of Baker Act proceedings for all three youth. Reviewed documentation supported the three youth found to be in crisis were placed on one-to-one supervision at the time of discovery and prior to transport to Jackson Behavioral Health Hospital in Miami, Florida. All three youth were transported by law enforcement to Jackson Behavioral Health Hospital. A review of the Baker Act records and the program's logbooks confirmed each youth was placed on constant supervision, as required, upon return to the program. Each youth record indicated an Assessment of Suicide Risk (ASR) and mental health status examination was completed, prior to lowering the youth's supervision level to close supervision, as required. A mental status examination was completed prior to lowering the youth to standard supervision.

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 a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on March 12, 2019. The DHA holds an active, unrestricted license under Chapter 458, Florida Statutes, with a license expiration date of January 31, 2022 and the certificate of insurance expires on May 16, 2021. The DHA is a medical physician with specialty training in pediatrics. In the event the DHA is not on-site, the DHA does have a required doctor of equal licensure to cover for absences of any kind. Duties have been delegated to medical doctor who holds a clear and active license in the State of Florida which expires on January 31, 2022 to act on behalf of the DHA and is a medical physician with specialty training in pediatrics. The program does not utilize an advance registered nurse practitioner/advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly.

Reviewed physician sign-in logs for the past six months supported the DHA was on-site weekly as required; however, one record reflected the DHA had a ten-day lapse between on-site visits. The DHA on-site visit was on June 23, 2020 and the following on-site visit was not until July 3, 2020. The DHA is responsible for communication with program staff regarding youth medical needs and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation, and on-going monitoring of medications and chronic medical medications. Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans as needed. An interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and reviews healthcare policies and procedures, and nursing protocols.

An interview with the DHA confirmed this practice. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2021 and the certificate of insurance expires on July 31, 2020. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires on February 28, 2022. The optometrist license expires on February 28, 2021.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an

annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on October 22, 2019, and the facility administrator documented a review on March 16, 2020. The program maintains three full-time registered nurses (RN) and two part-time RNs. One RN is the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by the HSA.

Reviewed training curricula and plan reflected a new nursing staff would receive the required pre-service and orientation training to include on-the-job training. The program has not had any new medical staff hired since the last annual compliance review. The program maintains a nursing protocol manual developed and approved by the DHA on July 10, 2019. Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures on various dates throughout the annual compliance review period. Treatment protocols were reviewed by the DHA on June 16, 2020 and remained effective without change to include nursing protocols, non-licensed medical and emergency protocol guide, and approved first aid kit content and designee. The medical tech training curriculum was updated on the treatment protocol.

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 parent/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent/guardian who have legal custody and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. A review of five youth healthcare records found four were applicable for a signed AET. Each of the four reviewed youth healthcare records contained a copy of the signed AET and the word "Copy" was clearly stamped on each. One youth was eighteen years old upon admission to the program and the youth healthcare record contained the required signed consent. Each reviewed AET and/or Release of Information form or Court Order was filed in each youth's healthcare record in the appropriate section. There were no original AETs reviewed. An interview with nursing staff indicated the licensed practical nurses review all admissions in the Department's Juvenile Justice Information System and validates the AET. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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 the parent/guardian is informed of significant changes in the youth's medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five reviewed youth healthcare records supported three were applicable for parental notification.

Reviewed documentation supported each parent/guardian was notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic condition. Each of the three reviewed youth records required parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent. Five youth healthcare records were reviewed and none were applicable for off-site care; therefore, three additional applicable youth healthcare records were requested. Reviewed documentation in the three applicable youth healthcare records supported the parent/guardian was notified of the off-site care. Verbal parental/guardian consent is obtained as soon as possible after an order is written. Verbal consent is obtained for any OTC medication which has not been previously approved. For new prescriptions, significant dosage change, or for discontinuing a medication; a parental notification is also completed. All attempts are made to verbally contact the parent/guardian prior to a youth leaving for the emergency room (ER). The parent/guardian is also contacted upon the youth's return with the results of the ER visit. Written notification is completed after the return from the ER.

Nursing interviews indicated parental/guardian notifications are written and sent the same day as the event to include off-site appointments, new intake, seen on-site by the designated health authority, and/or any other pertinent medical event. Three of the five reviewed youth healthcare records supported each youth was prescribed a psychotropic medication. Documentation supported the required parent/guardian consents were obtained for each youth. The reviewed healthcare records documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parent/guardians received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Copies of all correspondence were maintained in the applicable youth healthcare records.

Three out of the five healthcare records were applicable and received immunizations. Policy and procedures outline the AET provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian shall be provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. When the parent/guardian does not consent to the vaccinations, the Parent Notification of Health-Related Care: Vaccination/Immunizations form is sent with the required VIS to obtain consent. There were no applicable reviewed healthcare records of the parent/guardian not consenting due to religious reasons. Program practice is for the nursing staff to pull each youth's immunization record from the Florida Shots website within the first week of admission and have the designated health authority document a review of the record. This practice was confirmed by the nursing staff in an interview.

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 receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth healthcare records supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). Reviewed Chronological Progress Notes documented consent and results of a pregnancy screening for each of the five youth who were sexually active. An interview with nursing staff indicated a nursing assessment is conducted immediately following the initial search, shortly after the youth's arrival. The licensed practical nurse notifies the designated health authority (DHA) by telephone, text, or verbally, if on-site, with the youth's history and identified chronic condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. None of the five reviewed healthcare records were applicable for a change in custody.

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 establishing a system whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The 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. For youth with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review of five youth healthcare records supported each youth received a healthcare orientation on the day of admission as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for female adolescents. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay documented in the healthcare record. Five reviewed youth healthcare records 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 practice is for the designated health authority (DHA) to be notified by telephone, text message, or verbally if on-site of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form

and the DHA signs the form at the next on-site visit. A review of five youth healthcare records reflected the DHA was notified by telephone and the Notification of Admission form was filed in the practitioner's section of each healthcare record. In addition, the nurse documents the DHA notification on the Nursing Chronological/Notification Progress Note – Female Admission form and the form is filed in the nursing chronological notes section of the healthcare record.

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 nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth healthcare records supported a new HRH was completed for each youth within seven days of the youth's admission. Reviewed practice validated the HRH was completed on the same day of each admission. The nursing staff provided their electronic or written signature on the HRH. The DHA documented a review of the HRH on the completed CPA. An interview with nursing staff confirmed the practice and indicated the HRH is also completed whenever any new significant medical event or change occurs and then annually, thereafter.

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 receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program also maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth healthcare records reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form.

All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. One youth record reflects an "X" was marked on the CPA without any further elaboration on the abnormality by the DHA. An informal interview with the registered nurse (RN) stated the DHA made this in error and will be on-site on September 22, 2020 to correct the error and will initial the error. All five reviewed CPAs did not complete sections numbers twenty-three, twenty-four, twenty-five, and twenty-six (pelvic and rectum examination) and each documented deferred by clinician due to age on the CPA and not medically necessary.

Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable. A review of five youth healthcare records reflected each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the past year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a Tier I tuberculosis screening. All Tier I tuberculosis screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were also documented on the Department's Infectious and Communicable Disease

(ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff also review the Department's Juvenile Justice Information System to ensure there is a documented TST and to ensure the TST is current and documented as required. The nursing staff also utilizes a tracking log to monitor TST/PPD due dates. There were no youth in the program with symptoms suggestive of active TB. The program's procedures outline if 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.

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 (STIs). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of five youth individual healthcare records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and was performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all five youth. Each youth identified as sexually active also receive a pregnancy test and results were documented in the healthcare record. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present.

Nursing staff interviews confirmed the program's practice. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth healthcare records supported each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. A reviewed of five youth healthcare records reflected one consented for testing. Two additional records were reviewed to support the program's practice.

The program utilizes the designated health authority (DHA) to provide pre and post-counseling. Reviewed youth healthcare records validated when youth received pre-counseling, testing, and post-counseling; the youth's Health Education Record form was updated. The results were placed in a sealed envelope marked "Confidential" with the youth's name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff also maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing if applicable, date of testing, pre-testing date, post-testing date, and provider name. Five interviewed youth indicated they can request HIV testing. Each interviewed youth indicated they can receive gynecological services, if necessary.

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 all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's sick call process upon admission.

The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires on February 28, 2022 and the optometrist license expires on February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program offers youth the opportunity to make a sick call request, seven days a week, once daily conducted by the licensed nursing staff. Each weekday sick call is conducted from 11:40 a.m. to 12:40 p.m. and 2:30 p.m. to 3:00 p.m. On the weekends sick call is conducted from 12:30 p.m. to 1:00 p.m. and 4:30 p.m. to 5:00 p.m.

A review of five youth individual healthcare records found four youth completed a Sick Call Request form at least one time during their stay. 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. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. The program's procedures outlined the healthcare staff will automatically refer the youth to the designated health authority (DHA) for an evaluation and treatment. Reviewed healthcare records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff supervisors and youth care worker II staff received medical technician training delivered by the RN.

An interview with the RN indicated refresher training is provided annually. The program maintains sick call boxes mounted to the wall located in each of the two dormitories. The box is monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. During the annual

compliance review, there were no youth who filled out a sick call or required episodic care; therefore, observation of the program's sick call process could not be observed. Five interviewed staff indicated nursing staff conducts sick call. Five youth were interviewed and each reported being seen within one day of submitting a sick call request. Five interviewed staff stated sick call is conducted by nursing staff.

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. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth individual healthcare records found all five youth requiring episodic and/or first aid care during their stay in the program. 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. Nursing staff also maintained an Episodic/First Aid Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews validated the program's practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log.

The program maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains two AEDs located in the multi-purpose/staff conference room and program operations room. Nursing staff ensure the AEDs are functioning adequately and include the inspection of the batteries and pads to ensure they are in working order. The AED procedures and instructions are also provided by audio, as indicated by the nursing staff. Reviewed documentation supported the AED batteries expire in April 2022 and April 2023 and the pads expire on October 31, 2021 and November 2020. The batteries were last changed on March 2018 and April 2019 and the pads were changed on December 2019 for both AEDs.

Reviewed documentation for six first aid kits including the two kits used during youth transport, supported each contained the required items and all items were current and all were within their expiration period. A list of the items contained in each first aid kit were maintained on an inventory log with the date of the weekly inspection along with nursing staff initials. The program also maintains four full suicide response kits, which are located within the medical office, master control, multi-purpose/staff conference room and the program operations room. Each kit contained a knife-for-life, wire cutters, needle nose pliers, and seat belt cutters. The first aid kits are checked weekly and the AED and suicide response kits are checked monthly by nursing staff to ensure each are adequately supplied and in operating order.

An observation of the facility program's AED, first aid kits, and suicide response kit was completed and all contents were accounted for. The reviewed training records found all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current CPR and AED certifications. Reviewed training records supported shift supervisors, youth care worker II staff,

and the facility administrator have been trained in the administration of the epinephrine auto-injector. The program conducts announced and unannounced mock emergency medical drills monthly on each shift. A review of drills conducted for the past twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. Observation of postings informing staff of their right and responsibility to call 9-1-1 was observed and located in master control. The program reported emergency telephone numbers were located in each office and the medical clinic was accessible to staff but inaccessible to youth. Five interviewed staff indicated they are able to call 9-1-1 when a youth is identified with a medical emergency.

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

The program maintains a written policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. 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 none of the youth went off-site and were not applicable; therefore, three additional applicable youth healthcare records were reviewed. Two youth required off-site care and/or emergency care and one youth was seen off-site for dental care. Each of the three off-site care events were documented in the healthcare records. The reviewed youth healthcare records indicated each youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record.

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; however, due to the Covid-19 pandemic a follow-up was not conducted as the dental office was closed until further notice. An interview with nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call/Referral Log Form. Three reviewed youth healthcare records was applicable for off-site emergency care and reviewed documentation supported the parent/guardian was notified.

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 ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. 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 indicated four youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening

(FEPHS) form. All four youth were classified with a medical grade of two through five. Each youth were currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records reflected each youth received periodic evaluations as required.

An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more often. An interview with nursing staff indicated youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The RN indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth and as needed. In addition, the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. In an interview, the psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. The program did not have any youth taking anti-tuberculosis (TB) medication or who were pregnant. Reviewed documentation supported the Department's Problem List was updated, as required

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 medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and documented. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered.

An interview with nursing staff indicated only a licensed practical nurse completes the admission and any applicable medications are verified with the youth's medical records and the youth's parent/guardian. A review of five youth individual healthcare records indicated three were admitted into the program on prescribed medication and two were prescribed medication subsequent to admission. Nursing admission notes documented the youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication and verbal notification or telephone was noted. The program's practice is to notify the DHA for all youth admissions. Reviewed documentation reflected the DHA or psychiatrist resumed the prescribed medication for the youth. Reviewed Medication Administration Records (MARs) validated the practice.

There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Each of the three applicable reviewed youth healthcare records reflected the prescribed medication was continued, discontinued, changed, or a new medication was

ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications.

Five reviewed youth individual healthcare records found each youth had a MAR outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All three applicable youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. It was observed, all medications were maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two licensed registered nurses (RNs). If there is only one RN on-site, the inventory is completed by the RN and a shift supervisor. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff maintain locked cabinets in the medical clinic with OTC medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff, who are also shift supervisors are permitted to assist youth in OTC medications when nursing staff are not on- site.

Opened OTC medication is stored in the locked medication cart. Closed and unopened OTC medication is stored in a locked cabinet in the medication administration room. Observations of the medication administration room and medication cart were found to be clean and organized and all medications were separated in the medication cart as required. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. Two youth were applicable for a refusal of medication and it was clearly documented on each MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. During the annual compliance review, there were no youth on the sick call list or episodic list. Due to the COVID-19 pandemic and the Centers for Disease Control and Prevention (CDC) guidelines an observation of medication administration could not be observed.

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's procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. There were no applicable youth taking any controlled substances; however, it was observed the program does have a secure locked box within the secured locked medication cart. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the temperature is monitored daily. Five interviewed staff and five interviewed youth reported medication is administered by nursing staff.

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 all medications shall be identified and secured in a locked area designated for storage of medications. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications are not stored with injectable or topical medications. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications. The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly.

Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two licensed registered nurses (RN). Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires on July 31, 2022. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nursing staff to dispose of the medication by placing the medication in an All-Purpose RX Destroyer System bag and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. All non-controlled medications are sent back to 1st Choice Pharmacy for credit. Three OTC medications were reviewed and the inventories were accurate. Three sharps were reviewed and validated each inventory was accurate. A review of the program's inventory count from the past six months validated no discrepancies were identified.

4.17 Infection Control – Exposure Control Plan	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 exposure control and infection control ensuring staff, youth, volunteers, 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 Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on March 16, 2020 and designated

health authority (DHA) on April 25, 2019. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms.

The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program had no instances in which the Dade County Health Department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease.

The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The plan includes risk assessment and methods of compliance. 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. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. The plan is accessible to all staff and is maintained in the medical clinic, master control, and in the administrative offices.

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, to ensure all youth are provided gender-sensitive and trauma-informed primary services, gynecological care, and obstetrical services. Five youth individual healthcare records were reviewed and none of the youth were applicable for pre-natal care. Additional records were requested from the program; however, at the time of the annual compliance review, the program did not have any pregnant youth reside at the program. An interview with the Health Services Administrator (HSA) confirmed the program has not had any pregnant youth since the last annual review; therefore, additional health records could not be reviewed. The program provided the training agenda/sign-in sheets for gender-specific and pregnancy complication staff trainings. Five youth were questioned if they have received prenatal, obstetrical, or gynecological services while in the program and they all indicated they have not needed the services.

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

The program maintains a written policy and procedures ensuring all licensed staff are credentialed and current. The program has licensed nurses to include on-site nursing coverage provided by registered nurses (RNs). Reviewed documentation supported all RNs licenses were clear and active for each nurse according to Florida Department of Health Medical Quality Assurance. All RNs had a valid and current cardiopulmonary resuscitation (CPR) certification.

Standard 5: Safety and Security

5.01 Youth Supervision (Critical)	Failed 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 to be one staff to five youth during awake hours and one staff to six youth during sleep hours. The ratio for off-site activities, transportation, and visitation is one staff to five youth. In an informal interview, the assistant facility administrator stated the driver is not considered as part of ratio when transporting youth. Observations of staff supervision for four days during the annual compliance review week included classroom activities, line movement, school breaks, formal and informal head counts, and outdoor recreation activities. The observations ensured staff-to-youth ratios were maintained as required. In addition, a check of at least five vehicles was conducted daily to ensure vehicles were locked in the parking lot.

A tour of the program verified the buildings were clean, well maintained, and graffiti free. There were no unsecured chemicals and tools. The facility administrator (FA) reported the program has fifty-two security cameras in which fifty were working and two cameras were damaged by youth and not working. A work order for the cameras has been approved. During the annual compliance review week outdoor activities and/or movement were observed and found 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 Positive Performance System. Five interviewed staff explained formal counts are conducted every hour and informal counts are conducted when master control calls. If there is a discrepancy in the count, all movement stops during the counts, and youth dormitories are checked.

5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training	Limited 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 the behavior management system (BMS). The program's version of the BMS is the Positive Performance System (PPS), which is designed to foster compliance with the program rules and teaches youth alternative pro-social methods of dealing with behavior. In addition, youth learn about acceptable and unacceptable ways of dealing with problem situations. The program utilizes Girls 4 Success and the Values and Beliefs system which youth are provided daily opportunities to earn points, incentives, and recognition. The system design acknowledges the consistent needs for immediate reinforcement and recognition. A written description of the PPS 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 PPS 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 PPS system levels. The five levels include Level One: Foundation, Level Two: Radiance, Level Three: Harmony, Level Four: Elegance, and Level Five: Grace. The PPS 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 youth were informed about the program's PPS system 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 PPS system for all staff. A review of five pre-service and five in-service training records confirmed each staff was trained in the PPS system utilized at the program, as required. Observations made during the program tour revealed the program had postings in the dormitories of the PPS system rewards for positive behaviors. 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. The PPS addresses a ratio of four to one positive to negative consequences. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited. The program altered the PPS with an internal system, Alternative Placement Programming without the consent of the Department. The Alternative Placement Programming did not follow the contracted PPS. A critical deficiency was identified, and the program is currently on an Outcome-Based Corrective Action Plan (OBCAP). Five staff were interviewed and verified the PPS system uses a points and level system which includes four to one ratio for rewards and

consequences. All five staff stated youth receive incentives such as snacks, special meals, access to an MP3 player, and hygiene products. All five staff stated items cannot be taken away from a youth as a consequence to negative behavior; however, youth can lose access to the MP3 player and monthly incentives. Five interviewed youth confirmed they were aware of the PPS and provided information on the PPS within their youth handbook. The facility administrator (FA) was interviewed and confirmed the program utilizes a Growth and Changes/Positive Performance System. This system includes a daily point card and behavioral referral system.

5.03 Behavior Management System Infractions and System Monitoring	Limited 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 Positive Performance System (PPS), which requires positive and negative consequences in a ratio which exceeds four-to-one positive-to-negative consequences. The PPS 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 policy and procedures were reviewed to ensure there was a protocol where staff are provided feedback regarding the implementation of the PPS system. The program's contract was reviewed to ensure all required parties were involved in the development, implementation, and on-going maintenance of the PPS system. The program altered the PPS on April 20, 2020, with an internal system Alternative Placement Programming, without the consent of the Department. The Alternative Placement Programming did not follow the contracted Positive Performance System. A Major deficiency was identified, and the program is currently on an Outcome-Based Corrective Action Plan (OBCAP).

On July 29, 2020, the program stopped using the internal Alternative Placement Programing and went back to the contracted PPS system. The program no longer utilizes room restrictions as a form of imposing sanctions for inappropriate behavior. A review of five pre-service and five in-service training records confirmed each staff was trained in the PPS system utilized at the program, as required. In addition, the designated mental health clinician authority (DMHCA) trained education staff in the program's PPS system to be included during school hours. Five staff and five youth were interviewed, and each confirmed staff discuss imposed sanctions, consequences, and alternative acceptable behaviors with the youth. Each of the interviewed youth were aware of the PPS, aware it is posted throughout the program, and were provided information on the PPS within the youth handbook.

All five youth explained the difference between each level and how youth can move from level to level. All five interviewed youth verified youth are never allowed to punish other youth. Youth reported they can earn daily and weekly points to move up to the next level which includes more privileges. Incentives include special meals, nail polish, and additional television time. All five youth stated staff does not reward youth equally and some staff show favoritism. One youth rated the PPS as poor, three rated it as fair, and one rated it as good. All five interviewed staff

stated youth are informed of the consequences and are given the opportunity to explain their behavior during special treatment team. Five interviewed staff stated they received feedback from supervisors regarding their implementation of the PPS. The facility administrator (FA) was interviewed and confirmed the program utilizes a PPS tracker/level system and consequences are monitored through special and monthly treatment team meetings.

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. The program has fifty-two cameras of which fifty cameras were operational at the time of the annual compliance review. A work order to repair the cameras has been approved and the program is waiting for the repair technician to repair the cameras. The camera system stores thirty days of recordings. It is the program's practice for master control to call for a count every five 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. The room check forms identify the name and room number of each youth. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming. During the use of the alternative programming, the program was unable to provide video documentation to validate youth were being observed at least every ten minutes while they were in their rooms. The program's video surveillance system has the capability of maintaining records for up to thirty days. However, the program provided written documentation of conducting five-minute checks when the youth were placed in their rooms. Reviewed documentation of a sample of Ten-Minute Check and Common Area Search Logs supported the youth were being observed as required while in their rooms. During the annual compliance review week a review of randomly selected one-hour periods on five different dates was conducted and verified staff conducted checks of youth in their sleeping quarters in five minute intervals. Five interviewed staff stated room checks are conducted every five minutes when youth are placed in their room for sleeping or non-punishment reasons.

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 conducts formal head counts each hour and informal head counts at least twice during each shift as well prior to youth movement. The program's policy indicates counts are also conducted during power outages, escapes, riots, or any other disruptions which may occur. A review of randomly selected dates and times in the facility logbooks for the previous six months validated head counts and movements were conducted at the beginning of each shift, after outdoor activities, during emergency situations such as riots and during drills (actual or simulated). In addition, the program logbooks included documentation of new admissions, releases, transfers, and youth temporarily away from the program. Documentation verified there were youth temporarily away from the program due to being placed in the Department's Detention Center and/or the county jail. The daily census is documented in the facility logbook at the start of each shift. All formal and informal counts documented in the logbook included the time of the count and number of youths at each location.

Observations made during the annual compliance review week indicated it is the program's practice to conduct hourly formal counts. In addition, observations included counts conducted in the classrooms, dormitories, and outdoor activities. Informal interviews of five staff were able to explain formal counts are conducted every hour and informal counts are conducted when master control calls. If there is a discrepancy in the count, all movement stops during the counts and youth dormitories are checked.

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 maintains a spiral-bound logbook with numbered pages for each month. Observations made during the annual compliance review week 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. 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. Logbooks included entries for emergency situations, use of mechanical restraints, population counts, law enforcement access to youth, perimeter checks, and youth placed in controlled observation. In addition, admissions and releases were documented as well as transports away from the program. The program ensures direct-care staff including each supervisor, are briefed during shift changes. Each staff signs the shift briefing sign-in sheet to acknowledge receipt of the information. Reviewed logbooks reflected the program consistently document internal incidents reported to the Florida Abuse Hotline and/or the Department's Central Communications Center.

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, which includes replacing a damaged key. 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 attached keys are recorded on the key log form. A random review of three staff and their assigned keys matched the key log form. 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 six months. 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 to identify materials considered to be contraband, to prevent contraband from entering the facility and consequences when found in the possession of youth in the program. 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 the past six months 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. The program's policy and procedures, with orientation training provided to all new staff 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. The interviewed facility administrator (FA) stated the program's policy 10-3 Chapter 10 Safety and Security: Contraband Searches, is followed as it relates to contraband and illegal contraband.

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. Full body searches are conducted by two staff of the same gender as the youth being searched and conducted in a private area. Searches are conducted by a same gender staff over the youth's clothing. Parent/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 and were conducted in a manner 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 movement, after outdoor recreation, upon departing educational classes, youth handling Class B tools, youth attending groups or interviews, and when youth moved from one area to another. During the week of the annual compliance review, there were no transports, new admission, visitation, or off campus activities to observe searches. Five staff were interviewed and each stated youth are searched after every movement and full body visual searches are conducted when returning to campus from an off-site activity. Five youth were interviewed and each indicated searches occur during all movement, when items are missing, after visitation, and 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. A check of at least five vehicles was conducted daily to ensure the vehicles were locked in the parking lot.

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 the safety and security of youth and the community when youth are transported outside of the facility. The program uses two vans to transport youth. Each van utilized for the transportation of youth is required to pass an annual safety inspection. Reviewed documentation verified all approved drivers had a valid driver's license. The program completes a driver's license check on a monthly basis. The program assigns a ratio of one staff to five youth during transport, not including the driver. The program provides secure transportation for high-risk and secure maximum risk youth determined to be at greater risk.

Observations of a transport could not be observed because there were no transportations scheduled during the week of the annual compliance review. Five staff were interviewed specific to what type of communication device staff are provided with during transport and two responded the program's cellular telephone and all five staff indicated two-way radios are issued as the transport communication device. An informal interview with the assistant facility administrator (AFA) confirmed staff are provided with a company cellular telephone during transportation of youth. Four of the five staff stated the safety equipment in the transport vehicles included a first aid kit, seat belt cutter, fire extinguisher, and window punch. One staff stated they do not transport youth. All five staff confirmed they are not allowed to use personal vehicles to transport youth. One of the five interviewed staff stated the transport vehicles are searched for contraband prior to and after each use. Four of the five staff stated the vehicles are not searched. Four of the five interviewed staff stated they would contact the program if an emergency response arises during vehicle transport. One of the four staff did not transport youth and was unsure of the process. Five interviewed youth stated they never saw anyone place contraband in a transport vehicle. Four of the five youth stated they feel staff are driving transport vehicle(s) safely and one youth did not feel staff were driving safely. This information was provided to the facility administrator (FA), who advised this would be addressed with program staff.

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 facility administrator (FA), assistant facility administrator (AFA), and the physical plant manager (PPM) are 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. The deficiencies documented during the annual compliance review included, two broken cameras, two doors in the maintenance room in need of repair, damaged front gate from the waste management truck, and the bathroom tiles and lights in the Journey dormitory bathroom were damaged.

Documentation reflected a vendor will be contacted to repair the two cameras. Two quotes were received from separate vendors and a major maintenance fund request will be submitted. A fencing vendor has provided a quote for the damaged gate, which was forwarded to waste

management. A vendor will be contacted for the broken tiles and lights. A review of reports for the previous six months revealed a weekly safety and security audit were conducted. A review of security video surveillance footage during the week of annual compliance review indicated the digital video recording (DVR) device maintains recordings for thirty days. An interview with the FA indicated the program completes Weekly Safety and Security Audit as outlined in the program's facility operational procedures (FOPs).

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 have a tool management system which ensures youth do not use tools or equipment as weapons or for security breaches. The policy addresses the issuance, inventory, and control of equipment and tools. A review of the past six months of inventory logs and the tool storage room located in the maintenance shop, verified tools are securely stored when not in use, easily marked for identification, and inventoried prior to and following work activities. All sharp edged and pointed tools are inventoried daily when in use. The maintenance staff is responsible for conducting the inventories and securely maintaining all Class A tools and equipment. The maintenance staff completes a Daily Tool Log Inventory List which documents each tool in inventory.

All maintenance tools were inaccessible to youth and were observed to be secured in the maintenance shop. Tools were primarily stored using a shadow-board system in a locked tool room within the locked maintenance shop and were marked for easy identification. Observations of the tool storage area found it was well organized and secure. 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 room.

A review of five staff training records and five youth case management records indicated staff and youth are trained in the safe use of Class B tools. In addition, a Youth Risk Assessment is conducted monthly by the case manager in order to qualify to use Class B tools. Youth are not permitted to use Class A tools. There was no instance of a missing/lost tool for the past six months. Prohibited tools at the facility include machetes, bowie knives, and other long bladed knives. If a tool is broken or inoperable, the physical plant manager (PPM) places a tag on the shadow board indicating the tool is broken. The facility administrator (FA) is notified and the tool is placed on the Tool Inventory and Audit form. The tool is disassembled and disregarded in a trash receptacle away from the facility. A Tool Purchase form is filled and approved by the FA to buy a replacement tool. If a tool is missing, the program will stop all youth movement, staff supervising youth and surrounding areas are to stay vigilant, and the program will be searched until the tool is found. All five interviewed staff stated youth can use brooms and mops. In addition, two staff stated youth can use scrub brushes.

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. A review of the program's procedures verified staff are required to complete a sign-out and sign-in log when Class B tools are taken and are returned to the designated storage room. A Youth Risk Assessment is conducted monthly by the case manager in order for youth to use Class B tools. Five youth case management records were reviewed and all five youth had a Youth Risk Assessment completed by the case manager. The program staff-to-youth ratio during a work project is no less than one staff to five youth. Program staff search youth after a work detail has been completed. The assistant facility administrator stated youth conduct cleaning work detail on the weekends. An observation of a youth cleaning was conducted by viewing camera footage. The youth was properly supervised while sweeping and searched after the job was completed. The broom and dustpan were returned to the Class B storage closet. Five youth were interviewed and each responded they use mops and brooms, while four youth indicated they also use scrub brushes

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

The program 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 and includes the initials of both the staff and vendor at the time of entrance and at the time of exit from the program.

A review of the past six months of completed forms indicated the documentation consistently recorded the number of tools brought into or removed from the program. Additionally, the forms included the initials of the maintenance staff and vendor at both entrance and exit. 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. The maintenance staff meet with all outside contractors upon their arrival to review the program's guidelines and restrictions including contraband items. Reviewed documentation supported the forms were signed by the outside contractors and witnessed by the maintenance staff. A review of four vendor project invoices and the program's contractor binder revealed the program maintained a contractor sign-in sheet, a Prison Rape Elimination Act (PREA) acknowledgement, and 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. In addition, documentation was entered in the program's logbook detailing the time, date, contractor/vendor name, and which staff escorted the contractor.

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 March 20, 2020 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, gang/riots, hostage situations, and chemical spills 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 fire evacuation routes are posted throughout the facility. All fire extinguishers were inspected on May 20, 2020 and are good for one year from the date of inspection. The fire marshal conducted a fire safety inspection on May 06, 2020 and verified the program passed the fire sprinkler system inspection, the construction final inspection, and the fire alarm inspection.

Five interviewed staff all reported they had participated in a fire drill and escape drill in the previous twelve months. Four staff indicated their participation in suicide drills. Three staff reported taking part in drills related to severe weather. Two staff indicated they participated in chemical spill drills. One staff indicated they participated in a hostage situation. One staff participated in a flooding drill and one staff participated in a terrorism drill. All five interviewed youth responded they had participated in fire drills and have been instructed on what to do in the event of a fire. An interview conducted with the 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 facility administrator (FA) was interviewed and indicated the COOP is available to all staff and is located in the administration building and in master control. The plan was approved by the Department on March 20, 2020 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. An informal interview with assistant facility administrator verified there is a generator which powers the facility and the Department's detention center for continuous operation and services during emergency or disaster situations. The generator is tested weekly to ensure it is in good working order. In addition, the program has flashlights in the administration building and water bottles in the maintenance room.

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

The program 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. Hazardous chemicals included on the Master Daily Chemical Inventory log 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 log identified each item by brand name and the number of the chemicals in inventory. Even though the Master Daily Chemical Inventory form was constantly updated, there was no staff initials of the person conducting the inventory from June to March 2020, which was addressed in the program's last annual compliance review. The log starting in April 2020 revealed staff were initialing and making the needed updates confirming the logs to have been correctly documented.

The storage area was observed and the log matched the inventory with the actual items on hand and determined the types of items stored. 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 maintenance staff, the assistant facility administrator (AFA), and all direct-care staff have keys to the Class B storage closet. The program maintained 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. The locked laundry room had laundry soap which was inventoried on the Master Daily Chemical Inventory log. A sign was posted in the laundry room prohibiting youth from using the laundry detergent. The Class B and laundry room were observed and the log matched the inventory with the actual items on hand and determined the types of items stored.

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

The program 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 three of the five youth responded they are permitted to use paint under the direct supervision of staff, for art projects. Two interviewed youth responded they do not use chemicals. All chemicals were found to be stored in areas inaccessible to youth. The assistant facility administrator stated youth clean the dormitories on the weekends. An observation of the youth sweeping the dormitory was viewed by the security video. The youth did not use any chemicals. The program maintains a service agreement with an outside vendor for periodic pest control services. A review of the program's Preventative Maintenance Checklist verified maintenance schedules and repairs are being conducted as outlined in Florida Administrative Code or according to the contract language, whichever is greater.

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 utilizes Waste Management for the disposal of such items. Empty chemical bottles are stored in the maintenance room and transported to the local landfill by maintenance staff. Food items are not prepared on-site as the meals are prepared for the program off-site and delivered to the program. 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 and observations of the multipurpose room area found there is a designated and locked storage room where the mops, buckets, and brooms are maintained. The program has a utility sink and/or floor drain which is used to dispose of liquid waste resulting from janitorial work. An interview with the facility administrator (FA) validated the maintenance staff's practice. An

interview with the program's 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.

The 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 has a written policy and procedures for youth to have visitation and communication with family members in order to re-establish family and community relationships. During admission, each youth is provided with the program's visitation, telephone and mail policies and guidelines. The program's visitation policy indicated consideration for requests of alternative visitation arrangements with parent/guardians, if needed. The program conducts visitation for all youth on Saturday's and Sunday's from 12:00 p.m. to 3:00 p.m.; however, due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control (CDC) on-site visitation has been suspended at the Departments direction on March 13, 2020. The program is providing alternative measures such as allowing youth to make Zoom calls to parent/guardians. In addition, youth can write letters or call by telephone at least once a

week to approved family members. A review of the past six months of the telephone and mail log verified youth have consistent communication with family members.

Five reviewed youth case management records documented each youth signed acknowledging the receipt of information concerning visitation, telephone, and mail procedures upon admission. According to the assistant facility administrator all incoming and outgoing mail is checked for contraband in the presence of the youth. The program contacts the youth's juvenile probation officer to verify the youth's parent/guardian and other family members are not under current or past investigation for youth with a history of human trafficking. The program posted visitation schedule and rules at the front of the facility outside the administration building. Initially, four of the five interviewed youth each reported they have been provided opportunities to communicate with their family members by mail, telephone, and/or at visitation. A follow-up interview with the youth which was marked as no on the interviews verified it was an error and stated the youth have the opportunity to communicate with their family members.

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 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. An inspection of the controlled observation room verified the door was metal with a shatter-resistant window. All the light fixtures were covered with shatter-resistant materials, the vents were not easily accessible, there were no electrical outlets in the room, and the electric switches were located outside the room. Reviewed documentation confirmed the program utilized controlled observation fifty-four times within the previous six months. Three Controlled Observation Reports were reviewed and documentation verified 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 a search of the youth before the youth was left alone in the controlled observation room.

5.24 Controlled Observation	Limited 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 fifty-four times within the previous six months. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming. As part of the alternative programming plan, youth were at times, confined to their room. The program did not document the youth being locked in their rooms as controlled observation with their alternative programming plan; therefore, they did not complete the required documentation. A review of the current documented practice 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/or was likely to compromise the security of the program or jeopardize the youth's safety or the safety of others. Reviewed documentation of three selected Controlled Observation Safety Check forms confirmed the program conducted safety checks every ten minutes for each youth. Each controlled observation report contained a Health Status Checklist form completed by a healthcare professional or staff of the same gender as the youth. One of the three reviewed placements lasted longer than two hours and included the required documentation of extensions granted every two hours by the facility administrator or designee.

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. During the annual compliance review period, the program was placed on an outcome-based corrective action plan for utilizing alternative programming. As part of the alternative programming plan, youth were at times, confined to their room. During the use of the alternative programming, the program did not document the youth being locked in their rooms as controlled observation; therefore, the program did not complete controlled observation safety checks for these instances. The programs controlled observation policy requires safety checks to be completed every fifteen minutes on all youth placed in controlled observation. A review of the program’s current documented practice including a review of three Controlled Observation Safety Check forms was conducted and found all observations were completed every ten minutes, exceeding the requirement of fifteen minutes. Each entry indicated the time, code explaining the 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. All three 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.