STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Miami Youth Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
10855 Southwest 84th Street
Miami, Florida 33173

Review Date(s): September 22-25, 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:

Teves Bush, Office of Accountability and Program Support, Lead Reviewer (Standard 1 and Interviews)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Peter Keelan, Office of Education, South Region Education Coordinator (Standard 2)
Gabriel Medina, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Gary Mogan, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Patrick Morse, Office of Accountability and Program Support, South Regional Supervisor (Standard 3)

Program Name: Miami Youth Academy
Provider Name: TrueCore Behavioral Solutuions, LLC
Location: Miami-Dade County / Circuit 11
Review Date(s): September 22-25, 2020

MQI Program Code: 1289
Contract Number: 10000
Number of Beds: 28
Lead Reviewer Code: 154

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

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/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	Non-Applicable
4.19	Licensed Medical Staff*	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	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	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Miami Youth Academy is a twenty-eight-bed program for fourteen to eighteen-year-old males, located in Miami, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides Substance Abuse Overlay Services (SAOS) to include substance abuse assessments, treatment, and relapse prevention. In addition, the program fosters each youth by providing evidenced-based services to include Thinking for a Change (T4C), Impact of Crime (IOC), Restorative Justice, Pathways to Self-Discovery and Change, and Living in Balance. Additional treatment services required by the program's contract include gender-specific services Boys Council and Young Men's Work. The program also provides individual, group, recreational, and family therapy. Program administration is comprised of a facility administrator (FA), assistant facility administrator (AFA), a director of clinical services, and a health service administrator. Case management services are provided by two case management staff and a transition services manager. Mental health staff at the program include the director of clinical services, one licensed therapist, and two non-licensed therapists. The programs' contract requires a certified recreational therapist; however, the previous recreational therapist resigned from the position on May 17, 2020. Medical services are offered seven days a week and are provided by the health services administrator and registered nurse. The program contracts with a licensed medical doctor (MD) to serve as the designated health authority (DHA). The DHA is on-site once a week for four hours. Educational services are provided by the Miami-Dade County Public Schools (MDCPS) on a year-round basis. Due to the COVID-19 pandemic, educational services have been provided by way of virtual learning of twenty-five hours a week. The layout of the program includes one main building which consist of a dormitory area, kitchen, two classrooms, living, and dining areas. The program has twenty-three operating security cameras providing coverage. At the time of the annual compliance review, the program had four vacant youth specialist I positions. An amendment to the program contract was approved by the Department on September 7, 2020 indicating the recreational therapist position to be deleted beginning October 3, 2020 through June 30, 2021.

Strengths and Innovative Approaches

- Miami Youth Academy participates in on-site and off-site Narcotics Anonymous (NA) local chapters, providing access to additional substance abuse services for youth.

- Due to the COVID-19 pandemic, the program has been utilizing video teleconferencing when conducting youth visitation. Youth are provided the opportunity during regular visitation days and hours, to visit authorized family member utilizing the Zoom platform.

- The program youth benefit from vocational skills development in culinary arts by earning a Safe Serve certification, preparing food for special events, and hospitality practices. Select youth learn about food service managing through food order process and rotation, and food service operation documentation requirements.

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 in place to ensure all newly hired staff and volunteers receive an initial background screening. The program had a total of eleven new staff hired since the last annual compliance review. A review of staff personnel records verified each staff received an initial Clearinghouse background screening. Each new staff received a background screening prior to their start date and completed a pre-employment assessment with a passing score. The program also reviewed the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS), and the Florida Department of Law enforcement (FDLE) results for each newly hired staff prior to hiring. The program had one newly hired volunteer since the time of the annual compliance review. A review of the volunteer records verified a background screening was completed. The Annual Affidavit of Compliance with Level 2 Screening Standards was signed on December 5, 2019 and was received by the Department's Background Screening Unit on January 2, 2019, meeting the annual requirement. The Department of Education received an annual screening on December 5, 2019, meeting the annual requirement.

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 to ensure all staff and volunteers receive a background rescreening every five years from their initial date of employment. There were three staff eligible for five-year rescreening during the annual compliance review period. Each reviewed staff received a background rescreening within ten business days prior to the staff's five-year anniversary date. The program had no volunteers or interns requiring a rescreening during the annual compliance review period.

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

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

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

The program has a written policy and procedures ensuring the program provides an abuse free environment. The facility operating procedures for abuse and neglect reporting, along with the program's manual, addresses the code of ethics. Staff are required to sign an acknowledgment form indicating they reviewed the required information. A review of eleven staff personnel records reflected all staff reviewed the program's code of ethics. Observations during the annual compliance review week indicated staff modeled pro-social behavior for youth throughout the day. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were also observed posted throughout the program. Youth have unimpeded access to a telephone to contact the Florida Abuse Hotline or the CCC if they feel they have been abused or neglected. At the time of the annual compliance review, there were five incidents reported to the CCC for physical, psychological, or emotional abuse since the last annual compliance review, at which management took immediate action to address the incidents. There were no Prison Rape Elimination Act (PREA) investigations, nor any open Department of Children's and Families (DCF) investigations, law enforcement, or Office of the Inspector General (OIG) investigations pending. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on April 7, 2020. An interview with the facility administrator (FA) indicated staff will be in regular attendance, no gambling on the premises, call in within two hours of shift, must follow dress code and safe work practices, reframe from dating other staff, not be arrested, but if so, must report to the supervisor immediately. Staff must not violate program rules of safety and security and not bring in contraband. Staff will not purposely damage TrueCore property and will not physically assault youth or other staff. Staff will not sleep while on duty supervising youth. Staff are monitored through coaching sessions, written warnings, suspensions to include termination. Three staff were interviewed and each knew the process to contact the Florida Abuse Hotline or the CCC and have never observed a co-worker forbidding a youth to make a call. One youth stated they

have heard staff using profanity toward a youth when issues get heated and two have never heard staff use profanity toward a youth.

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

The program has a written policy and procedures to ensure immediate action is taken to address incidents of physical, psychological, and emotional abuse. The program had five incidents of abuse toward a youth since the last annual compliance review. The program found each incident to have substantiated findings of physical abuse. A review of the reports indicated the facility administrator (FA) took immediate action to address the concerns by removing the staff from youth contact or terminating employment. Three staff were interviewed and were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC) to report suspected abuse. An interview with the FA indicated all abuse allegations are taken seriously when reported. The alleged staff is immediately removed from youth contact and all notifications are made. A full investigation is immediately conducted. The outcome is then determined, and disciplinary actions taken up to termination. The program has signs posted throughout the building which display the telephone numbers for the Florida Abuse Hotline and CCC numbers. There is a telephone located on the wall for youth to utilize to call the Florida Abuse Hotline or CCC. At all times, if a youth asks to make the call, they are given privacy and are allowed to place the call. Any time a complaint is submitted, it is addressed in the management meeting along with staff meetings to ensure there is no future issue.

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

The program has a written policy and procedures for reporting incidents to the Department's Central Communications Center (CCC) within the required two-hour time frame. The program had a total of nineteen CCC reports in the past six-months. A random review of six CCC reports verified five incidents were reported within the two-hour time frame. One incident was reported to the CCC four days late. Each of the reviewed CCC's were documented in the facility logbook, as required. A review of the program incident reports and youth grievances indicated none were required to have been reported to the CCC. An interview with the facility administrator (FA) regarding the program's incident reporting process indicated staff are to immediately notify the shift supervisor on duty of any incident. The shift supervisor will immediately notify administration. The staff must then write an incident report before the end of their shift. The assistant facility administrator (AFA) and the FA will then decide if the incident is CCC reportable and will report the incident within the required two-hour time frame. The FA indicated staff are knowledgeable in contacting the Florida Abuse Hotline or the CCC by ensuring staff receive training on the Florida Abuse Hotline during in-service and pre-service training period. The CCC and Florida Abuse Hotline telephone numbers were posted throughout the program. Staff are allowed to call when requested. Also, incidents are logged in the logbook and discussed during morning management meetings. The FA was employed in their new position

on August 26, 2020 and is unsure of why the program experienced an increase in CCC reports. The FA did indicate, since his employment, the program has provided additional training and fidelity checks to ensure staff are aware of policy and provided feedback on their performance.

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 maintains a written policy and procedures related to Protective Action Response (PAR) including the use of verbal and physical intervention techniques and mechanical restraints. A review of the program's PAR binder indicated there were six PAR incidents in the past six months. A review of the PAR reports indicated each was completed prior to the end of the staff's workday and included statements from all staff involved. One PAR resulted in an injury to a youth. The Department's Central Communication Center (CCC) was notified within two hours of the incident and a PAR Medical Review was conducted by the nurse. The youth alleged abuse in this incident and the Florida Abuse Hotline was contacted. In each of the reviewed reports, a Post-PAR interview was conducted by administration, and reviewed by the facility administrator within seventy-two hours. The program has a current PAR plan approved by the Department's Office of Staff Development and Training on January 10, 2020. The program's PAR rate during the annual compliance review period was 3.83, which is above the statewide Residential PAR rate of 2.23. An interview with the facility administrator (FA) did not provide a reason as to why there was an increase in PARs this year compared to last year. The FA indicated the process for monitoring PAR incidents and use of force includes a PAR report must be written before the end of shift from which it occurred. A review of the PAR document is conducted by the staff mentor, assistant facility administrator (AFA), and then the FA. Three staff were interviewed and were able to explain the program's PAR process and procedure.

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 outlining the pre-service training requirements for newly hired staff. The program's policy indicates all newly hired staff will receive a minimum of 120 hours of training which are computer-based and/or instructor-led topics and shall be completed within 180 days of employment. According to the program's contractual requirements, newly hired staff will receive 129 hours of training within 180 days of employment and specific training requirements for different position classifications such as management, case managers, mental health, and direct care staff. An annual training plan for pre-service training was approved by the Department's Office of Staff Development and Training on February 17, 2020. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. A review of three staff pre-service training records verified each reviewed staff completed required 120 hours of pre-service training requirements within 180 days of employment as indicated in the program's policy to include suicide prevention, emergency procedures, child abuse reporting, professionalism, ethics and standards of conduct, cardiopulmonary resuscitation (CPR), first aid, emergency procedures, and Prison Rape Elimination Act (PREA) trainings. All three staff received the

Department's required 120 training hours within the required time frame; however, there were two staff who did not complete the contractual requirements of 129 hours of training within 180 days of employment. All reviewed pre-service training was entered 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 outlining the in-service training requirements for program staff. Staff are required to have twenty-four hours of instructor-led and/or web-based training each year. Supervisors are required to have an additional eight hours of training in the areas of management, leadership, personal accountability, employee relations, communication skills, or fiscal training. The program has an annual training plan approved by the Department's Office Staff Development and Training on February 17, 2020 to include all required contractual trainings, as well as the program's required internal trainings. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. A review of three staff in-service training records indicated staff completed the required twenty-four hours of training and had supporting documentation to reflect their cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid trainings were up-to-date. Each reviewed record verified completed training in suicide prevention, ethics, Protective Action Response (PAR), communications skills, professionalism, as well as the contract required training elements of Facility Entry Physical Health Screening, Residential Assessment of Youth (RAY), Massachusetts Assessment of Youth Screening Instrument, Second Version (MAYSI-2), and the Department's Juvenile Justice Information System (JJIS). One supervisory staff training record was reviewed and indicated staff completed the required eight hours of management training. All trainings were 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 three-phase grievance process which consists of informal, formal, and appeal phases. Youth are informed of the grievance process at the time of admission. Grievance forms are available and accessible to youth in the day living area located in a hanging file holder. Youth who have difficulty completing the form may receive assistance by staff on the instructions, preparing, and submission of a grievance. The program had a total of forty-six grievances submitted during the past twelve months. All grievances are maintained in a designated binder for one year. Five grievance were reviewed and were found in the designated binder. A review of the grievance forms verified each youth was provided the proper form and

was resolved at the formal phase. A review of three staff training records verified grievance training was provided. An interview with the facility administrator (FA) indicated the transitional service manager checks the grievance box every morning and all grievances submitted are taken to the morning meeting to review with the management team, and then addresses them with the youth. When the form is fully completed, it is filed in the grievance binder. In the event the youth disagrees with the results, the form is given to the FA for further review and final action. Three staff were interviewed and knew the program's grievance process. Three youth were interviewed and were able to explain the program's grievance process and stated they can receive assistance if they need to complete a grievance.

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

The program provides interventions and treatment which incorporates evidenced-based models which are cognitive-behavioral. These interventions are based upon social learning theory highlighting skills and modeling of anti-criminal attitudes and behaviors. The evidenced-based curriculum used by the program include Thinking for a Change (T4C), Living in Balance, and Impact of Crime (IOC). The program has a total of one clinical staff and three non-clinical staff trained in facilitating evidenced-based, promising practice, and/or practice with demonstrated effectiveness groups. Each clinical staff holds at a minimum a bachelor's-level degree and non-clinical staff hold at a minimum an associate's-level degree. Each of the four staff have over five years of experience working with youth. A review of the program's activity schedule, coupled with the group sign-in sheets and the treatment sessions table identified in the program's contract, indicated groups were held as required. A review of three youth performance plans verified a goal identified the need for youth to participate in at least one of the required group trainings. An interview with the facility administrator (FA) indicated group delivery is determined by the clinician's experience of providing the curriculum and educational experience. Counselors are matched to youth based on the youths' treatment needs.

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's treatment services include the use of the social and life skills curriculum ARISE Life-Skills and Thinking for Change (T4C). The program identifies youth in need of services by reviewing the risk and criminogenic needs identified from the Residential Assessment for Youth (RAY). A review of the program's activity schedule and group sign-in sheets verified groups were held, as required, with a majority of the youth's time spent in structured, therapeutic activities, with a minimum of one hour of each youth's day devoted to the delivery of treatment services targeted to address identified risk, criminogenic, and treatment needs. The program has a total of four staff trained to provide service delivery. A review of staff training records verified the program has two staff trained to deliver life skills training groups. Three youth were interviewed and was able to describe the new skills and behaviors they have been taught. Each

of the three youth also stated they practiced the skills outside of group such as breathing techniques, walking away, and medication.

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 utilizes the Impact of Crime (IOC) curriculum to assist the youth in accepting responsibility for the harm their criminal actions have caused in the community. The program provides opportunities for the youth to participate in activities intended to restore victims and communities such as volunteering at food banks and writing apology letters. An interview with the facility administrator (FA) indicated the program utilizes the IOC curriculum where youth are enrolled in restorative justice groups while at the program. A random review of youth performance plans and group sign-in sheets, coupled with the program's activity schedule, verified the practice. A review of staff training records indicated staff conducting IOC are trained in the curriculum. Observation of IOC groups verified it was conducted according to the daily schedule and by a trained staff. Due to the COVID-19 pandemic, the program has suspended all victim community services and outreach. Three youth were interviewed and stated they receive IOC counseling.

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 provides delinquency intervention and gender-specific treatment services for youth in the program which demonstrates a component addressing the needs of a targeted gender group. The program utilizes Young Men's Work and Talks to Young Men curricula for male youth who could benefit from a mentor or positive male role model. The program is required to conduct Boys Council once a week as outlined by the program's contract; however, the group was not provided for the past twelve months. A review of the curricula and the program's activity schedule indicated gender-specific groups are designed to target the needs of the youth in the program and were conducted, as required. Three youth were interviewed and were able to describe the new skills and behaviors they have been taught. Each of the three youth stated they have practiced the skills they learned in group. An interview with the facility administrator indicated the program has groups which is designed to show strong male leadership and behaviors.

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 ensuring an internal alert system is designed to inform staff of youth with health-related concerns, mental health, and safety and security risks. The policy explained how and when the alerts are to be entered and updated as well as who is responsible for updating the Department's Juvenile Justice Information System (JJIS). The program maintains an on-going alert list so information concerning a youth's special conditions, suicide risks, safety and/or security risks are effectively communicated to staff in a manner which preserves the youth's privacy. Alerts are identified at the time of a youth's admission either through an interview with the youth and/or supporting documentation within the intake packet. Alerts are then entered into the Department's JJIS and added to the program's internal alert list. The internal alerts list is conspicuously posted in the briefing room which identifies security risks, mental health/clinical staff for suicide risks and other mental health alerts, along with medical for health conditions and medications, and the food service staff for dietary and allergies. Mental health staff can enter alerts when the youth is added, removed, and/or stepped down from precautionary observation (PO). Medical alerts and food allergies are entered in JJIS by medical staff. The assistant facility administrator (AFA) updates the youth with security alerts on the internal alert list and JJIS. A review of three youth who had a total of eleven alerts entered in JJIS were also documented on the program's internal alert system; however, the program was not consistently documenting in JJIS who entered the alert. Further review of JJIS alerts indicated medical staff were not providing their first initial, last name and position to the alert. An interview with the facility administrator indicated a pre-classification meeting is held prior to youth arrival. Any medical concerns are discussed. Medical alert procedures are discussed prior based on the needs of an illness a youth has. Alert rosters are reviewed and updated daily. All medications are tracked and the designated health authority (DHA) oversees medical treatment on-site. The program discusses risk factors of the youth and set alerts based on mental health issues, dietary needs, or illnesses as well as safety and security issues such as gang affiliation or escape risk. These alerts are discussed during the morning meetings and labeled on the alert boards and on JJIS. Three staff were interviewed and stated they are informed of youth alerts in briefings, logbooks, shift reports, and alert board.

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 has a written policy and procedures for record management. The program maintains individual records for case management, healthcare, and mental health and substance abuse. A review of three individual healthcare, three mental health and substance abuse, and three case management records were observed to have been marked "confidential." The case management records are labeled with additional youth information such as name, date of birth, committing offense, legal information, county of residence, and the assigned juvenile probation officer. Youth records are secured in the respective program office inaccessible to youth and identifies the youth's name, Department identification number, and date of birth.

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

The program has a youth advisory board (YAB) which consists of youth who have exhibited leadership and mentoring skills while in the program. The YAB is a formal board meeting held once a month where the youth in the program work directly with staff formulating ideas to promote a positive relationship and input between youth and staff. Youth have the opportunity to provide the board members feedback to discuss during the YAB meetings. The program also utilizes the "Let's Talk" form which provide youth the opportunity to address issues, problems, or concerns which may not require a grievance. Daily meetings are held with the youth after school to address any immediate issues and provide the youth with staff expectations. Interviews completed with five randomly selected youth confirmed the program has a process allowing them to provide input about what happens at the program. An interview with the facility administrator (FA) revealed the program conducts weekday meetings to receive youth input, ideas, and suggestions concerning the program. During the intake process, case management sends out a parent/guardian survey which asks the parent/guardian what they want their child to be working on.

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 established a community advisory board which meets quarterly to serve as a support to the program and a link to the community. The facility administrator (FA) solicits and maintains a collaborative partnership with the Department and local stakeholders in the community to include representatives from the Miami-Dade Police Department, community partners, the business community, the school district, volunteers, State Attorney's Office (SAO), faith community, and a parent/guardian of a former youth. A review of the program's advisory board agenda and sign-in sheets for the past twelve months indicated one meeting was held in November 2019. A meeting was scheduled for March 2020; however, due to the COVID-19 pandemic, it was cancelled. There was no indication a meeting was scheduled or held for June 2020. During the annual compliance review week, the program sent out letters to the board

member inviting them to the next meeting in October 2020 by way of conference call or video conferencing. An interview with the facility administrator (FA) stated the community advisory board meetings are scheduled quarterly. The program solicits membership and active involvement of interested community partners including, but not limited to representatives from law enforcement, the judiciary, the school board or district, the business community, and the faith community. In addition, the FA indicated they recruit a victim, victim advocate, or other victim services community representative and a parent/guardian whose child was previously, rather than currently, involved in the juvenile justice system.

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 written policy and procedures to establish and utilize effective channels of communication among the program staff, corporate leaders, other agencies, stakeholders, and between youth and staff. The program conducts shift briefings, monthly all-staff meetings, daily management team meetings, and quarterly community advisory meetings to review and address pertinent information and follow up on program operations, health services, mental health services, case management, education, human resource, and support services. The program conducts daily management meetings to discuss daily operations as well as staff performance. In order to minimize staff turnover, the program recognizes an employee of the month who demonstrates teamwork, leadership, and positive work ethic. Staff who are selected are given a monetary gift and their photograph is displayed in the program lobby. The program also recognizes monthly birthday celebrations and allow staff to participate in spirit week to dress according to the chosen theme of the day. The program also provides free coffee daily as well as lunch during the all-staff meetings. Youth surveys are conducted upon the youth's release from the program. A review of the surveys found they included feedback for direct care workers, case management, mental health, food, and medical services. Staff are also surveyed to provide their concerns or input for the program. An interview with the facility administrator (FA) indicated the program works hard to keep staff on board. The FA indicated the program hosts job fairs and recruits on-line. The FA indicated the administration works on creating different things to boost job morale. The FA stated the outcome data being used by the program for program planning and assessment purposes are weekly Performance Outcome Report (POR) morning meeting minutes, and youth and staff surveys. The outcome data is used to identify trends in the program and develop plans to address the issues or concerns which may arise. Three staff were interviewed and stated staff meetings are held monthly and staff and youth concerns are discussed, facility issues, and drills. When asked if staff are briefed on any annual reports and/or youth and parent/guardian survey results, one staff stated yes, and two stated no. Three staff were interviewed on how well the communication is at the program. Two staff stated good and one stated fair. When asked why, the one staff stated some staff have personal issues with other staff and they do not get along. The three interviewed staff stated they can provide input and feedback into the program by speaking to human resources, administration and placing a comment in the suggestion box located in the front lobby.

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

The program has a written policy and procedures to ensure the annual performance evaluations is based on their established performance standards. A review of three staff personnel records

indicated each staff received a ninety-day performance evaluation which included staff comments, signatures and dates, as well as the supervisor's signatures, dates, and performance rating calculations. Each staff also received an annual evaluation and may receive more than one evaluation throughout the year, as deemed appropriate by the supervisor. A review of three staff records indicated the program maintains position descriptions which outlines the position expectations and essential functions, requirements of the position, knowledge, skills and abilities, physical requirements, and work environment. Three staff were interviewed, and two stated formal evaluations are conducted monthly and every ninety-days. One staff stated they have not had an evaluation. An interview with the facility administrator indicated each staff receives a performance evaluation. New employees receive a ninety-day evaluation. All staff who have over one year of service will receive evaluations annually.

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

The program has a written policy and procedures regarding recreation and leisure activities. The activities are geared to provide a range of supervised and structured indoor and outdoor recreation activities for the youth and shall be based on the developmental levels and needs of the youth in the program, as well as youth input about their preferences and interests in various activities. According to the program's contract, the program is required to have a recreational therapist to provide treatment services and recreational activities to the youth by using a variety of techniques such as proper body mechanics, sports, music, arts and crafts, and community outings. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. A review of the staff roster indicated the program employed a certified recreation therapist until May 17, 2020. A new employee was transferred into the position on the same date. A review of the new employee's credentials indicated the staff holds a bachelor's-level degree in recreation and sports medicine; however, is not certified as a recreation therapist. Contract amendment ten was approved by the Department on September 7, 2020 and indicated the recreation therapist position will be deleted effective October 3, 2020 through June 30, 2021. According to the program, the employee in the recreation therapist position is resigning from the position on September 25, 2020 due the deletion of the position. Three staff and three youth interviews indicate the youth are provided one hour of recreation to included football, basketball, kickball, volleyball, board games, and indoor exercise.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures regarding the notification of parents/guardians as well as notification to the youth's committing court upon admission. The program requires phone contact with the parent/guardian within twenty-four hours, a written correspondence to the parent/guardian mailed within forty-eight hours, and notification to the youth's committing court within five days of admission. Three youth records were reviewed, and each contained documentation the program notified each parent/guardian by telephone, within twenty-four hours of the youth's admission. Each of the three reviewed records included documentation indicating the program notified the court in writing within forty-eight hours of the youth's admission. Three youth records contained supporting documentation to confirm the youth's juvenile probation officer (JPO), committing court, and all required parties were notified within five working days of admission.

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

The program has a written policy and procedures to ensure each youth admitted to the program receives an orientation of the program's rules, goals, and expectations of behavior. The program orientation includes the description of program services available, the program's daily schedule, and the program's behavioral expectations and consequences of not meeting the established behavioral expectations. Orientation also includes the description of the staff's use of Protective Action Response (PAR), the physical layout of the program, the program's disaster readiness, the code of staff conduct, the rights of the youth while in residence at the program, reporting of grievances, a detailed description of how to utilize the Florida Abuse Hotline, how to utilize the Department's Central Communications Center for youth over eighteen, the introduction and description of the Prison Rape Elimination Act, and how to report sexual misconduct. In addition, a description of the interventions, mental health and substance abuse services provided to youth are discussed during the orientation process. Three youth case management records were reviewed, and each record documented evidence the youth participated in the program's orientation. The documentation revealed the orientation included a review of the program's search policy, the performance and treatment planning process, dress code requirements, the established hygiene expectations, the process to obtain medical and dental care, the program's visitation policy, and a review of the telephone and correspondence policy. Each reviewed youth record contained a signed orientation checklist documenting youth participation in the orientation process and the receipt of an orientation packet as well as a copy of the program's youth handbook. There were no new admissions during the review week; therefore, an observation of an admission could not be conducted. Three youth were interviewed, and each youth confirmed the orientation was conducted on the day they were admitted to the program.

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

The program has a written policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Three youth case management records were reviewed, and none were applicable for being eighteen years or older. An interview with the regional compliance manager verified the program had only two applicable eighteen-year-old youth during the last twelve months. The program indicated they only had two applicable youth active records, and both were reviewed for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. Each youth record contained consent forms signed by the youth allowing the program to share with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.

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 has a written policy and procedures outlining the classification process for each newly admitted youth. The program's classification system promotes safety and security, as well as effective delivery of treatment services. The program's classification factors included physical characteristics, age, maturity level, history of violence, gang affiliation, criminal behavior, physical and sexual aggression level, suicide risk, as well as the youth's current risk to reoffend. Three youth case management records were reviewed. Each reviewed record had an initial classification which was completed on the day of admission. The initial classification forms included a review of the youth's physical characteristics, age, maturity, a history of violence, gang affiliation, criminal behavior, and sexual aggression or a vulnerability to victimization. Each completed classification form also included the identification of suicidal, mental, behavioral, medical, or security risks. A review of three youth case management records reflected each youth had an initial classification and Vulnerability to Sexual Aggressive Behavior (VSAB) Assessment completed upon admission. The classification process takes into consideration a review of alerts entered into the Department's Juvenile Justice Information System (JJIS). Each reviewed youth record indicated the alerts were entered in JJIS as required. Two of three youth records were applicable for reassessments. An additional youth record was reviewed for reassessments and verified all three applicable youth had an increase in their individual privileges or freedom of movement, and an increase of work privileges or activities involving the use of tools or instruments. It is the program's practice to complete a monthly reassessment for each youth. Reviewed documentation supported monthly reassessments were completed in each of the three youth case management records. The interviewed facility administrator stated

a classification meeting takes place before the youth's arrival. The program also completes a risk assessment during the intake process and then on a monthly basis.

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

The program has a written policy and procedures addressing gang identification and notification. The policy includes the notification to the local law enforcement agency and the youth's home county law enforcement agency. Three reviewed youth case management records showed one youth record was applicable for gang identification. Two additional applicable records were selected and reviewed. Each of the three youth records confirmed the notification to the law enforcement was made to the identified local law enforcement agency and the youth's home county law enforcement agency. In addition, documentation supported the educational staff and the youth's assigned juvenile probation officer (JPO) were also notified. Each youth's record contained a documented alert in the Department's Juvenile Justice Information System.

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

The program has a written policy and procedures to ensure youth identified as gang related are provided gang prevention and intervention activities. In addition, the policy and procedures ensure a plan can be developed for youth who wish to disassociate with a criminal street gang. The program maintains a binder which contains the names of the youth identified as members of or affiliated with a criminal street gang. In addition, an alert is placed on the alert board located in the conference room. The program's gang prevention and intervention curriculum used is Gangs: Fifty Stories of Fractured Lives. In addition, the program facilitates the Impact of Crime (IOC) curriculum to address gang intervention activities. The program maintains sign-in sheets documenting youth participation in the gang intervention groups. Three reviewed youth case management records showed one youth record was applicable for gang identification. Two additional applicable records were selected and reviewed. Each of the three applicable youth have participated or were currently participating in the anti-gang intervention curricula. Each of the youth individual performance plans (IPP) included goals for gang prevention and intervention strategies. The facility administrator was interviewed and stated all youth who enter the program identified as a gang member, gang affiliation, or identified at the program are placed on the alert board and documented as a gang member. The youth are enrolled to attend the program's gang group and follow the gang curriculum.

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

The program has a written policy and procedures which outlines all initial Residential Assessments for Youth (RAY) be completed within thirty days of admission. Three youth case management records were reviewed. Each youth case management record indicated the RAY was completed within thirty days of each youth's admission to the program. Each initial RAY was maintained in the youth's case management record and completed in the Department's Juvenile Justice Information System. Two of the three records were applicable for a RAY Reassessment and were completed within the required time frame. One youth was admitted to the program less than ninety days.

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

The program has a written policy and procedures to ensure Youth Needs Assessment Summary (YNAS) is completed within thirty days of youth admission into the program. Three reviewed case management records contained a completed YNAS. All reviewed records documented the YNAS was completed within thirty days of the youth's admission. All records indicated the YNAS was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a written policy and procedures in place regarding the individual performance plan (IPP) being developed within the initial thirty days of each youth's admission. A review of three youth case management records revealed all records contained an initial IPP which was created within thirty days of the youth's admission. All three youth records documented the youth's plan was developed with participation of the treatment leader, youth, parent/guardian,

medical representative, living unit representative, administrative representative, and mental health representative. The education staff have not been on-site due to COVID-19 restrictions; however, there was no documentation of education staff participating in the development of the initial IPP after February 2020. Each of the youth's IPP outlined all the required elements, such as the youth's individualized goals, top three criminogenic needs, youth and staff responsibilities, delinquency interventions, court sanctions, target completion dates, and goals for transition. All three reviewed IPP outlined staff and youth responsibilities to accomplish the goals. In addition, each three of the reviewed youth records contained the youth's recreation plan within the youth's IPP. All three youth case management records contained documentation indicating a copy of the IPP was sent to the committing court, assigned juvenile probation officer (JPO), and parent/guardian. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD). There was one applicable youth under the guardianship of the Department of Children and Families (DCF) who was a part of the youth's performance plan development. Three youth were interviewed. Each youth indicated participating in the development of the IPP, knew which goals they were working on, and were provided a copy of their IPP.

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

The program has a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY). One of three reviewed youth records was applicable for a performance plan revision. Two additional youth records were reviewed. All three reviewed youth case management records found performance plan revisions were completed for each youth. Revisions were made to each of the youth's individual performance plans (IPP) due to RAY reassessment results and youth's demonstrated progress toward completing goals. In addition, one youth's IPP was updated due to transition services being rendered. A review of three closed case management records indicated revisions were made based on the transition conference, the intervention and treatment team revised the youth's IPP to facilitate transition activities targeted for completion during the last sixty days of the youth stay in the program.

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

The program has a written policy and procedures to address the completion of performance summaries and the transmittal of the summaries. Summaries included reports on mental health, education, performance plan goals progress, staff and peer interactions, significant events, the youth's level of motivation to change, and anti-social and pro-social behaviors. Two of three open youth case management records reviewed were applicable for the completion of a ninety-

day summary. An additional youth record was reviewed. All three youth were provided the opportunity to review the performance plan and add comments. Three applicable case management records were reviewed, and each contained a release summary sent to the committing court within the required time frame. Each of the records reviewed reflect the required signatures of the youth, treatment team leader, the staff whom prepared the summary, and the facility administrator (FA) or designee. Each record showed copies of the summary being sent to the committing court, juvenile probation officer (JPO), and parent/guardian within the ten-day requirement. Three youth case management records confirmed each youth's performance summary was completed within the ninety-day time frame. None of the three reviewed records were applicable for a release sent with a Pre-Release Notification (PRN). Three closed youth records were reviewed and each included documentation a PRN was sent to the supervising juvenile probation officer (JPO) and a signed copy is retained in youth's case management record within the required time frames. Once approved by the committing judge, the program provided written notification to the youth's parent/guardian of the planned release date. A Residential Assessment for Youth exit assessment was completed upon the youth's release from the program. The JPO was provided a performance summary, transition plan and any psychological/psychiatric reports completed upon release from the program. The reviewed records did not contain an objection by the court. Each reviewed record was not applicable for the Sexually Violent Predator Program (SVPP). Each reviewed record was not applicable for a victim notification.

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 extends invitations to each youth's parent/guardian encouraging their participation in the intervention and treatment team meeting for developing the individual performance plans (IPP). Three case management records were reviewed, and two of three case management records contained documentation the parent/guardian participated in the development of the IPP and treatment team meetings by telephone. One youth's parent/guardian was incarcerated and was not able to participate in case management services until they were recently released. Each record contained documentation of attempts through telephone contacts and mail to involve the parent/guardian in the case management process. The program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting if they are unable to attend. During the annual compliance review, a formal treatment team meeting was observed. The treatment team leader, youth, mental health staff, medical staff, living unit representative, transition services manager, recreational therapist, and administrative representative were present and provided input. Education staff provided written input and the parent/guardian and juvenile probation officer participated by telephone. The youth was able to demonstrate the skills learned and discuss progress made while at the program. Three interviewed youth verified the parents/guardians participate in case management services during treatment team by telephone or video conferencing calls. A formal interview with the facility administrator verified during the intake process, the youth's parents/guardians are provided the opportunity to participate in the admission process. This program engaged parent involvement in treatment by telephone and/or in person during formal treatment teams, visitation, and weekly calls home. Family day is conducted quarterly which provides the youth to visit with their family members and an opportunity for the family to meet with the treatment team staff.

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

The program has a written policy and procedures in place which addresses the treatment team process and the members of the treatment team. The program's treatment team members consist of the case manager who serves as the treatment team leader, youth, representatives of program administration, the youth's living unit representative, clinical/medical staff, the youth's juvenile probation officer (JPO), parent/guardian or Department of Children and Families (DCF) case worker, and when applicable the program's gang prevention specialist. Formal treatment teams are held for each youth at least once every thirty days and informal treatment teams are held on a bi-weekly basis. Two of three youth case management records reviewed were applicable for a treatment team meeting. An additional youth record was reviewed. All three youth records contained supporting documentation of each youth's treatment team meeting included signatures of each required member attendance. Reviewed documentation confirmed the parent/guardian and JPO participated by telephone. The education staff provided written input. There was one case management youth record applicable for a thirty-day treatment team meeting involved with the DCF services. The program's practice is to send an invitation in advance to the DCF representatives to participate in the meetings.

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

The program has a written policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's individual performance plan (IPP). Two of three youth case management records reviewed were applicable for the incorporation of other plans into the IPP. An additional youth record was reviewed. Each reviewed record documented the incorporation of the youth's treatment and education plans into the IPP. All three youth records indicated the program incorporates therapeutic activity into the youth's treatment plan based on the development levels and needs of the youth. At the time of the annual compliance review, the program had one youth involved with the Department of Children and Families (DCF). A review of the applicable youth's record confirmed the youth did not have an active case plan with DCF. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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 to address formal and informal treatment team meetings, ensuring the case manager meets informally with each youth at least bi-weekly and formal treatment team meetings occur at least once every thirty days. Two of three youth case management records reviewed were applicable for formal and informal treatment team reviews. An additional youth record was selected. A review of three youth case

management records confirmed each youth received formal treatment team reviews every thirty days and informal treatment team meeting at least bi-weekly. Documentation verified the treatment team leader, youth, mental health staff, medical staff, living unit representative, transition services manager, recreational therapist, and administrative representative were present and provided input during treatment team meetings. Education staff provided written input and the parent/guardian and juvenile probation officer (JPO) participated by telephone. The Residential Assessment for Youth (RAY) was reviewed, and when necessary, revisions to the individual treatment and/or performance plans are discussed at the formal review. An observation of a formal treatment team meeting was conducted during the annual compliance review week and verified the participants reviewed the performance goals, positive and negative behaviors, RAY reassessment results, and treatment progress. The youth was able to demonstrate the skills learned and discuss progress made while at the program. Interviews completed with three youth revealed they are provided with the opportunity to demonstrate skills they are learning and working towards in the program, during treatment teams. In addition, the youth stated staff review youth performance which includes progress on performance plan goals, positive and negative behavior, and treatment progress.

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

The program provides Type 2 career educational programming which is conducted and supervised by the Miami-Dade County School District. The instructional programming is founded upon stressing interpersonal communication skills and behaviors, which aside from being age and skill appropriate for the involved youth, contribute to positive and suitable work habits for gaining employment, as well as improved living standards. The youth involved having employability identified as a post-release goal were introduced to creating a résumé which summarized past education, work experience and/or career training, as well as a completed sample employment application. These documents were incorporated into their exit portfolios along with the documentation essential for gaining employment such as a birth certificate, social security card, and a valid State of Florida identification or driver's license. Also included in the exit portfolio was a post-release plan for success calendar. This is a schedule of appointments for services which are identified in the youth's transition plan. The appointments, the identified location, and contact information of a Career Service Office near the youth's returning home address of which the youth may or will utilize to further their employment skills training and employment search are documented. One youth did not have a valid Florida identification card and a social security card even though there were blank applications present in the youth record. The interviewed director of case management stated the mother was to mail the youth's birth certificate to the program to start process of obtaining the social security card and Florida identification card; however, the program did not receive the birth certificate prior to the youth discharge. Each reviewed closed record contained documentation verifying the youth's parents/guardians, as well as the youth's juvenile probation officer (JPO), the youth's case manager, and other individuals involved in the creation of the youth's transitional planning had knowledge and supported the youth's post-release goals. An interview with the facility administrator (FA) indicated the youth are provided SafeStaff vocational services in the program. An interview with the lead teacher indicated the career education services and assessments provided to the youth in the program is the Florida View Interest Survey, SafeStaff Food Handling Certification, and résumé writing.

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

Under the direct supervision of the Miami-Dade County School District, the program's educational component provides 250 days of instruction distributed over twelve months annually at a minimum of twenty-five hours a week with minimal interruptions. This was verified as a result of conducting a verbal interview with the program's lead teacher, as well as review of the facility logbook for the past six months. Upon review of the provided academic calendar, classes begin at 8:00 a.m. and continuing until 1:50 p.m. with forty minutes for a scheduled lunch period Monday through Friday each week. Observation of youth during school indicated youth were provided educational instructions for each subject by way of virtual leaning due to the COVID-19 pandemic.

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 transitional 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 educational plans. Youth receive a transition plan which included elements of the youth's needs assessment plan and the electronic educational exit plan which addressed educational services and interventions which were primarily based upon the youth's post release educational goals. Three closed youth records were reviewed and each record contained a transition plan and identified key services and monitoring responsibilities by individuals essential for the youth's educational reintegration back to the community, the recommended educational placement for the youth post-release, as well as specific monitoring responsibilities by individuals who are responsible for coordination and provision of support services for the youth upon their return back to the home community. Further review indicated the youth, parent/guardian, a representative of the educational program, the program's transitional representative, as well as a representative of the youth's home school district signed the plans acknowledging their monitoring responsibility. An interview with the lead teacher indicated the services and interventions addressed in the youth's transition plan are academic needs, special education, and re-entry needs. Three youth were interviewed and two stated they were involved in the development of their educational plan. One stated he was not involved. Three youth were interviewed to determine how well they believe the program prepares them for high school, vocational school, employment and/or college. One stated well and two stated very well.

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

The program has a written policy and procedures regarding transition planning and transition conference requirements. Three closed youth records were reviewed. The reviewed documentation validated a transition conference was held at least sixty days prior to the targeted release date. All three youth records documented the program sent written notification to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. All youth records documented the youth, treatment team leader, clinical, medical, and education staff participated in the transition conference as evidenced by the signatures on the transition plan signature page. The JPO and parent/guardian participated by telephone. Each youth's JPO, parent/guardian, education staff, and any other pertinent parties were invited to provide written input if they were unable to participate in person. All reviewed records identified the target completion dates and identified the individuals responsible for completion of the transition goals. Each of the three closed youth records contained documentation indicating the invitation to the Community Re-Entry Team (CRT) meeting. Each reviewed closed youth record confirmed the youth participated in a CRT meeting prior to their release from the program.

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

The program has a written policy and procedures pertaining to exit portfolios. Three closed records were reviewed for compliance with the completion of exit portfolios. All records contained documentation the exit portfolio was discussed and started at or prior to each youth's transition conference. All exit portfolios included the transition plan, completed assessments, a résumé, employment application, educational records, a calendar with dates, times, and locations of follow-up appointments within the community, and vocational certifications when applicable. One of three reviewed records contained a copy of the youth's birth certificate, social security card, and State of Florida issued identification card. One youth was undocumented and was not applicable to apply for a social security card or State of Florida issued identification card. One youth did not have a valid Florida identification card and a social security card even though there were blank applications present in the youth record. The interviewed director of case management stated the mother was to mail the youth's birth certificate to the program to

start process of obtaining the social security card and Florida identification card; however, the program did not receive the birth certificate prior to the youth's discharge.

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

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

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 has a written policy and procedures outlining the guidelines for the creation and review of safety plans for all youth. Each plan shall identify warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Each initial plan shall be developed by the multi-disciplinary team, prepared with the youth parent/guardian, and clinical staff, within fourteen days of admission. The plan incorporates any recommendations from previous or current clinical assessments and is updated every thirty days. Three youth safety plans were reviewed. Each contained the required elements and incorporated recommendations from previous or current clinical assessments. Three reviewed youth records documented the initial plans were completed within the fourteen-day time frame of the youth's admission. All three youth records reflected the safety plans were updated every thirty days. Two of three interviewed youth stated they were involved in the development of their safety plan and one youth did not think they had a safety plan. The program maintains a safety plan on each youth and is securely located in the conference room which is easily accessible to staff. Three interviewed staff knew the safety plan for each youth was located in the conference room. Two of three staff stated the safety plan was reviewed during every treatment team meeting and one staff was not sure when it was reviewed. Two of three staff stated the last time they reviewed the safety plan was within the past week and one newly hired staff stated they reviewed the safety plan when they were first hired. A formal interview with the facility administrator verified safety plans are updated monthly during treatment team reviews.

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 8:00 a.m. to 4:00 p.m. and is available for emergency consultation services twenty-four hours a day, seven days a week. The DMHCA serves as the program's mental health and substance abuse authority ensuring compliance with the Substance Abuse Overlay Services (SAOS) requirements. The DMHCA has the responsibility for directing the program's psychological and treatment services to include technical and administrative duties, testing, individual therapeutic services, group therapy, and family therapy. The DMHCA supervises one licensed clinical social worker (LCSW) and two non-licensed master's-level therapists; however, at the time of the annual compliance review there was one therapist vacancy. In addition, the DMHCA supervises one contracted board-certified behavior analyst (BCBA). 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. Interview with the DMHCA indicated they provide oversight in the clinical department. The DMHCA ensures each youth is receiving their individual therapy, groups, and family therapy services as prescribed. The DMHCA conducts monthly mental health and substance abuse record audits to ensure quality assurance. A mental health tracker is used to track and ensure services are being completed within the specified time frames, as well as daily and weekly oversight through clinical supervision to ensure each youth is receiving all supportive treatment interventions. Additional responsibilities include oversight of Assessments of Suicide Risk, crisis intervention, diagnostic assessments, interview and examinations, and administration and interpretation of psychological and psychiatric testing. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and participates in weekly meetings with the psychiatrist to discuss each youth receiving services. 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)	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 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 and two master's-level non-licensed therapists. The licensed clinical social worker (LCSW) maintains a clear and active license in the State of Florida with an expiration date of March 31, 2021. The LCSW works under the supervision of the DMHCA and provides group and family process-oriented therapies using various professional treatment modalities. The LCSW prioritizes individualized treatment plans to focus on youth mental health and substance abuse issues, ensuring monthly updates reflecting progress. The LCSW is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:00 p.m. The program maintains a comprehensive plan for mental health and substance abuse services. The procedures documented a review by the facility administrator on December 10, 2019. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021. 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 facility administrator 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 27, 2020. The program was utilizing a master's-level non-licensed therapist from Okeechobee Youth Development Center on a part-time basis from August 2-20, 2020 coming on-site three times each week. The non-licensed therapist is scheduled to take the vacant position full-time beginning October 25, 2020. The program contracts with a part-time board-certified behavioral analyst (BCBA) scheduled to be on-site for approximately four hours a week. Reviewed credentials supported the BCBA is due for recertification August 31, 2021. The BCBA provides consultation to the multi-disciplinary treatment team, clinical, and case management departments regarding youth behavioral issues. The BCBA provides assessments, drafts functional analysis, and individual behavioral plans. The BCBA trains direct care staff and clinical staff on the implementation of the behavioral plans and related issues. At the time of the annual compliance review, the program had ten youth in their population. The non-licensed master's-level therapist carried a caseload under the required sixteen youth limit. The program's therapists provide mental health and substance abuse treatment services under the direct supervision of designated mental health clinician authority (DMHCA). The program is licensed

through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021. 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 to include the BCBA. 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. Reviewed training documentation supported the two previous master's-level non-licensed therapist completed the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The current non-licensed therapist was recently hired and is currently in training to complete the required suicide risk and crisis intervention training.

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

The program has a policy and procedures to 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. 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 Substance Abuse Overlay Services. 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 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). At the time of the annual compliance review, the program had a census of ten youth. A review of three 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 the three applicable non-licensed clinical 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 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. Two of the three 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. Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results. An interview with the facility administrator indicated when the youth arrives at the program, they are immediately given a MAYSI-2 within one hour in order to screen any risks the youth might have for suicide and drug use. If there is a hit for suicide, the youth will immediately go on a suicide alert and are screened utilizing the ASR to see if they are to remain on suicide precautions or taken off.

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 comprehensive 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 are 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 three mental health and substance abuse records and an interview with the designated mental health clinician authority (DMHCA) supported the practice. Reviewed practice supported the program assesses each youth during the admission screening process utilizing the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and Assessment of Suicide Risk (ASR). Within the first two weeks of admission, the youth works with their primary therapist to complete the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Trauma Symptoms Children's checklist (TSCC – Youth Sixteen and Under), or Trauma Symptom Inventory (TSI – Youth Seventeen and Older), Reynolds Adolescent Depression Scale, Second Edition (RADS-2), and Structured Assessment of Violence Risk in Youth (SAVRY). The initial assessments, as well as the follow-up testing, are completed within a two-week time frame and are incorporated in the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. All the pertinent information from the initial screening process, as well as parent/guardian and juvenile probation officer (JPO) interviews, are also included in the comprehensive evaluation. Three reviewed youth mental health and substance abuse records contained an evaluation completed within thirty days of admission by a non-licensed therapist. Reviewed practice supported the licensed mental health therapist and/or the licensed clinical social worker reviewed and signed the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation within the required ten calendar days. 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. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2020. 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, and a consent for urine collection and analysis.

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

The program 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 three youth mental health and substance abuse records documented each youth received an initial classification upon admission. According to staff interviews, this is the first time the multi-disciplinary treatment team is convened in order to conduct the youth classification for room assignment and to develop the initial mental health and substance abuse treatment plan. Reviewed documented practice supported each youth record contained an Admission Card and an Initial Mental Health and Substance Abuse Treatment Plan created on the day of admission. 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. A review of case notes for each 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 individual therapy, group 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 licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. Three youth were interviewed and indicated they each participate in individual and family therapy. Three program staff were interviewed regarding mental health and substance abuse groups at the program. Each interviewed staff reported the clinical therapists facilitate groups. An interview with the designated mental health clinician authority (DMHCA) and facility administrator confirmed the program offers Substance Abuse Overlay Services (SAOS).

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 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. A review of three youth mental health and substance abuse records found each contained an Initial Mental Health Substance Abuse Treatment Plan documented on the Department's Initial Mental Health/Substance Abuse (MHSA) Treatment Plan form developed 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 signed on the day of creation. All three reviewed youth mental health and substance abuse records were not applicable for the youth being admitted on prescribed psychotropic medication; however, each initial plan included the youth's requirement for the completion of a psychiatric evaluation. Program practice is to refer each youth upon admission to receive a new psychiatric evaluation, regardless of the youth's history or requirement. All three reviewed youth mental health and substance abuse records contained a completed Individualized Mental Health and Substance Abuse Treatment Plan. Each individualized plan was 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 Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy. One youth was applicable for psychiatric services subsequent to the psychiatric evaluation prescribing medications and the individualized treatment plan included the applicable services. All three 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. Each reviewed plan documented the 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. All three reviewed plans were applicable of having parent/guardian input and signatures; however, none of the reviewed plans documented the parent/guardian participated in plan development. Each plan documented 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 three 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 indicated the treatment plan is updated annually or revised as warranted. Three closed 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 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 in each record.

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

The program maintains a policy and procedures ensuring mental health and substance abuse treatment services are provided through Substance Abuse Overlay Services (SAOS) programming. Youth with a Diagnostic and Statistical Manual of Mental Disorders (DSM–5) and the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition (ASAM PPC-2R) who have been identified to be in need of substance abuse treatment shall be provided services. All specialized treatment services are provided by licensed and master's-level therapists. Clinical services include mental health and substance abuse evaluations, mental health and substance abuse 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. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2020. 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), a licensed clinical social worker (LCSW), and the non-licensed master's-level therapists. 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). At the time of the annual compliance review, the program had ten youth in the census. Therapist caseloads were no more than five youth for each therapist. The program provides each youth with group therapy services seven days a week. The program's contract outlines substance abuse services provided include Living in Balance, Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Adolescent Cannabis's Users (MET/CBT 12), Pathways to Self-Discovery and Change, Seeking Safety, and

Life Centered Education. Required substance abuse and mental health services include Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Adolescent Coping with Depression, Coping with Stress, and The Shyness and Social Anxiety Workbook. Reviewed documentation supported all required groups were conducted during the last twelve months with the exception of MET/CBT 12, Seeking Safety, and The Shyness and Social Anxiety Workbook for Teens: Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) Skills to Help You Build Social Confidence. Interview with program staff indicated the program's contract grid, Exhibit 7, indicated the Seeking Safety and The Shyness and Social Anxiety Workbook curricula were based on need. The program utilizes the Trauma Symptoms Checklist as a screening tool for youth to assist them in evaluating the applicable need. Based on the results of the screening tool the program's population demonstrated only one youth met the criteria based on diagnosis for post-traumatic stress disorder (PTSD) for Seeking Safety and zero youth met the criteria for diagnosis of Generalized Anxiety Disorder for The Shyness and Social Anxiety Workbook. The program indicated since one youth is not enough to hold a group, the applicable youth is receiving individual services and is outlined on their individualized mental health and substance abuse treatment plan. In addition, the MET/CBT 12 curriculum is noted as based on need. The program utilizes the Cognitive Behavioral Therapy approach throughout all curricula. This group is used as an alternative for youth who have fully completed other curricula or who are not progressing or responding to the primary substance abuse curriculum. The program indicated this did not meet any applicable youth profile in the last twelve months. The program has a contracted part-time board-certified behavior analyst (BCBA). Reviewed credentials supported the BCBA is due for recertification August 31, 2021. The BCBA is on-site for approximately four hours each week. 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.

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 showed 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 practice registered nurse (APRN). A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site bi-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 showed 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 Miami Youth 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 bi-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 three mental health and substance abuse records indicated one youth was 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. The program indicated there was only one additional applicable youth record for a youth entering the program on psychotropic medications. A review of both applicable youth records found each was assessed by the psychiatrist at least every thirty days. Subsequent to admission, one additional youth was referred to the psychiatrist for assessment and was prescribed psychotropic medication. Each completed assessment was documented on the Department's CPPN, including page three, and was 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 to review youth in the program.

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 designated mental health clinician authority (DMHCA) on December 11, 2019. 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 interview with the 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 procedure. 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 three suicide response kits located in the conference room, laundry room, and in the school. 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 during the admission screening process. A review of three youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All three reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The program indicated there was only one youth who had been placed on precautionary observation (PO) three times in the last twelve months. The youth was 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 the licensed mental health counselor (LMHC). The 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 who completed the admission ASRs 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 prior to the removal of constant supervision. Upon completion of the Follow-Up ASR, the youth was transitioned to close supervision and remained on this level 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. In addition, there was telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. A review of the Department's Juvenile Justice Information System (JJIS) 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. Interview with the DMHCA and reviewed program policy and procedures indicated the

program does not utilize secure observation. 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). Three interviewed staff each indicated when a youth expresses suicidal thoughts staff would 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 three youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All three 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 a youth who placed on precautionary observation (PO) three times within the last twelve months. The youth was placed on PO each time due to expressing suicidal ideations to staff. Three applicable PO records and Suicide Precaution Observation (SPO) Logs were reviewed. Program practice is to complete the Department's SPO Log form. The reviewed SPO Logs and Close Supervision Visual Checks (CSVC) Logs 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 CSVC Logs documented visual checks every five minutes. All three reviewed logs were not applicable for 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 applicable youth placed on PO was discharged at the time of the annual compliance review; therefore, an interview could not be conducted.

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 three pre-service staff training records and three in-service 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 training. A review of mock suicide drills showed each staff participated in mock suicide drills at least quarterly. There were forty-nine staff applicable for participation in quarterly mock suicide drills. Reviewed documentation supported all forty-nine staff participated in at least one 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 designated mental health clinician authority (DMHCA) indicated the program attempts to complete mock drills once a month on each shift. Reviewed documented practice validated the practice with the exception of A-shift missing a drill in April 2020, B-shift missing a drill in January, April, June, and August 2020, and C-shift missing a drill in January, April, May, and June 2020. Interview with the facility administrator validated the program provides at least one drill conducted monthly on each shift to ensure staff are trained in all scenarios. Drills are reviewed in the morning management meeting and in the all-staff meetings. Three interviewed staff indicated mock suicide drills are conducted monthly. 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 detailing 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 plan was reviewed and approved by the designated mental health clinician authority (DMHCA) on December 11, 2019. 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 crisis intervention, suicide prevention, and emergency services. The plan states crisis intervention will be provided as needed in a one-to-one setting for youth who require immediate processing relating to the specific incident. The program's crisis intervention services include anger control issues, depressive symptoms, maladaptive coping mechanisms, and impaired impulse control.

In the event a youth exhibits out of control behaviors, the program's direct care staff place the youth on mental health alert and refer to a qualified mental health professional for a crisis assessment. A review of three youth mental health and substance abuse records found there were no youth requiring a crisis assessment. According to an interview with the designated mental health clinician authority (DMHCA), the program had no applicable youth requiring a crisis assessment in the last twelve months. 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 use services plan, which was last revised and approved by designated mental health clinician authority (DMHCA) on December 11, 2019. 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. Three 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)	Non-Applicable
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

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

Standard 4: Health Services

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

The program 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). The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, and is a medical doctor with specialty training in pediatrics and surgery with a license expiration date of January 31, 2022. The DHA is a current member of the American Board of Pediatrics. The DHA is scheduled to be on-site weekly for approximately two hours. Reviewed physician logs for the past six months validated the DHA was on-site weekly for two hours. The program has an independent contractor agreement with the back-up licensed osteopathic physician, specializing in internal medicine with a license expiration date of March 31, 2022. The DHA is on-call twenty-four hours a day, seven days a week for consultation for acute medical concerns, emergency care, and coordination of off-site care. The program's policy and procedures outline specific duties of the DHA to include conducting Comprehensive Physical Assessments (CPA), conducting sick call and/or conducting medical evaluations and treatments based on referrals either through the program's sick call process or episodic care. An interview with the DHA reflected they understood their role to visit once a week, conduct CPAs, examine youth with chronic conditions at a minimum of every other month, examine youth returning from off-site emergency room visits, and to review and sign the facility operating procedures for medical and to review and approve the nursing protocols. The program does not utilize a physician's assistant (PA), or an advanced practice registered nurse (APRN).

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 supported the DHA signed all healthcare policies and procedures on January 8, 2020, the new facility administrator (FA) reviewed and signed on August 26, 2020, and the psychiatrist signed on February 20, 2020. The program maintains a training requirement whereby newly employed healthcare personnel shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures. The program has three full-time registered nurses (RN). One RN serves as the health services administrator (HSA). Reviewed documentation and interviewed staff indicated all nursing staff reviewed, signed, and dated a cover page indicating their review of the FOPs, treatment protocols, and other procedures on June 19, 2020 and September 14, 2020.

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 Authority for Evaluation and Treatment (AET) form is signed by the parent/guardian who have legal custody or legal guardianship. 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 until the youth leaves the custody of the Department. The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. 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. Three youth Individual Healthcare Records (IHCR) were reviewed for the presence of the Department's Authority for Evaluation and Treatment (AET) form. Reviewed documentation supported the original AET was filed in one youth IHCR and a copy was filed in the other two. Each copy was clearly marked as copy in bolded red lettering. One youth was over the age of eighteen. The one applicable record was reviewed, and documentation supported the youth signed a Release of Information Authorization Form for Youth Eighteen Years of Age or Older. An interview with the health services administrator (HSA) reported when a youth is admitted without a properly signed AET, the nursing staff immediately notifies the facility administrator (FA), who will then contact the youth's assigned juvenile probation officer (JPO) or juvenile probation officer supervisor (JPOS) for assistance in obtaining the signed 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 are informed of significant changes in the youth's 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. Program practice indicated the parents/guardians are notified within twenty-four hours with a written notification. Verbal consent is obtained as soon as possible after an order is written. Verbal consent is obtained for any over-the-counter (OTC) medications which has not been previously approved. Each documented a staff member witnessed all telephone call conversations on the third page of the Clinical Psychotropic Progress Note (CPPN) where treatment recommendations, applicable prescriptions, and diagnostic information was discussed with the parent/guardian. A review of three youth Individual Healthcare Records (IHCR) validated each maintained documented practice of parental/guardian notification. Each reviewed IHCR indicated one youth required additional vaccinations/immunizations and the parent/guardian was notified for approval prior to administration. One youth was taken to the emergency room and reviewed documentation supported the parent/guardian was notified as required. The program's practice is for all youth to receive a comprehensive psychiatric evaluation within fourteen days of admission. The program's practice is to complete page three of the CPPN regardless of prescribed medications. Each reviewed record contained documentation of a completed psychiatric evaluation and page three of the CPPN was sent to the parent/guardian. The program's policy and procedures for obtaining consent for all youth

include discontinuation of medication, significant changes in medication, and newly prescribed psychotropic medications. All three reviewed youth IHCRs supported whenever a psychotropic medication was initially prescribed, discontinued, or drug dosage significantly changed, parent/guardian verbal consent was obtained and documented on page three of the Department's CPPN and a copy was mailed to the parent/guardian for their signature. The consent/notification forms utilized were the appropriate Office of Health Services (OHS) forms. Three youth IHCRs were reviewed, and each was applicable for vaccinations being verified within thirty days of admission. Each record documented receipt of the youth's vaccination history on the day of admission. Each reviewed record further supported a copy of the Department's Immunization Tracking Record and a copy of the Florida Shots immunizations record. The program documents vaccination/immunization consent on the Department's Parental Notification of Health-Related Care Vaccinations / Immunizations form. An interview with the program's lead registered nurse (RN), who serves as the health services administrator (HSA), confirmed when a youth's vaccination / immunization record is not included in the youth's IHCR upon admission, it will be obtained through the Florida Shots web-site on the day of admission. There was one applicable youth in the custody of the Department of Children and Families (DCF). A review of supporting documentation reflected the court had authorized all treatment and procedures. No reviewed records were applicable for a Religious Exemption from Immunization.

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. A review of three youth Individual Healthcare Records (IHCR) validated 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). The RN notifies the designated health authority (DHA) 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. Youth are not placed in general population until any identified healthcare needs do not require immediate medical attention and/or a referral for further assessment. A review of three youth IHCR supported the Department's FEPHS form was completed by a RN on the date of admission. One youth had one change in custody. Reviewed documentation supported a new FEPHS re-screening was completed by the RN for the youth returning on the date after a change in custody occurred. An interview with the program's health services administrator (HSA) reported any time there is a physical custody change a new FEPHS screening is completed.

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

The program maintains a written policy and procedures to ensure all youth receive an orientation to healthcare services coupled with health education. The health education shall be provided by the healthcare staff in writing. A review of three youth Individual Healthcare Records (IHCR) validated 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 male adolescents. A review of three youth IHCR supported each youth received a general care orientation upon their admission to the program conducted by a registered nurse (RN). Each healthcare orientation was documented on the Department's Health Education Record form as required. As part of the healthcare orientation and health education, each youth received training on environmental and exercise precautions to ensure the prevention of heat stress injuries through adherence to accepted heat stress and exercise tolerance guidelines. The program's policy outlines health education is provided through one-on-one teaching between the youth and healthcare staff, and through classes conducted by the Miami-Dade County School District, or in a group session conducted by the program's healthcare staff. Informal interviews with youth validated this practice.

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

Program practice is for the designated health authority (DHA) to be notified by telephone or verbally of all admissions and when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. A review of three youth Individual Healthcare Records (IHCR) validated the DHA was notified by telephone and the Notification of Admission form was filed in the practitioner's section of the IHCR. The program's procedures outline healthcare staff to provide the DHA with a comprehensive overview of all applicable admission orders, medication orders, preliminary laboratory studies, applicable diet orders, activity restrictions, and specific treatment orders for all youth with an identified health related condition. Each youth's IHCR documented the DHA notification was made by telephone on the day of admission. In addition, youth admitted on prescribed psychotropic medications documented the psychiatrist was notified of each youth's admission. Two youth were identified with a known or suspected chronic condition during the admission process. The youth were admitted with prescribed psychotropic medications. The nursing staff updated the Chronic Conditions Log after the notification was completed. None of the reviewed IHCRs reflected the youth were in need of an emergency response.

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 three youth Individual Healthcare Records found a new HRH was completed for each youth within seven days of the youth's admission. Reviewed practice supported the HRH form was completed on the day of admission. Each completed HRH was then reviewed and signed by the designated health authority (DHA) prior to the completion of the CPA. The program's practice is to complete a new HRH and CPA annually. An interview with the program's health services administrator (HSA) confirmed the practice of completing the HRH upon admission.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. 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. A review of three youth Individual Healthcare Records (IHCR) validated 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." The CPA is the standardized physical assessment of a youth, conducted by the designated health authority (DHA). When a youth is admitted into the program with a current CPA, the registered nursing (RN) staff reviews the CPA and documents the findings in the admission note. Program practice is for the DHA to review the previous CPA while examining the youth and completes a new CPA no later than seven days from admission and prior to the youth engaging in strenuous exercises and extreme outdoor weather conditions. Youth are not to be placed into general population until their healthcare needs are identified and are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. Upon admission and re-entry, all youth are screened for Tier I tuberculosis (TB) utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. A review of three youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to TB. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. For the initial CPA, one youth refused an examination of their genital area. His initials and signature were clearly marked on the CPA form. The Department's Problem List was updated as required. An interview with the program's health service administrator (HSA) reported youth are assessed at the time of admission with the FEPHS. In addition, TST/PPDs are administered at the time of admission for all youth and then annually thereafter. There were no current youth with symptoms suggestive of active TB and no youth on anti-TB medications at the time of the annual compliance review.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of three youth healthcare records found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infectious Screening form. There were no applicable youth who were out of the Department's custody for over thirty days and/or requiring a rescreening due to presenting symptoms. An interview with the program's health service administrator (HSA) reported youth are screened for STIs and offered testing at the time of admission. All youth have the opportunity to be tested upon request any time they are in the program. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered

counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. A review of three youth healthcare records validated each youth was provided the opportunity to receive counseling and testing for HIV. The program utilizes the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. Two youth consented and one did not. Youth interviews concluded all responded they can ask and receive a confidential HIV test. The DHA provides pre-testing, post-testing, and counseling. A copy of the program's 500/501 certification by the Department of Health (DOH) was obtained with an expiration date of March 17, 2021.

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. 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 protocols approved by the designated health authority (DHA). Emergency dental care services shall be provided by the contracted/licensed dentist and/or the youth will be transported to the emergency room. Youth admitted to the program are assessed by the healthcare staff upon admission. Through an interview with the health services administrator (HSA) and a review of the youth's previous medical and dental history, the healthcare staff note any identified medical and/or dental issues on the Department's Facility Entry Physical Health Screening (FEPHS) form. All youth shall be able to make Sick Call Requests and have their complaints treated appropriately through an established sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call is provided twice a day, Monday through Friday from 10:30 a.m. to 10:45 a.m. and 2:00 p.m. to 4:00 p.m. Sick call is provided on Saturday and Sunday from 12:30 p.m. to 1:00 p.m. and 4:30 p.m. to 5:00 p.m. Only a licensed healthcare staff may conduct sick call and all sick call encounters are conducted in the medical clinic to ensure youth privacy. The youth complete a Sick Call Request form and place it in the mounted/designated sick call box in the dormitory and nursing staff check the sick call box every two hours. Completed Sick Call Request forms are filed in chronological order in the nurse's chronological note section in the youth's healthcare record. In addition, all sick calls are documented on the Department's Sick Call Index and on the Sick Call Referral Log. A review of three youth healthcare records reflected all three youth completed a Sick Call Request form at least once during their stay. No youth presented a similar sick call complaint three or more times within a two-week period. Reviewed youth records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed in the nursing chronological notes section of each healthcare record. When a licensed healthcare staff are not on-site, all Sick Call Request forms are turned into the shift supervisor for review. The supervisor is required to review the sick call complaint promptly, but no longer than two hours after the request was submitted. The DHA and/or designee, as well as the health service administrator are on-call and available for consultation twenty-four hours a day, seven days a week to determine if the sick call requires immediate attention and/or instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar with and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. An interview

with the HSA reported all supervisors are trained on the sick call process in pre-service training and refresher training is provided annually. During the annual compliance review week, there were no youth who requested to be seen by the nurse and/or the DHA. Three interviewed staff indicated nursing staff conduct sick call. Three interviewed youth were interviewed and found one indicated they can be seen by medical immediately, while two responded they could be seen within one day.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. The program maintains a written policy and procedure 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. 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). Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Care Log. The program maintains an AED located in the day room hallway mounted to the wall. All staff who have direct contact with or provide supervision of youth, including transportation, shall be trained in Sick Call complaints to include emergency complaints and immediate transfer of youth who require emergency medical, mental health, and dental care services. The facility administrator (FA) is required to ensure all telephones within the program have access to outside lines to ensure unimpeded access to the emergency use of 9-1-1. An interview with the health services administrator (HSA) confirmed all program telephones have access to call 9-1-1. A review of three youth healthcare records supported each had at least two or more encounters of episodic care provided on-site by the registered nursing (RN) staff. A review of three youth healthcare records supported each had at least one or more encounters of episodic care provided on-site by the registered nursing (RN) staff. The RNs documented their findings in problem-oriented SOAP (subjective, objective, assessment, plan) elements. The program maintains eight first aid kits throughout the program. Four kits were located in administration office area, medical clinic, operations office, kitchen, and in the multi-purpose day room. The program has two kits which are designated for the program's transportation vans and are maintained in the administration area. The first aid kits and emergency equipment are approved by the DHA. The DHA has designated the RNs to inspect the contents of the first aid kits weekly and to inspect the emergency equipment each month. Items are to be replenished as needed. Weekly checks are documented on the program's Weekly First Aid Kit Inspections form. The DHA approved the contents the first aid kits are required to contain and a review of three random kits supported each contained all required elements. The program maintains a written policy and procedures ensuring the program-based AEDs are properly managed. The program maintains one AED located in the multi-purpose day room hallway. Reviewed documentation supported nursing staff conduct a monthly check on each AED and document the findings on the Emergency Equipment Monthly Inspection Log. All staff, volunteers, and interns are authorized to provide assistance to victims of sudden cardiac arrest, if they have been trained in the use of the AED, as documented in their respective training record. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. In addition, all nursing staff maintained current certifications in CPR and AED. The AED procedures were observed as audio instructions and the AED was demonstrated by

the nursing staff during the week of the annual compliance review. Reviewed AED batteries indicated an expiration date of August 28, 2021. The pad expiration date reflected August 4, 2023. The program also maintains three suicide response kits located in the laundry room, conference room, and teacher's office, each containing a knife-for-life, wire cutters, and needle nose pliers. The AED and suicide response kits are inventoried monthly by nursing staff to ensure they are fully stocked and operational. A review of the program's mock emergency medical drills reflected a drill was conducted on each shift monthly for the last twelve months. The demonstration of CPR and use of AED was conducted each quarter. Observations made during the tour of the facility found postings throughout informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in main master control, operations office, multi-purpose conference room office, medical clinic, therapist's offices, and case manager's offices. Reviewed training records supported all supervisory staff have been trained in the administration of the Epinephrine Auto Injector. Three interviewed youth indicated they can see a dentist in the event they have tooth pain and/or doctor if needed while at the program. Three interviewed staff reported they could personally call 9-1-1 when a youth has been 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 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 three youth healthcare records found all three-youth requiring off-site care and/or emergency care. The nursing staff placed all off-care care findings, instructions, and information in the DHA folder for review and documentation of signature. Reviewed documentation supported the parent/guardian was notified as required. The Department's Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the 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. The healthcare records contained the completed Summary of Off-Site Care form and applicable follow-up and discharge paperwork. The DHA documented their review of the off-site care findings, instructions, and information. An interview with the program's health service administrator (HSA) reported the program calls the DHA after all off-site visits are completed and the RN receives telephone orders from the provider. All youth with off-site emergency room visits are scheduled to see the DHA upon the next on-site visit. None of the reviewed youth required a follow-up off-site procedure.

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. A review of three youth healthcare records indicated each youth was classified with a medical grade of two through five and were admitted with an identified chronic condition

as documented on the Facility Entry Physical Health Screening (FEPHS) form. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, coupled with the date of last visit, and next visit date scheduled. No youth was found to have a communicable disease. A review of the three Individual Healthcare Records (IHCR) indicated all were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All youth were taking prescribed medication on an ongoing basis and there was one youth currently undergoing treatment for physical health condition which included a body mass index (BMI) greater than thirty. An interview with the designated health authority (DHA) and the health services administrator (HSA) indicated chronic conditions are monitored and evaluated every sixty days and are documented in the DHA Physician Order Log. An interview with the program's HSA reported youth identified with a chronic condition are placed on the appointment calendar, on the Monthly Periodic Tracker, and on the Chronic Conditions List to ensure the DHA follows-up with each applicable youth. The psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations in each reviewed record. All on-site evaluations were maintained in the chronological progress notes and treatment orders were clearly written. The Department's Problem List was updated for each youth as changes occurred.

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

The program maintains a written policy and procedures ensuring medical staff verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medications or order/prescriptions for medications, the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified as indicated. Reviewed 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 documented. Program practice is to notify the DHA for all youth admissions. All prescribed medications shall be obtained from a licensed vendor, according to a contractual agreement. Emergency prescriptions may be obtained from a local pharmacy. A review of three youth Individual Healthcare Records (IHCR) reflected each youth was admitted on prescribed medications. Reviewed nursing admission notes and Facility Entry Physical Health Screenings (FEPHS) documented the youth's current medications in each instance. Reviewed documentation supported the registered nursing (RN) staff completed a Nursing Chronological/Notification Progress Note in all instances. The DHA and the psychiatrist were notified by telephone of the youth's admission providing a history, obtaining admission orders, and to continue the prescribed medications. In addition, the RN staff completed the DHA Notification of Admission form documenting current medications, applicable chronic conditions, allergies, and medical grade. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the continuation of medications. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The RN staff complete the Prescription Medication Verification Checklist and Medication Receipt, Transfer, and Disposition form when youth are admitted with current prescribed medications ensuring all medications have a current and valid order and are given pursuant to a current prescription. The program maintains a pharmacy provider agreement with a 1st Choice Pharmacy signed April

20, 2019 and maintains a current Class II Type B pharmacy license through the Department of Health with an expiration date of February 21, 2021. A review of three youth IHCRs validated each youth was applicable for prescribed medications. Each reviewed IHCR documented a current and valid prescription order. Each IHCR was applicable for the youth being admitted on medications, a change to medications, or a new medication being ordered. In each instance, the physician's order sheet clearly documented the medication and dosage. The program maintains a written policy and procedures ensuring medications shall be provided pursuant to a physician's order written in the IHCR. All three reviewed youth IHCRs supported each contained a standard Department Medication Administration Record (MAR) outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. Each medication was administered in accordance with the approved nursing protocols and physician's order. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. The initial MAR for each record matched the medications listed. The medications are maintained in blister packs documenting the number of pills in each prescription order. The program maintains a written policy and procedures ensuring the provision of psychiatric services. The program maintains a weekly psychiatric list identifying the youth's prescribed psychotropic medications. An interview with the health services administrator (HSA) indicated they participate with the psychiatrist and DHA in a weekly meeting to discuss psychotropic medication management. Reviewed documentation supported the psychiatrist was on-site weekly as required. Each reviewed MAR supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed nursing staff initialed the MAR for each administered medication entry. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. There were no indications of lapses and/or errors in the medication administration of the sample size reviewed. One of the three reviewed IHCRs documented refusal of medications at least one time on the reviewed MARs. In addition, RN staff complete a Refusal of Treatment form and place it in the nursing chronological notes section of the IHCR. Observations of the medication administration room and medication cart were found clean and organized and all medications were separated in the medication cart as required. The program maintains a secured refrigerator located in the medical clinic utilized for medications. At the time of the annual compliance review, the program had no current prescribed medications stored in the refrigerator. According to the HSA, the program has no other bulk supply of medications stored. The program's practice is to order youth-specific thirty-day supplies when prescribed. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required. Three interviewed youth confirmed the nursing staff provide medication to youth while one youth indicated they do not take medication.

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

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. 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's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The plan was reviewed and approved by the facility administrator (FA) on August 26, 2020. The designated health authority (DHA) documented a review on January 8, 2020.The corporate office documented a review on July 10, 2017. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. The plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV), as well as infectious diseases caused by blood-borne pathogens. The plan includes procedures for other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly to include pediculosis and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), food-borne illnesses such as those caused by Escherichia Coli (E. Coli), and bio-terrorist agents. The program's plan outlines procedures regarding chemical exposures and universal precautions. The program provides all staff with the opportunity for Hepatitis B immunizations and access to protective equipment. An interview with the health services administrator (HSA) reported there have been no instances in which the local health department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified for an infectious disease. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the FA has a process in place to establish a separate record containing all documents for youth and staff who have experienced a facility or occupational exposure. An interview with the program's FA explained the program's Exposure Control Plan/Infection Control Plan is located in the medical office, and in the facility operating procedure (FOP) binder in the administration area. An interview with the program's HSA coupled with a review of records supported all youth receive infection control training upon their admission and annually.

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

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

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

Daily clinical care is performed by on-site licensed medical staff. The designated health authority (DHA) is clinically responsible for all healthcare services provided to youth. A review of all licensed medical staff found their registered nurse's medical licenses to be clear and active pursuant to administrative rule. The program does not employ any licensed practical nurses (LPN). All registered nurses (RN's) have current cardiopulmonary resuscitation (CPR) certification. A review of the provider's contract for health services, the use of a RN was included as a clinical manager/health services administrator (HSA).

Standard 5: Safety and Security

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

The program maintains a written policy and procedures to ensure active supervision of youth, and to verify the program's compliance with the ratio outlined in the contract. During the annual compliance review week, youth and staff movement were daily observed during the four days of the review. The program's contract requires a staff-to-youth ratio of one-to-eight during awake hours and observations completed indicated the program followed the required ratio. A total of fifteen instances of observations were completed when youth were in school, lunch time, in the day room, meals, group therapy, individual therapy, line movement, breaks, medication pass, daily meetings, and other schedule constructive activities. When asked, staff knew the exact number of all youth for whom they are assigned to supervise at all times. Staff were supervising youth while engaged in full schedule activities, and in all instances youth and staff interactions observed were positive. Staff closely monitor youth behaviors, and consistently applying the program's behavioral management system. Youth were always accompanied by staff. Daily schedule posted and available to youth in each living area. Staff interviews and surveys demonstrated they are aware of the policy and procedures on youth supervision including ratio requirements, reconciling the count, the use of radios, communication with medical and mental health staff when youth are not located. Facility perimeter checks are conducted when new shift starts. The program conducts at least six formal counts and ongoing informal counts within each twenty-four-hour period. If for any reason discrepancies are found during the checks, they are immediately communicated to staff to ensure they will be taken the necessary steps to get them corrected. A review of the program's logbooks for the previous six months confirmed head counts and movements, perimeter checks, and room checks were conducted as required.

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

The program maintains a written policy and procedures to ensure the consistent implementation and staff training in the behavior management system (BMS). The review of the program's BMS revealed it contained all the elements required by the contract. The program has a written description of the BMS in the Youth Handbook which offers a detailed explanation of the program system. Program rules and expectations are addressed in the handbook. The BMS is based on youth successful completion of the youth's treatment plan goals, performance plan goals, daily performance, compliance with schedule activities, participation in groups, increasing social skills, self-management, daily living skills, maintenance of a positive attitude, and development of positive relationship with staff, and the other youth. The program's system

utilizes character point cards to keep track of youth's points earned daily for positive behavior, and the amount of points earned determine the youth's level in the program. The system has four levels plus an orientation period for each youth. According to the level obtained youth receive incentive activities at the end of each week. The Youth Handbook contained the program rules governing conduct, as well as a guide for staff who describes in detail the decisions regarding the types of youth's behaviors and listed moderate behavior violations, major violations, and consequences and award recognitions for positive behavior. Rewards utilized by program includes game night, extra food/snacks, second bed time, extra social activity, fast food or a special meal, day in parks, go-karting, top golf, bowling, positive citizen awards, and outings within the community. Three surveyed youth confirmed the incentives. All of them confirmed BMS System is posted and was provided to them in the Youth Handbook. Observations made by the members of the review team during the four days of the annual review confirmed program staff adhered to the BMS when interacting with youth and adhered to the required ratio when redirecting the youth. The program has an Agreement for Educational Services with the Miami-Dade County School District regarding the implementation of the BMS during school hours, and the coordination of information and services between the program and the program's school. Interview with the program's assistant facility administrator (AFA) indicated there has not be any change in the BMS since the last annual compliance review. Postings of the BMS were observed in the Youth Handbook, the facility administrator's (FA) office, and the AFA office. Interview with the FA indicated the program's BMS tracks the daily, weekly, and monthly performance of the youth. Character point sheets are used to record the points the youth earned for positive behavior throughout the day. Based on the points earned for the day, according to the level the youth is on, they will receive a daily incentive for the day. There are four levels to the program plus an orientation level. Three youth were interviewed indicating consequences included level freeze, incentive freeze and apology letter. Incentives included canteen, fast food, awards, and video games. All three interviewed staff knew the program's BMS.

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

The program maintains a written policy and procedures regarding the implementation of the behavior management system (BMS), and to ensure the consistent administration of rewards and consequences. The program's system placed an emphasis on rewards and positive reinforcement, is responsive to the characteristics of the program's population. Youth must abide by the rules of the program, and staff consistently enforce those rules. The program's BMS complement the program's performance planning process, including coordination with any individual behavior plan when applicable. The program's system is based on structure and includes planning, the promotion of respect, is pro-active, provides clear and good instructions, incorporates a high level of involvement, engages the youth, address positive social skills, embraces tolerance, concentrates on modeling, provides training, and contains predictable

consequences. The program uses a variety of rewards and incentives to encourage youth participation and completion of the program. Positive and negative behavior are identified daily and incentives are in place to encourage youth to improve their performance. If youth display negative behaviors and receive numerous consequences may extend the orientation level until youth can show positive progress. The program does not utilize room restriction for major infractions. To graduate, youth will have to achieve the goals in their treatment plans and have a plan for success when they return to their community to ensure they understood the impact of their crime on their victims and the community where they will return. The program has a Monthly Incentive Calendar which was reviewed. The calendar includes daily, weekly, and monthly incentives, was well planned, posted for visibility for all staff and youth, and encourages youth leadership opportunities by asking youth for their input. Interview with the program's assistant facility administrator (AFA) indicated they and the facility administrator (FA) train the educational staff on the BMS plan to include use of BMS during school. Interview with the FA indicated youth rewards are monitored through a daily, weekly, and monthly tracker. Good citizen awards are given to youth who demonstrate positive behavior when interacting with other youth and staff. A raffle is conducted at the end of the week and a youth is selected and receives an incentive. Fidelity checks ensure rewards outnumber consequences at a minimum of four-to-one. Special treatment teams are held when serious infractions occur. Sanctions days, which are goals added when a youth does not comply the program rules after several prompts and are tracked on the BMS tracker. Staff received ninety-day evaluations after their hire day. They also have annual performance evaluations. Fidelity checks by AFA are conducted to ensure staff are adhering to the BMS and making sure it is fairly administered. The Monthly Incentive Calendar is posted to make sure youth are gaining their incentives properly. Two of the three interviewed youth indicated the BMS is good and one youth indicated the system is very good. All three interviewed staff indicated youth are informed of consequences at the 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 requiring program staff to conduct visual checks of each occupied room every ten-minutes when youth are in their sleeping quarters. Ten-minute checks are documented on a form which makes it easier for the staff to document the required frequency in real time and the initials of the staff conducting the check. The ten-minute check is completed by staff in different intervals of time. The program has a total of twenty-two recording video cameras from which video recording are maintained for at least thirty days. The video surveillance was reviewed and compared with the ten-minute checks documented by staff to confirm its accuracy. The video footage was reviewed on eight different days and times. Each reviewed video footage confirm ten-minute checks were conducted with the required frequency and in real time. An interview with the assistant facility administrator (AFA) and observation confirmed all the cameras were functional during the week of the annual compliance review. Ten-Minute Check Logs from the randomly selected dates and times, along with the corresponding video footage recordings, indicated checks were consistently conducted as required. Interview with the facility administrator indicated the program security cameras videotapes are maintained for thirty days. All three interviewed staff indicated rooms checks are conducted every ten minutes.

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

The program maintains a written policy and procedures to ensure youth are always accounted for through a system of physically counting youth at various times throughout the day. Observations, and a review of the program's logbook for the previous six months, demonstrated youth daily census counts, head counts, and youth movements conducted at the beginning of each shift, after each outdoor activity, and during emergency situations were documented on time. New admission, discharges, and youth temporarily away from program are also documented as required. In addition, the program utilizes the Department's Juvenile Justice Information System (JJIS) to track admissions, releases, and transfers. The review of the program's Continuity of Operations Plan (COOP) was also conducted. The program maintains an approved escape response plan to ensure appropriate levels of youth supervision is maintained. The plan was approved by the facility administrator (FA) on September 12, 2019. There were no youth temporarily away from the program during the annual compliance review week.

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 a chronological record of events, incidents, and activities in a central logbook. The assistant facility administrator (AFA) stated in an interview the program does not maintain living unit logbooks. The review of the program logbook from the previous six months indicated the program's logbook is bound with numbered pages, entries were made in ink with no ensures or white-out areas and no entries were destroyed or removed. Errors were struck through with a single line and dated and initialed by the staff correcting the error. Entries reviewed include the date and time of the event, the names of staff and youth involved, a brief description of the event, and the name and initial of the staff making the entry. Program policy requires assistant facility administrator (AFA) to conduct the review of the shift logbook on a weekly basis and document the findings of the review within the chronological flow in the master control logbook as required by policy. Documentation reviewed found AFA is documenting their review in the Facility Security Audit

and Safety Inspection report. A review of the logbook and shift report binder demonstrated staff have documented all the required events, incidents, and activities. In addition, important events such as emergency situations, special instructions for supervision and monitoring of youth, perimeter checks, youth's transportation, admission and releases, escapes, Department Central Communications Center (CCC) incidents, and medications were documented in the logbook. Reviewed practice supported the program logbook ensured incidents regarding the Florida Abuse Hotline and the Central Communications Center (CCC) were documented.

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

The program maintains a written policy and procedures for the assignment, inventory, tracking, storage and accountability of all keys used in the program, which was reviewed and approved by the facility administrator (FA) on August 26, 2020. The policy indicates once staff received the assigned facility keys, they sign the key control log to verify the keys are in the staff's possession. The policy requires documenting the return of keys on the control log as well, denoting signatures of both the employee and staff. There are two metal key lock boxes with limited access, located in the administration area where restricted and active keys are stored when not in use. The program has a key inspection log which was reviewed. Permanent issued keys are assigned to facility administrator (FA), assistant facility administrator (AFA), physical plant manager, and the administrative assistant (AA). Supervisors are responsible for the key distribution. The distribution and collection of keys was observed. In addition, a sampling of three staff members key rings was observed and compared to the inventory and the key log. Keys are bound on tamper resistant color-code ring with a tracking number. The program has one permanent key assignment acknowledgement form, a master key inventory, a permanent issue log, and a key repair form to ensure the program's key control and security. A review of the Department's Central Communications Center's (CCC) incident reports for the past six months indicated there was one incident where the facility keys were missing. A follow-up CCC incident report was completed a few minutes later indicating the missing keys were found.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program maintains a written policy and procedures which establish a system to prevent contraband and prohibited items entering the facility. Program defines items/material considered contraband as well as exceptions. The program's policy and procedures address any staff who is found in possession of contraband. The program's policy includes a list of approved youth items, and the Youth Handbook contained a list of seventeen prohibited items or unauthorized goods, and a list of ten items not allowed to be in the youth's possession. The program keeps a copy of the documentation in the youth's case management record and informed the youth of the consequences if found with contraband. Law enforcement was contacted if any found item is considered illegal as defined in state law, or if there is evidence of unlawful activity. The program documents the confiscation of any illegal contraband and the manner of disposition. Documentation reviewed and an interview with the assistant facility administrator (AFA) indicated outgoing mail is conducted daily and as needed at different times during the day. Searches and any relevant information are documented in the logbook. There have not been any incidents regarding contraband during the past six months. A review of the Department's Central Communications Center (CCC) incidents related to contraband confirmed the practice. Unannounced random youth searches are conducted, as well as searches of common areas before and after use by youth. Searches were observed during daily activities such as line movements, school, meals, and breaks, which confirmed they are conducted throughout the day as documented in the logbook. The program's perimeter security is checked on each shift. An interview with the facility administrator (FA) indicated, when discovered, contraband is handled in four ways. It can be disposed, mailed home, stored until youth is released, or returned to its owner. Illegal contraband is stored in the FA office until turned over to law enforcement.

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 as prescribed by Florida Administrative Code and based on the Protective Action Response (PAR) training manual. Youth Frisk and Fully Body Visual Search

forms were reviewed, and confirmed program is conducting fully body visual searches at the time of admission and return from medical appointments. Three staff were interviewed and were familiar with the policy and agreed no female staff can perform a search on a male youth. The program's policy indicates procedures to conduct searches during off-campus activities and visitation. Due to the COVID-19 pandemic and in adherence to the guidelines of the Center for Disease Control and Prevention (CDC), on-site visitation at the program and off-campus activities were suspended at the Department's direction effective March 13, 2020. During the time of this annual compliance review, visitation was reinstated if the program did not have pending or positive tests. The program developed a pandemic visitation plan and were asked to adhere to CDC guidelines but to host visitation when possible. There were no youth admissions during the annual compliance review week; therefore, no observations could be conducted. However, searches were observed at the time of treatment team meetings and when youth were in line. In each instance, the searches were conducted as required. Three youth were interviewed and knew when searches occur.

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 maintains a written policy and procedures to ensure the program vehicles are properly maintained, contain safety and emergency equipment, and are operated in a safe manner. At the time of the annual compliance review, the program had two operable vans to transport youth, and one car assigned for administrative duties. The inspections of the two vans found the doors to the youth passenger area cannot be opened from the inside. Both vans had installed safety screens and were equipped with a fully-charged fire extinguisher, seatbelt cutters, window punch, and operable seatbelts for each passenger. The vehicles first aid kits were stored in master control to be checked out when using the vehicles. Vehicle maintenance logs were provided which demonstrated regular maintenance has been performed. Annual vehicle inspections were conducted by Tires Plus of Kendall, Florida. The review of the vehicles invoice documentation revealed each vehicle received an annual inspection and any deficiencies were corrected. The program had a list of nine program staff members approved driver's list who was reviewed. In addition, the program has a log confirming the program consistently complete weekly vehicle inspections. A random check of six staff personal vehicles conducted in the program's parking lot with the help of the assistant facility administrator (AFA) found all of them were locked. Three staff were interviewed and each stated they are provided with a cellular telephone when transporting and knew the number of staff necessary to transport youth for any outside activities including medical appointments.

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 appropriate staff-to-youth ratio is maintained while youth are transported off program grounds, and youth, staff, and the public

are safe and secure. Staff are not permitted to leave a youth unattended in a vehicle and youth are not permitted to drive the program or staff vehicles. The program had a list of nine staff members assigned to provide secure transportation to the youth in the program and the list is updated monthly. Interview with the assistant facility administrator (AFA) indicated the program used the one staff to five youth ratio during all transports, and there is one staff of the same gender of youth being transported. The AFA also indicated youth are usually transported to court, medical appointments, emergencies, and incentives activities; however, due to the COVID-19 pandemic and in adherence to the guidelines of the Center for Disease Control and Prevention (CDC), transportation to outings, community services, educational activities, and others had been cancelled. Reviewed documentation and interview with program staff indicated the human resources department utilizes the Department of Motor Vehicles to check staff driver's licenses monthly. The authorized driver's binder documentation reflected the program has been conducting monthly checks consistently. Three youth were interviewed and indicated the program staff drive the vehicles safely. Three staff were interviewed and indicated the equipment in the transport vehicles consists on first aid kit, fire extinguisher, seat belt cutter, and window punch. Three staff members were interviewed regarding the emergency response process for emergencies during vehicle transport. One staff stated to contact the program and the Department's Central Communication Center (CCC), another staff stated to notify police and the program, and the other staff stated to notify the supervisor.

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 to ensure the maintenance of a safe and secure physical plant, grounds, and perimeter. The program maintained three policies and procedures related to housekeeping and sanitation, one for preventive and corrective maintenance, and one for perimeter security. A review of the Facility Security Audit and Safety Inspection Log confirmed the facility administrator (FA), and the assistant facility administrator (AFA) are responsible for conducting the weekly security inspections, documenting the findings and any corrective action needed, including time frames to correct any issues related to the safety of the youth. The weekly safety and security audits include the inspection of the facility cameras, radios/communication, keys, locks and doors, vehicles, and living areas to include the youth rooms and bathrooms. In addition, the facility management complete facility security and perimeter checks on each shift which were documented in the program's logbook. A review of the weekly reports and the internal system verified deficiencies are corrected and confirmed issues are addressed during weekly management meeting ensuring deficiencies are corrected timely. Interview with the FA indicated each deficiency is tracked and a work order is submitted with a time frame to fix the issue. The report is also sent to the Department's for oversight. Issues are then discussed, and a plan is outlined to fix the deficiency in a feasible time frame.

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 an extensive written policy and procedures addressing the proper control and management of tools to ensure youth do not use tools or equipment as weapons or security breaches. The policy requires the inventory and inspection of the class A tools prior to being issued for work and following work activities. The policy indicated prohibited tools included machetes, bowie knives, and long blade knives, such as swords. Training documentation

reviewed confirmed all applicable staff were trained in the safe use of tools. Tools are maintained in the physical plant manager's mechanic shop located outside of the program's secured fenced perimeter area, inaccessible to youth. Class A tools are placed on a shadow board to ensure an accurate count of the tools. Class B tools are located inside the laundry. The inventory for class B tools is conducted daily to ensure tools are accounted for by applicable staff. The physical plant manager is the tool control manager who controls the access and secure of the class A tools. The program has a sign in/out log for class A and class B tools. The physical manager conducts daily reviews of class A tools inventory and monthly review of class B tools inventory as well as the tool area inspection. A review of the inventory sheets verified this practice.

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 in order to prevent injuries to themselves, other youth and staff. The policy covered the issuance, inventory, and control of tools. Policy requires ongoing supervision of youth while using tools to maintain safety and security in the program. Policy requires assessing youth risk to self and others to determine their eligibility to use class B tools, and participation in work projects which it is based on their level achieved in the program's behavior management system (BMS). The youth ratio is one staff to four youth while using tools. A review of three youth case management records verified risk assessments are completed and identified whether the youth is eligible to handle tools. The policy requires the inventory and inspection of the class A tools prior to being issued for work and following work activities. The inventory for class B tools is conducted daily to ensure tools are accounted for by staff. Class B tools include mops, brooms, and scrub brushes with handles. A review of the class B tool inventory log sheet confirmed the program's practice. A review of three staff in-service training records indicated each staff completed training in the appropriate use of tools. Three staff were interviewed, and each stated youth are allowed to use brooms, mops, buckets and 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 which establishes guidelines required for outside contractors, which includes information about tool control and restrictions. Reviewed documentation found the program utilized a written notification form to be completed, signed, and dated by each outside contractor who contained a complete tool inventory list and amount of all the tools being brought into the program, and control of each tool. The contractor tool inventory list was signed and dated for each responsible contractor, and the program's physical plant manager or designee, who inspect all tools and equipment at arrival and at departure. At no time can any tool be left unattended while in the facility, and the tools entering to the designated work area are limited to only those required to complete the necessary job. If a tool is missing and cannot be located, the contractor must immediately notify the facility administrator (FA), assistant facility administrator (AFA) or the physical plant manager. The program guidelines indicated youth are restricted from entering any work area in which outside contractors are working, and a final inspection of the work area must be completed by the

contractor and the physical plant manager prior to departure. Personal cellular telephones, and/or electronic devises capable of taking pictures or audio/video recording are prohibited in the secure area. In addition, each contractor must sign a contractor acknowledgement and notification of Prison Rape Elimination Act (PREA). The review of five tool inventories for contractor services rendered at the program revealed the contracted workers sign-in and sign-out of the facility related to services performed.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory Compliance
The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.	

The program maintains a written policy and procedures to ensure the program 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 review of the drill logs for the last six months confirmed the program completed unannounced drills on a random basis under varied conditions to include fire drills, program disturbance drills, chemical spill drills, missing key drills, escape drills, lighting in the area drills, and evacuation drills. Further review indicated the drills were conducted in accordance with the Continuity of Operations Plan (COOP) requirements. Reviewed drill forms confirmed each drill documented the type of drill, date and time, list of staff participants, brief scenario, and findings and recommendations. Drills were reviewed, signed and dated by the facility administrator (FA), and/or assistant facility administrator and the program's safety and security coordinator. In addition, the program has policy and procedures regarding a program disturbance plan which was reviewed, signed, and dated by the FA and the designated safety and security coordinator on October 5, 2019. A tour of the program revealed egress plans were posted throughout the facility, and fire extinguishers inspected annually by A-Advanced Fire & Safety, Inc. Three youth were interviewed and knew what to do in case of a fire.

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 written policy and procedures to ensure a Continuity of Operations Plan (COOP) is developed, updated as necessary and maintained for the continuity of mission essential functions of the organization in the event an emergency prevent occupancy of its program's primary office building/location, in compliance with state law and the Department's policy. A review of the COOP validated the plan was submitted and approved by the Department on March 16, 2020. The COOP contained alternative housing plans were included in the case the program be required to vacate due to an emergency or disaster. Interview with the assistant facility administrator (AFA), and documentation reviewed found the program maintained the listed and required critical and medical identifying information for each youth in an administrative copy easily accessible and mobile in the event of an emergency. Observation

confirmed copies of the COOP are maintained in the facility administrator (FA), and the AFA offices, and are readily available to staff. Interview with the FA indicated the COOP plan is available to all staff and copies are kept in the FA office, AFA office, and the conference 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 to ensure all youth and staff are safe from the effects of unauthorized use of flammable, poisonous, toxic, and caustic materials. A tour of the program and observations found the program stored all the toxic items and materials in local metal cabinets within a secure building outside the secure fenced perimeter of the program inaccessible to youth. The program reported all areas of the facility have been disinfected daily since the onset of COVID-19 pandemic. Reviewed documentation indicated the program has a complete a Chemical Inventory Log which is reviewed and up-dated daily. A review of the Chemical Inventory Log was conducted and documented all flammable, poisonous, and toxic items and hazardous materials within the program. Copies of the Safety Data Sheets (SDS) for stored materials were provided and reviewed. Reviewed documentation revealed the program's inventory and the SDS sheets information matched the actual items within the program.

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 written policy and procedures prohibiting youth from handing flammable, poisonous, toxic, and caustic materials. Documentation reviewed and interview completed with the assistant facility administrator (AFA) indicated the physical plant manager maintains strict control of these items, and ensures youth do not use, handle, or clean up with any dangerous or hazardous chemicals. Youth do not have access to areas where items are being stored. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waste. Documentation reviewed found the program implemented a daily program cleaning schedule. The program contracted pest control with ORKIN, and garbage disposal with Waste Management. The program maintained a preventive maintenance checklist which was reviewed. The program procedures indicated the facility administrator (FA) authorize in writing all staff positions authorized to handle any chemicals. Three youth were

interviewed and stated they do not handle any chemicals. During clean-up, staff would pour or spray the chemical and the youth would wipe it up.

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 to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused flammable, toxic, caustic, and poisonous materials are kept in the locked area located off the program and disposed according to the Safety Data Sheets (SDS) directions. These items are inaccessible to youth. Disposals procedures are in accordance with OSHA standards. The program contracted with AAA Above All Septic and Drain, Inc. to dispose grease or any other residues. Reviewed documentation confirmed the program conducted chemical spills drills regularly. There have not been any incidents of chemical spill at the program within the last six months.

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 maintains a written policy and procedures to allow youth to have visitation and communication with family members while in the program. Youth are informed of visitation upon admission during the orientation process. The program's Youth Handbook, provided to each youth upon admission outlines visitation policy and guidelines; however, due to the COVID-19 pandemic, and in adherence to the guidelines of the Centers for Disease Control and Prevention (CDC), on-site visitation at the program has been suspended at the Department's direction since March 8, 2020. During the time of this annual compliance review, visitation was reinstated if the program did not have pending or positive tests. The program developed a pandemic visitation plan and were asked to adhere to CDC guidelines but to host visitation when possible. Youth are given the opportunity to engage in video conferencing with family member to substitute for the suspended in person visitation. Youth are provided with writing materials, and self-addressed stamped envelopes to send letters to approved family members.

The program maintained a Correspondence Log which was reviewed. Youth have incoming mail Tuesdays and Thursdays and out-going mail Wednesdays. Youth have unimpeded access with the courts, attorneys, their assigned juvenile probation officers (JPOs), and Department of Children and Families (DCF) case workers, when applicable. Youth are permitted weekly telephone calls. Youth's use of telephone was documented in each youth's case management chronological documentation. Three youth were interviewed, and each confirmed they can call their parents/guardians or send a letter to them.

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

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

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

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

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

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