STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## Annual Compliance Report

## Oak Grove Academy Re-Review

***Rite of Passage, Inc.***
**(Contract Provider)**
**11180 NE 38 Street**
**Jasper, Florida 32052**

***Review Date(s): July 21-24, 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 that do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated. |
| **Limited Compliance** | Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator that result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically. |
| **Failed Compliance** | The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery. |

## Review Team

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

Juan D. Youman, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Warren Garrison, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Jill Foy, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Tara Frazier, Office of Accountability and Program Support, Regional Monitor (Interviews)
Jennifer Harris, TrueCore Behavioral Solutions, LLC, Community Case Manager (Standard 2)
Travis Ligon, Office of Prevention Services, Procurement Specialist (Standard 5)

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
RE-REVIEW ADDENDUM

Program Name: Oak Grove Academy
Provider Name: Rite of Passage, Inc.
Location: Hamilton County / Circuit 3
Review Date(s): July 21-24, 2020

MQI Program Code: 1450
Contract Number: 10590
Number of Beds: 40
Lead Reviewer Code: 141

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

### Original Review 12/13/2019

| Overall Rating Summary |
|---|
| **This program has received an overall program compliance rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.** |

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

| Limited Ratings | Failed Ratings |
|---|---|
| 1.13 Gender-Specific Programming | 2.05 Gang Identification: Notification of Law Enforcement |
| 2.04 Classification Factors, Procedures, and Reassessment for Activities | 2.06 Gang Identification: Prevention and Intervention Activities |
| 2.07 Residential Assessment for Youth (RAY) | 2.09 Performance Plan Development, Goals and Transmittal * |
| 2.10 Performance Plan Revisions | 2.11 Performance Summaries and Transmittals |
| 2.16 Career Education | 2.13 Members of Treatment Team |
| 2.21 Exit Conference | 2.14 Incorporation of Other Plans Into Performance Plan |
| 3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff | 2.15 Treatment Team Meetings (Formal and Informal Reviews) |
| 3.06 Mental Health and Substance Abuse Treatment | 2.19 Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT) |
| 3.13 Suicide Prevention Training * | 2.20 Exit Portfolio |
| 4.01 Designated Health Authority/Designee * | 3.07 Treatment and Discharge Planning * |
| 5.05 Census, Counts, and Tracking | 3.11 Suicide Prevention Services * |
| 5.06 Logbook Entries and Shift Report Review | 3.12 Suicide Precaution Observation Logs * |
| | 5.04 Ten Minute Checks * |
| | 5.16 Fire, Safety, and Evacuation Drills |
| | 5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials |
| | 5.26 Safety Planning Process for Youth |

### Re-Review 07/24/2020

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

| Limited Ratings | Failed Ratings |
|---|---|
| 2.09 Performance Plan Development, Goals and Transmittal * | |
| 5.26 Safety Planning Process for Youth | |

# Standard 1: Management Accountability
# Residential Rating Profile

## Indicator Ratings

| Standard 1 - Management Accountability | | Re-Review - 7/24/2020 | Original Review 12/13/2019 |
|---|---|---|---|
| 1.01 | Initial Background Screening * | Satisfactory | Satisfactory |
| 1.02 | Five-Year Rescreening | Satisfactory | Satisfactory |
| 1.03 | Provision of an Abuse-Free Environment * | Satisfactory | Satisfactory |
| 1.04 | Management Response to Allegations * | Non-Applicable | Satisfactory |
| 1.05 | Incident Reporting (CCC) * | Satisfactory | Satisfactory |
| 1.06 | Protective Action Response (PAR) and Physical Intervention Rate | Satisfactory | Satisfactory |
| 1.07 | Pre-Service/Certification Requirements * | Satisfactory | Satisfactory |
| 1.08 | In-Service Training | Satisfactory | Satisfactory |
| 1.09 | Grievance Process | Satisfactory | Satisfactory |
| 1.10 | Delinquency Intervention and Facilitator Training | Satisfactory | Satisfactory |
| 1.11 | Life Skills Training Provided to Youth | Satisfactory | Satisfactory |
| 1.12 | Restorative Justice Awareness for Youth | Satisfactory | Satisfactory |
| 1.13 | Gender-Specific Programming | Satisfactory | Limited |
| 1.14 | Internal Alerts System and Alerts (JJIS)* | Satisfactory | Satisfactory |
| 1.15 | Youth Records (Healthcare and Management) | Satisfactory | Satisfactory |
| 1.16 | Youth Input | Satisfactory | Satisfactory |
| 1.17 | Advisory Board | Satisfactory | Satisfactory |
| 1.18 | Program Planning | Satisfactory | Satisfactory |
| 1.19 | Staff Performance | Satisfactory | Satisfactory |
| 1.20 | Recreation and Leisure Activities | Satisfactory | 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: Youth Management
# Residential Rating Profile

## Indicator Ratings

| Standard 2 - Assessment and Performance Plan | | Re-Review - 7/24/2020 | Original Review 12/13/2019 |
|---|---|---|---|
| 2.01 | Initial Contacts to Parent/Gaurdian and Court Notification | Satisfactory | Satisfactory |
| 2.02 | Youth Orientation | Satisfactory | Satisfactory |
| 2.03 | Written Consent of Youth Eighteen or Older | Satisfactory | Satisfactory |
| 2.04 | Classification Factors, Procedures, and Reassessment for Activities | Satisfactory | Limited |
| 2.05 | Gang Identification: Notification of Law Enforcement | Satisfactory | Failed |
| 2.06 | Gang Identification: Prevention and Intervention Activities | Satisfactory | Failed |
| 2.07 | Residential Assessment for Youth (RAY) | Satisfactory | Limited |
| 2.08 | Youth Needs Assessment Summary (YNAS) | Satisfactory | Satisfactory |
| 2.09 | Performance Plan Development, Goals and Transmittal * | Limited | Failed |
| 2.10 | Performance Plan Revisions | Satisfactory | Limited |
| 2.11 | Performance Summaries and Transmittals | Satisfactory | Failed |
| 2.12 | Parent/Guardian Involvement in Case Management Services | Satisfactory | Satisfactory |
| 2.13 | Members of Treatment Team | Satisfactory | Failed |
| 2.14 | Incorporation of Other Plans Into Performance Plan | Satisfactory | Failed |
| 2.15 | Treatment Team Meetings (Formal and Informal Reviews) | Satisfactory | Failed |
| 2.16 | Career Education | Satisfactory | Limited |
| 2.17 | Educational Access | Satisfactory | Satisfactory |
| 2.18 | Education Transitions Plan | Satisfactory | Satisfactory |
| 2.19 | Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT) | Satisfactory | Failed |
| 2.20 | Exit Portfolio | Satisfactory | Failed |
| 2.21 | Exit Conference | Satisfactory | Limited |

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

## Indicator Ratings

| Standard 3 - Mental Health and Substance Abuse Services | | Re-Review - 7/24/2020 | Original Review 12/13/2019 |
|---|---|---|---|
| 3.01 | Designated Mental Health Clinician Authority or Clinical Coordinator | Satisfactory | Satisfactory |
| 3.02 | Licensed Mental Health and Substance Abuse Clinical Staff * | Non-Applicable | Non-Applicable |
| 3.03 | Non-Licensed Mental Health and Substance Abuse Clinical Staff | Satisfactory | Limited |
| 3.04 | Mental Health and Substance Abuse Admission Screening | Satisfactory | Satisfactory |
| 3.05 | Mental Health and Substance Abuse Assessment/Evaluation | Satisfactory | Satisfactory |
| 3.06 | Mental Health and Substance Abuse Treatment | Satisfactory | Limited |
| 3.07 | Treatment and Discharge Planning * | Satisfactory | Failed |
| 3.08 | Specialized Treatment Services* | Satisfactory | Satisfactory |
| 3.09 | Psychiatric Services * | Satisfactory | Satisfactory |
| 3.10 | Suicide Prevention Plan * | Satisfactory | Satisfactory |
| 3.11 | Suicide Prevention Services * | Satisfactory | Failed |
| 3.12 | Suicide Precaution Observation Logs * | Satisfactory | Failed |
| 3.13 | Suicide Prevention Training * | Satisfactory | Limited |
| 3.14 | Mental Health Crisis Intervention Services * | Satisfactory | Satisfactory |
| 3.15 | Crisis Assessments * | Non-Applicable | Non-Applicable |
| 3.16 | Emergency Mental Health and Substance Abuse Services * | Satisfactory | Satisfactory |
| 3.17 | Baker and Marchman Acts * | Satisfactory | Non-Applicable |

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# Standard 4: Health Services
# Residential Rating Profile

## Indicator Ratings

| Standard 4 - Health Services | | Re-Review - 7/24/2020 | Original Review 12/13/2019 |
|---|---|---|---|
| 4.01 | Designated Health Authority/Designee * | Satisfactory | Limited |
| 4.02 | Facility Operating Procedures | Satisfactory | Satisfactory |
| 4.03 | Authority for Evaluation and Treatment | Satisfactory | Satisfactory |
| 4.04 | Parental Notification/Consent | Satisfactory | Satisfactory |
| 4.05 | Healthcare Admission & Rescreening Form | Satisfactory | Satisfactory |
| 4.06 | Youth Orientation to Healthcare Services/Health Education | Satisfactory | Satisfactory |
| 4.07 | Designated Health Authority/Designee Admission Notification | Satisfactory | Satisfactory |
| 4.08 | Health-Related History | Satisfactory | Satisfactory |
| 4.09 | Comprehensive Physical Assessment/TB Screening | Satisfactory | Satisfactory |
| 4.10 | Sexually Transmitted Infection & HIV Screening | Satisfactory | Satisfactory |
| 4.11 | Sick Call Process | Satisfactory | Satisfactory |
| 4.12 | Episodic/First Aid Care/Emergency Care | Satisfactory | Satisfactory |
| 4.13 | Off-Site Care/Referrals | Satisfactory | Satisfactory |
| 4.14 | Chronic Illness/Periodic Evaluations | Satisfactory | Satisfactory |
| 4.15 | Medication Management | Satisfactory | Satisfactory |
| 4.16 | Medication/Sharps Inventory and Storage Process | Satisfactory | Satisfactory |
| 4.17 | Infection Control/Exposure Control | Satisfactory | Satisfactory |
| 4.18 | Prenatal Care/Education | Non-Applicable | Non-Applicable |

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

# Standard 5: Safety and Security
# Residential Rating Profile

## Indicator Ratings

| | Standard 5 - Safety and Security | Re-Review - 7/24/2020 | Original Review 12/13/2019 |
|---|---|---|---|
| 5.01 | Youth Supervision * | Satisfactory | Satisfactory |
| 5.02 | Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training | Satisfactory | Satisfactory |
| 5.03 | Behavior Management System Infractions and System Monitoring | Satisfactory | Satisfactory |
| 5.04 | Ten Minute Checks * | Satisfactory | Failed |
| 5.05 | Census, Counts, and Tracking | Satisfactory | Limited |
| 5.06 | Logbook Entries and Shift Report Review | Satisfactory | Limited |
| 5.07 | Key Control* | Satisfactory | Satisfactory |
| 5.08 | Contraband Procedure | Satisfactory | Satisfactory |
| 5.09 | Searches and Full Body Visual Searches | Satisfactory | Satisfactory |
| 5.10 | Vehicals and Maintenance | Satisfactory | Satisfactory |
| 5.11 | Transportation of Youth | Satisfactory | Satisfactory |
| 5.12 | Weekly Safety and Security Audit | Satisfactory | Satisfactory |
| 5.13 | Tool Inventory and Mangement | Satisfactory | Satisfactory |
| 5.14 | Youth Tool Handling and Supervision | Satisfactory | Satisfactory |
| 5.15 | Outside Contractors | Satisfactory | Satisfactory |
| 5.16 | Fire, Safety, and Evacuation Drills | Satisfactory | Failed |
| 5.17 | Disaster and Continuity of Operations Planning (COOP) | Satisfactory | Satisfactory |
| 5.18 | Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials | Satisfactory | Failed |
| 5.19 | Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials | Satisfactory | Satisfactory |
| 5.20 | Disposal of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory | Satisfactory |
| 5.21 | Elements of the Water Safety Plan, Staff Training, and Swim Test * | Non-Applicable | Non-Applicable |
| 5.22 | Visitation and Communication | Satisfactory | Satisfactory |
| 5.23 | Search and Inspection of Controlled Observation Room | Non-Applicable | Non-Applicable |
| 5.24 | Controlled Observation | Non-Applicable | Non-Applicable |
| 5.25 | Controlled Observation Safety Checks and Release Procedures | Non-Applicable | Non-Applicable |
| 5.26 | Safety Planning Process for Youth | Limited | Failed |

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

## Summary

Oak Grove Academy began receiving youth in March 2019. The program is a forty-bed program serving males, ages fourteen to nineteen, located in Jasper, Florida. The program is operated by Rite of Passage Inc, through a contract with the Department. The program provides medical, mental health, and substance abuse treatment overlay services. In addition, the program fosters each youth by providing Council for Boys and Young Men, Active Parenting, Impact of Crime, Aggression Replacement Training (ART), the University of Cincinnati Correctional Institute for Substance Abuse (UCCISA), and Seeking Safety. Additional treatment services provided includes family, individual, and group therapy, equine therapy, Home Builders Institute (HBI), and 4-H. Program administration is comprised of a program director, an equine program director, a staff development coordinator, and two shift supervisors. Case management and mental health services are provided by the designated mental health clinician authority (DMHCA), two transition service managers, four therapeutic managers, and one part-time therapeutic manager. Medical services are offered twenty-four hours a day, seven days a week, and are provided by a medical doctor, a health services administrator, three full-time nurses, one part-time nurse, and one psychiatrist. Educational services are provided by the program through the use of four teachers, one substitute teacher, and one paraprofessional. The layout of the program includes an administration building, cafeteria, two youth modules, two basketball courts, vocational building, and an education building. The program has fifty-eight cameras of which all were operational, providing video coverage. At the time of the annual compliance re-review, the program had two coach counselors vacancies.

## Standard1: Management Accountability

### 1.01 Initial Background Screening (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program began receiving youth on March 15, 2019. Since then, the program has employed sixty-five staff requiring an initial background screening. Five of the sixty-five staff at the program to include staff, teachers, and contracted staff, had background screenings which were completed after the employee's date of hire. Interviews with administrative staff indicated staff were hired but were not in the presence of youth until the background screenings were completed. The Annual Affidavit of Compliance with Level 2 Screening Standard was completed and sent to the Department's Background Screening Unit on June 19, 2019.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place to have a background screening completed for each staff prior to their hire date. A review of the staff roster at the program found the program hired ten employees since the last annual compliance review. Each of the employees were screened prior to being hired. Of the ten employees, three were required to be administered a pre-employment assessment tool. Each of the three employees received a passing score, and the score was documented in each staff record. The Annual Affidavit of Compliance with Level 2 Screening Standard was completed and sent the Department's Background Screening Unit on January 21, 2020. Interview with the program director revealed the program reviewed Central Communication Center (CCC) person involvement history report, Staff Verification System (SVS) module, and Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results prior to hire staff or utilizing volunteers who will have contact with youth.

### 1.02 Five-Year Rescreening

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures related to five-year rescreening. The program does not have any staff eligible for a five-year rescreening.

During the annual compliance re-review, the program received a Satisfactory **Compliance rating** for this indicator. The program has a policy and procedures concerning five-year rescreening for staff. The program does not have any staff eligible for a five-year rescreening, therefore this indicator will be rated non-applicable.

### 1.03 Provision of an Abuse-Free Environment (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures related to an abuse-free environment. Each staff record contained a signed code of conduct form, which identified expectations for ethical and professional behavior. The program director stated the program bases disciplinary actions on the severity of the offense. The Florida Abuse Hotline is called and the Central Communications Center (CCC) is notified within two hours of the incident being reported. Staff are also removed from the floor pending investigation and disciplinary action, up to termination. All youth and staff are required

to report any instance of abuse, even suspicion of abuse, according to the program's policy. All youth and staff have unimpeded access to self-report alleged abuse by utilizing the facility's telephone. Youth have access to this phone a minimum of three times each day. A tour of the facility found the Florida Abuse Hotline and CCC contact numbers were posted throughout the facility.

The program had a total of four alleged incidents related to physical, psychological, or emotional abuse since the program opened in March 2019. After investigations were complete, all staff were able to resume normal duties. A review of all incidents found there were four which involved a complaint related to physical, psychological, or emotional abuse and each were found to be unsubstantiated.

Seven youth interviewed stated they felt safe at the program. These seven youth revealed they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC. Five of the seven youth revealed staff are respectful when speaking to youth. The other two youth replied some of the staff are respectful most of the time. Five of the seven youth stated they have heard staff use curse words occasionally. One youth stated never, and the other stated often. Interviews with seven staff revealed the process for allowing staff and youth to call the Florida Abuse Hotline is to notify the supervisor and the program director. The supervisor will call the Florida Abuse Hotline when requested by the youth. The supervisor also reported, if possible, the staff attempts to resolve the issue first before the call is made. Seven staff revealed they have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. Five staff interviews revealed they have never observed a co-worker using profanity when speaking to youth, using threats, intimidation or humiliation when interacting with youth. The other two stated they have observed staff use profanity. An interview with the program director revealed the program scheduled a Trauma Responsive and Caring Environment (TRACE) self-assessment for January 2021.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place to ensure the program provides an abuse-free environment for staff and youth. All youth have unhindered access to report alleged abuse to the Florida Abuse Hotline and the Central Communications Center (CCC), if applicable. A review of staff records found all staff adhere to a Code of Conduct, as indicated by the staff signatures on the employee handbook. A tour of the program found contact information for the Florida Abuse Hotline and CCC posted throughout the facility. The program completed a TRACE self-assessment on July 7, 2020.

An interview with the program director revealed the program has not had any incidents related to physical, psychological, or emotional abuse since the last annual compliance review. The program director revealed if there are any allegations of abuse toward youth by staff, the staff are removed from the floor and an internal investigation is conducted. Staff will receive disciplinary action up to and including termination, depending on the severity of the incident. According to the program director, all incidents are reported in accordance with the Department's Statewide Procedures for Reporting of Incidents. All incident reports will be filled out completely and correctly. Staff with firsthand knowledge of the incident will be responsible for calling the CCC and completing the required forms. An internal incident report and CCC log is completed, and the shift supervisor and program director are notified of the incident. All incidents are reported to the CCC and/or the Florida Abuse Hotline within two hours of the incident. Five interviewed youth stated feeling safe at the program. The youth revealed they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC. The youth revealed staff are respectful when talking to youth, and they have never heard staff use curse

words when speaking to youth. Five interviewed staff stated the process for allowing staff and youth to call the Florida Abuse Hotline or CCC is to notify the supervisor and program director. Youth are allowed to make to call as soon as possible with the staff dialing the number. The call is also document on the call log. Staff interviews revealed staff have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. Staff reported never observing a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth.

**1.04 Management Response to Allegations (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program had a total of four alleged incidents related to physical, psychological, and emotional abuse since the program opened in March 2019. There was evidence of management taking immediate action to address incidents of physical, psychological, and emotional abuse. Each staff was immediately removed from the floor pending internal investigations. After the investigations were completed, each staff was able to return to their normal job duties. The program director stated the Florida Abuse Hotline and the Central Communications Center (CCC) numbers are posted throughout the facility. In management meetings, incidents are discussed, as well as identifying areas of needed training.

During the annual compliance re-review, the program received a **Non-Applicable rating** for this indicator. A review of applicable documentation and reports revealed the program has not had any allegations requiring management response. An interview with the program director revealed the program has not had any incidents of physical, psychological, or emotional abuse since the last annual compliance review; therefore, this indicator is rated as Non-Applicable.

**1.05 Incident Reporting (CCC) (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13,2019. The program had a total of twenty-three incidents reported to the Central Communication Center (CCC) within the last six months. The program created a corrective action plan due to an extensive increase in CCC reports related to supervision issues. Seven reports were selected for review. All seven reports were reported within the required two hours of gaining knowledge of the event. Six of the seven reports were documented in the logbook/shift report. A review of the internal incidents and grievances found none of them should have been reported to the CCC. The program director interview revealed the CCC must be notified within two hours of an incident or the abuse hotline is called. The program also completes an internal investigation and report accordingly.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place concerning incident reporting. The program had thirty-six incidents requiring the program to contact the Department's Central Communications Center (CCC) since the last annual compliance review. Seven reports were randomly selected for review. All of the incidents were reported to the CCC within two hours, as required. Six of the seven incident reports were documented in the program's logbook. A review of the internal incidents and grievances found there were no additional incidents which should have been reported to the CCC. The program experienced a decrease in the number of reportable incidents to the CCC. The program director stated all incidents shall be reported in accordance with the Department's Statewide Procedures for

Reporting of Incidents. All incident reports are filled out completely and correctly. Staff with firsthand knowledge of the incident are responsible for calling the CCC and completing the required forms, as well as documenting the incident on the internal incident report log and CCC log, and notifying the shift supervisor and program director. All Incidents are reported to the CCC and/or the Florida Abuse Hotline within two hours of the incident.

## 1.06 Protective Action Response(PAR) and Physical Intervention Rate

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. There was a total of fifty-two Protective Action Response reports in the last six months. A random selection of five PAR reports were selected for review. There was no alleged abuse by youth in any of the reports reviewed. None of the PAR reports resulted in injury to youth or staff and did not require a PAR Medical Review. Four of the five PAR reports had a review by a PAR certified instructor/supervisory staff. Four of the five reports had documentation of the administrator/designee reviewing the report within seventy-two hours. Four of the five reports were completed by the end of the staff members' work day. One of the staff statements was completed the day following the incident. For the one PAR report involving mechanical restraints, the Mechanical Restraint Supervision Log was completed. Each of the five reviewed PAR reports contained a post-PAR interview with the youth by the administrator or designee within a thirty minute time frame. All of the PAR techniques utilized were approved by the Department. The program's PAR plan was approved by the Department on March 13, 2019. There was evidence of the PAR reports being placed in the program's centralized file within forty-eight hours of being signed by the administrator. The program's PAR rate is 4.10 which is above the state rate of 2.35. The program director explained the program reviews the video of each PAR incident and talks to staff and youth. If there is an injury from the PAR incident then the Florida Abuse Hotline and the Central Communications Center are notified. There was evidence of the program submitting to the Department monthly summaries of all PAR incidents within two weeks of the end of each month.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place concerning physical intervention techniques. The program had twenty-six Protective Action Response (PAR) reports since the last annual compliance review. Five PAR reports were randomly selected for review. Four of the five reports were completed by the end of each staff member's workday. The remaining report was completed the following day. Each of the reports included statements from all staff involved. Each of the reports were reviewed by a PAR-certified instructor or supervisory staff. There was documentation indicating a Post-PAR interview was conducted with the youth by the administrator or designee within thirty minutes. Each PAR incident report was reviewed within seventy-two hours of the incident, excluding weekends and holidays, by the administrator or designee. The program's PAR rate during the annual compliance review period was 5.65, which is above the statewide Residential PAR rate of 2.28. An interview with the program director revealed the program begin to deal with more of mental health issues that substance abuse. The program has also learned the correct the processes to remove a youth not fit for the program. The program has improved the systems and have not had any PARs since May 2020. The program's PAR Plan was approved by the Department on February 11, 2020. The program has experienced a decrease in the number of PARs since the last annual compliance review. The program director stated the program monitors PAR incidents and use of force by reviewing video and discussing each incident during daily management meetings.

## 1.07 Pre-Service/Certification Requirements (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures related to pre-service training. A review of seven staff training records found five of the staff completed all required 120 hours of pre-service training within 180 days of hire. Two of the staff did not complete all required training within 180 days of hire. Six of the seven staff completed training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, child abuse reporting, emergency procedures, suicide prevention, and Prison Rape Elimination Act (PREA). One of the staff did not complete training in emergency procedures, child abuse reporting, and PREA. The staff received a memo of concern due to not completing the trainings in the required time frame, which could result in termination if the trainings are not completed. Staff has time to complete pre-service trainings, as the staff has not been employed with the program 180 days. Each of the trainings were documented in the Department's learning management system (SkillPro). All of the instructors were qualified to deliver trainings requiring certification (PAR, first aid, and CPR). A list of pre-service trainings was submitted to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training on March 15, 2019.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place requiring all staff to complete pre-service/training requirements. The program provided a list of staff considered to be direct care staff and who are included in the staff-to-youth ratio. All seven reviewed staff records documented the staff received training in the following essential skills prior to having contact with youth: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and forty hours of Protective Action Response (PAR). Each of the seven staff also received six hours of suicide prevention/intervention training, professionalism and ethics, including standards of conduct, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA). All pre-service trainings were documented in the Department's Learning Management System (SkillPro). A review of training records found all instructors were qualified to deliver training provided. On January 29, 2020, the program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics.

## 1.08 In-Service Training

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures related to in-service training. Due to the program opening in March of 2019, the program does not have any staff eligible for review of in-service training. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training which includes course names, descriptions, objectives, and training hours for any instructor-led trainings on March 15, 2019. The program has an in-service training calendar which is updated as changes occur.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures related to in-service training. The program did not have any staff eligible for review of in-service training during the annual compliance re-review period. The program submitted, in writing, a list of in-service training to the

Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led trainings on January 29, 2020. The program has an in-service training calendar which is updated as changes occur.

## 1.09 Grievance Process

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a grievance process which includes three phases. There is an informal, formal, and appeal phase. The program maintained copies of their grievances since opening March 2019. There was a total of seventy-one grievances. A random selection of seven grievances were chosen for review. Six of the seven were resolved within the correct time frames. One of the grievances was appealed to the program director but there was no documentation of the grievance being resolved. The program director explained the grievance process as three phases. Per the program director, phase one includes the youth attempting to solve the issue with staff or other youth with a one-on-one. For phase two, if not solved at phase one, an official grievance can be filled out which is handled by the shift supervisors. In phase three, youth can file an appeal if he feels the situation was not handled correctly, which goes to program director or clinical director. Seven staff were interviewed, and they all had an understanding of the grievance process. Interviews with seven youth revealed all of the youth knew where to get a grievance form and knew the process. Three of the youth stated they had not written a grievance. One of the youth stated the process does not work. All seven youth stated they could ask for assistance in completing a grievance form. A review of seven training records found each staff received training on the grievance policy and procedures.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place regarding the grievance process. A review of seven staff training records found each staff completed training on the grievance process. The program director stated the program's grievance process has three phases. Phase one is an informal grievance; attempting to solve the complaint with the staff and youth involved. Phase two is writing a formal grievance within twenty-four hours of the situation which is handled by the supervisor within forty-eight hours. If needed, an investigation is conducted, and a decision will be made on the grievance. Phase three is the appeal process in which a formal hearing will be conducted with staff, youth, and witnesses. The program director will have the final decision. Five youth interviews revealed grievance forms are located throughout the program. The youth revealed they fill out the form and place it in the grievance box or hand it to the supervisor. All five youth stated they can ask for assistance in completing a grievance form. Five staff were interviewed, and all were able to explain the grievance process. The program forty-four grievances since the last annual compliance review. A review of five grievances determined each of the grievances were resolved within the required time frame.

## 1.10 Delinquency Interventions and Facilitator Training

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has six staff trained to deliver the program's delinquency interventions. Four of the staff have master's degrees and the other two have bachelor's degrees. Each staff has ten years or more of experience working with adult or juvenile offenders. The program offers the following interventions: Impact of Crime (IOC), The Council for Boys, Aggression Replacement Therapy (ART), Thinking For a Change (T4C), and Seeking Safety and the University of Cincinnati Correctional Institute for Substance Abuse (UCCISA). There was no documentation of training

for two staff who were facilitating the trainings. A review of seven youth records found each of the youth were involved in a delinquency intervention addressing an identified priority need. Seven youth interviewed revealed they all participated in groups while at the program. The program director revealed the program looks at the contract and the Sourcebook of Delinquency Interventions to determine who was able to teach the groups.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program implemented interventions for each youth. Each of the interventions included evidence-based practices, promising practices, or practices with demonstrated effectiveness. The program currently has eight staff trained to deliver the program's interventions. Seven of the eight staff have a master's degree and the one staff has a bachelor's degree. Six of the eight staff have ten or more years of experience working with adult or juvenile offenders. The program offers Aggression Replacement Training (ART), Impact of Crime (IOC), The Council for Boys and Young Men, Seeking Safety, and the University of Cincinnati Correctional Institute for Substance Abuse (UCCISA). A review of the program's activity schedule found the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours.

A review of five youth records found each of the youth were involved in a delinquency intervention addressing an identified priority need. Five interviewed youth revealed they all participated in groups while at the program. A review of group sign-in sheets showed the delinquency interventions were conducted as outlined on the activity schedule. The program director revealed all of the staff complete pre-service training, which includes facilitating Positive Skills Development Groups. The program determines which staff would be appropriate for facilitating groups based on the staff's previous experience and performance during training.

## 1.11 Life Skills Training Provided to Youth

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures related to life and social skills training provided to youth. The program activity schedule included Aggression Replacement Training (ART), Seeking Safety, the Council for Boys and Young Men, and Active Parenting for youth. The program's clinical director revealed the program utilizes evidence-based group therapy, and fidelity checks were required to ensure services were delivered in the manner prescribed. A review of sign in sheets for ART, Seeking Safety, and the Council for Boys and Young Men revealed life skills were delivered at the program. Seven youth interviewed revealed they all participated in groups while at the program. Seven youth interviewed revealed they learned new skills and were able to practice the skills they had learned in groups. Sign-in sheets mirrored the program's activity schedule.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in reference to life and social skills. All the youth at the program receive life and social skills intervention services specifically addressing, at a minimum, identification and avoidance of high-risk situations possibly endangering self or others; communication, interpersonal relationships and interactions; and non-violent conflict resolution, anger management, and critical thinking, to include problem solving and decision making. According to the clinical director, the program utilizes Aggression Replacement Training (ART), The Council for Boys and Young Men, Seeking Safety, and the University of Cincinnati Correctional Institute for Substance Abuse (UCCISA). Five interviewed youth revealed they participated in substance abuse groups, Positive Skills Development Groups, Seeking Safety, and ART. Four of the five youth stated they have practiced new skills

learned in groups. A review of the activity schedule revealed life skills education/training groups were provided. Group sign-in sheets were reviewed and revealed groups were held as required.

## 1.12 Restorative Justice Awareness for Youth

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program utilizes the Impact of Crime (IOC) curriculum as the restorative justice practice. The curriculum allows for youth to have an opportunity to feel what it is like to be the victim of a crime and learn to empathize with victims. The program director stated the program also does community service projects. The program partnered with 4-H and the Drug and Alcohol Coalition of Hamilton County to provide support to the program. The program director stated youth are exposed to the victim's perspective through members of the Drug and Alcohol Coalition and members of local churches who speaks and share stories with the youth. The city manager has embraced the program's restorative justice piece with the adopt-a-park. The program has two staff trained to facilitate IOC to the youth in the program. The program provided supportive documentation to support life and social skills were delivered according to the program's group/activity schedule. Two of the seven youth records reviewed found the youth were not currently involved in the IOC training but will be enrolled in the new IOC group.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. According to the program's policy, the program provides activities and instructions 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 Impact of Crime (IOC) curriculum is used as the program's restorative justice practice. The curriculum allows for youth to have an opportunity to feel what it is like to be the victim of a crime and learn to empathize with victims.

The program director stated the program conducts IOC groups which requires every participant to complete a restorative justice community service project. Before the COVID-19 pandemic, the program participated in several restorative justice off-site events including rebuilding a museum, working at a food bank for the elderly, and restoring a farm, among many other things. The program director stated the program partnered with the drug/alcohol coalition, and they have spoken about different ways people are affected by drug and alcohol and a couple of community speakers have shared past experiences. It has been limited this year due to the COVID-19 pandemic. In order for youth to participate in activities to restore victims and communities, the youth must earn intern status and have a risk assessment completed prior to going off-site to participate in events.

## 1.13 Gender-Specific Programming

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of the program's contract revealed the program uses Council for Boys and Active Parenting for their gender-specific programming. A review of the program's activity schedule found a time in which gender-specific programming was offered. The Active Parenting training had not been conducted due to only having one youth identified as a parent. The Council for Boys is supposed to be offered once a week for ten weeks according to the program's contract. The Council for Boys has not been conducted since August 1, 2019 based on the sign-in sheets reviewed. The training had been consistently offered since the program opened March 2019. The program director revealed the program is an all-male facility, and is based around involving

the youth positively in every aspect of their lives from working on vocational skills, in the community, treatment groups, and education. Seven interviewed youth revealed they participated in groups while in the program.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. According to the program's contract, the program provides gender-specific treatment services. An interview with the program director revealed the program uses Council for Boys and Young Men for the gender-specific programming provided at the program. A review of the program's activity schedule determined gender-specific programming was provided. A review of sign-in sheets revealed The Council for Boys and Young Men was conducted at the program as required . Five interviewed youth revealed they participated in gender specific groups while in the program.

## 1.14 Internal Alerts System and Alerts (JJIS) (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program utilizes both an internal alert system and the Department's Juvenile Justice Information System (JJIS) to track youth alerts. The program's written policy and procedures outline how alerts are identified, documented, updated, and communicated to staff. A review of the internal alert system found it was consistent with the alerts, which were entered into JJIS. The program director stated youth meet with medical upon intake and have access to sick calls. The program has treatment meetings where medical issues are discussed. The program also uses their internal alert system. Seven staff interviews revealed the program has an alert book in which all staff review and sign daily. Mental health staff are responsible for making updates to mental health and substance abuse alerts and medical staff are responsible for making updates to medical alerts. Seven internal alerts were reviewed and were found to be consistent with the JJIS alerts. One of the youth selected did not have any alerts. Two of the six applicable youth records required a youth's status needing to be downgraded, and the program's licensed mental health professional downgraded each of the applicable alerts. Four of the six youth are currently prescribed medication, and the appropriate alerts were entered in JJIS and on the internal alert system. The program director also revealed the administrative nurse and clinical director are responsible for closing and entering alerts. The program staff review the alerts in JJIS frequently an internal alert system. Logbooks were reviewed, and updated alerts were found in the logbooks.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program utilizes both the Department's Juvenile Justice Information System (JJIS) and an internal alert system to track and document youth alerts. The program's written policy and procedures outline how alerts are identified, documented, updated, and communicated to staff. A review of the internal alert system found alerts were consistent with the alerts which were entered into JJIS.

The program director stated the program staff discuss medical issues every day during their morning management meetings. All documents are brought to the meeting for review and updates are reviewed. Five interviewed staff revealed the program has an alert book in which all staff review and sign daily each shift. Two staff also stated the medical department notifies staff daily of medical alerts. . The program director revealed the program has an internal alert process addressing all areas on one spreadsheet with a key describing the alert. The program director stated alerts are kept in the control room to referred to by any staff after reviewing them daily. Medical/food allergy alerts are opened and closed by the lead nurse.

Mental health/substance abuse alerts are opened and closed by the licensed clinical staff . Safety/security alerts are closed by mental health staff, and program director or designee.

All alerts for the five selected youth were reviewed. The internal alerts were found to be consistent with the JJIS alerts. One of the five applicable youth records required a youth's status needing to be downgraded, and the program's licensed mental health professional downgraded the alerts. Three of the five youth were prescribed medication and the appropriate alerts were entered in JJIS and on the internal alert system. Logbooks were reviewed, and updated alerts were found in the logbooks.

## 1.15 Youth Records (Healthcare and Management)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program maintains a separate individual management record, mental health/substance abuse record, and an individual healthcare record for each youth. All records were labeled "confidential." The file tab for each record include the youth's name, Department identification number, date of birth, county of residence, and committing offense. The sections in the individual management record were labeled as legal information, demographic and chronological information, case management and treatment team activities, and miscellaneous. Youth records were found to be secured in a locked file cabinet, also labeled "confidential", located in a locked office near each of the youth dorms.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program director revealed the program separates the youth records into three separate files: an individual healthcare record, individual management record, and an individual mental health/substance abuse record. All of the records were labeled "Confidential." The youth records were stored in a locked file cabinet labeled "Confidential." The file tab on the individual management record for each youth contained the youth's name, identification number, date of birth, county of residence, and committing offense. The individual management record contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous.

## 1.16 Youth Input

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a formal process to promote constructive input by youth. The program director stated the program has a student council called Rams Club, in which they discuss youth behaviors, campus activities, upcoming events, and recommendations. The program director stated the program has suggestion forms which can be found in the dorms for the youth to utilize, as well as an open door policy. The program also conducts team meetings in which youth are able to provide input and best practices. Youth also take surveys each month in which they provide their input to the program. Seven youth were interviewed concerning youth input at the program. One youth stated the program does not have anything, while another youth stated the program does not have anything formal for youth to provide input. Two other youth stated the program does have a student council, but he does not participate in it, while the other stated it had not started as of yet. Another youth revealed the student council recently started but they have not picked the youth to be a part of it. The last youth interview revealed the Ram status are advisors for other youth.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a formal process to promote constructive input by youth. The program director revealed the program utilizes a youth council called The Ram's Club in which youth meet with staff to discuss the program. The youth also complete surveys and discuss any issues during team meetings and school. The director revealed the youth have team meetings daily where youth can express concerns and share ideas. A review of youth surveys and minutes from The Ram's Club revealed the youth are able to provide input. Five interviewed youth revealed the youth have an input box on the mod, youth are able to talk to staff, and the program has a youth council in which youth can provide input regarding what happens at the program.

## 1.17 Advisory Board

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of sign-in sheets, agendas, and minutes found the program has quarterly advisory board meetings. There was documentation of the program soliciting active involvement from the local community to include law enforcement, judiciary, business community, school board or district, and faith community by letter. The program director also recruits victims, victim advocates, or other victim services community representatives, and a parent/guardian whose child was previously involved in the juvenile justice system. A review of the sign-in sheets revealed the program has a representative from each of the areas, as required, and each attends the meetings quarterly. The city manager, who is also on the board, helped the program adopt a park in the area. The program director revealed the community advisory board (CAB) is very engaging and helpful and wants the best for the program and the young men. The program director also revealed the CAB provided support for the holidays and open house, as well as found sponsors to adopt the program's youth for Christmas. A board member was not available for interview during the annual compliance review week.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a community advisory board (CAB) meeting at least every ninety to 120 days. There was documentation indicating the program director actively solicits community partners including representatives from law enforcement, the judiciary community, the school board or district, the business community, and the faith community. There was documentation indicating the program director recruited 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. The program had not changed their recruitment efforts since the last review. A review of the minutes and sign-in sheets revealed the program held CAB meetings every ninety to 120 days prior to COVID-19. Due to the COVID-19 pandemic, the program has not had in-person meetings since March 2020. The program director revealed the CAB meets quarterly; however, the meetings have been affected by the COVID-19 pandemic. The program attempted virtual meetings but did not have any success. The CAB members are helpful and are one of the reasons the program is so involved in the community. The CAB was able to help provide Christmas gifts for all the youth and donate items to enhance the program. The program director revealed the program brings topics to the table and receive a meaningful feedback. One example of donations from the community is the equine located at the front of the program.

## 1.18 Program Planning

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program director stated the program has not completed any official surveys yet and plans to complete them at the one-year mark in March 2020. This is the program's first annual compliance review, so they have not had an opportunity to incorporate any Department reports into the program planning process. The program director revealed the program has not experienced a lot of turnover. The turnover the program had experienced was needed or because staff had moved. The program director also stated the program celebrated employee of the week. The program also held a hog roast dinner for staff. The program also planned an employee appreciation ceremony on Wednesday, December 18, 2019 to recognize staff. In order to minimize staff turnover, the program offers staff rewards, pay increases, as well as conduct wellness checks on staff. The program has weekly leadership meetings, quarterly off-site meetings, and daily shift change meetings, in which the staff have the opportunity to provide input and feedback on the program's operations. A review of agendas and minutes was conducted to verify these meetings occurred. Seven staff interviews revealed staff meetings are held daily, bi-weekly and monthly. Staff interviews also reveal they have not been briefed on any annual reports, and/or youth and parent/guardian survey results due to this being a new program. Seven staff were asked how effective communication is among staff at the program. Four of the staff responded very good, two stated good and one stated fair.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program provides training to all staff throughout the year. The program provided copies of youth and parent/guardian surveys. A review of the previous annual compliance review report was conducted, and it is incorporated into the program planning process. This was confirmed by the corrections made from the first annual compliance review. The program has a system of communication to keep staff informed and give them the opportunity to provide input and feedback pertaining to operation of the program. A review of staff meeting minutes and agendas determined the program conducts All Staff meetings quarterly and shift-to-shift exchange meetings daily to provide input and feedback. The program has a plan in place to eliminate staff turnover to include employee of the week, month, and year. Staff are given RAM Bucks, which are given out to staff who are nominated by supervisors, program director, or colleagues for going above and beyond the staff's job duties. The staff are able to cash in the RAM Bucks for incentive items provided by human resources. Five interviewed staff revealed the program conducts shift-to-shift meetings daily. Topics discussed include changes in the youth, behavior issues, incidents, and any issues or concerns. Three staff stated they are briefed on any annual reports and/or youth and parent/guardian survey results. The remaining two staff stated annual reports and survey results are not shared with staff. When asked how effective communication amongst staff at the program is, one staff stated very good, two staff stated good, one staff stated fair, and the last staff stated poor. The staff revealed input and feedback are provided through face-to-face conversations, emails, and the suggestion box. The program director has an open-door policy with staff.

The program director stated the program has employees of the week and month. The program recognizes staff with attendance and on-the-spot bonuses, in-person praise, and letters of commendations. The program director added the COVID-19 pandemic effected staff morale because the quarantine unit was not able to interact as they normally would. The program director stated the program uses youth, parent/guardian, and staff surveys for programming planning and assessment purposes. The program also has a suggestion box in the staff breakroom. Information is utilized to gain a true picture of how the program is operating and to

enhance the program. The program director stated the program has daily management meetings and supervisors have departmental meetings to pass along information. Prior to the COVID-19 pandemic, the program had All Hands meetings when needed to address things about the program. The program also used email and computer software to pass along important information and training.

## 1.19 Staff Performance

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures in place to determine the program's system for evaluating staff, performance standards, and frequency of evaluation. The program conducts ninety-day and annual evaluations for staff. A review of job/position descriptions revealed each staff member's performance standards were clearly identified. Performance evaluations were completed, as outlined in the program's policy. A review of the program's contract revealed all specific contractually required positions were maintained and performed, as outlined in the contract. The program director revealed staff receive a ninety-day evaluation and then an annual evaluation. Based on performance, staff may receive a two, four, or six percent pay increase. Seven staff interviews revealed staff receive a formal evaluation of their performance yearly, monthly, and ninety-day evaluations.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place to ensure a system for evaluating staff, at least annually, based on established performance standards. A review of job/position descriptions were reviewed, and each staff member's performance standard were clearly identified. The performance standards matched the job descriptions for each staff. The program director stated supervisors meet with their staff individually to discuss their performance. The staff are rated on different factors such as performance, interpersonal skills, and direct care, . The annual evaluation will result in a two percent, four percent, six percent pay increase, or a discussion of continued employment. Staff interviews revealed staff received a formal evaluation of their performance yearly.

## 1.20 Recreation and Leisure Activities

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures which provides activities based on the development levels and needs of the youth in the program. A review of the activity schedule found it documented a range of supervised and structured indoor and outdoor recreation activities for youth. The program's contract requires a recreational therapist, but at the time of the annual compliance review, the position was vacant and been vacant since August 2019. The program has continued to recruit and forward resumes of potential applicants, but the applicants were not meeting criteria for the position. Seven staff interviews revealed youth are involved in the following activities: football, volleyball, basketball and equine. The youth are also involved in health and wellness activities indoors. The time frame ranges from one hour to two and a half hours. A review of the logbooks and visual observation revealed activities were provided as required. Seven youth interviews revealed youth receive recreational time every day. The youth participate in basketball, football, and equine outside. Inside activities include working out and masonry. Six of the seven youth stated they are provided with varying degrees of mental and physical exertion throughout the day. Observation of recreational activities revealed the activities promote social and cognitive

skill development, creative, teamwork, health competition, mental stimulation, and physical fitness. The recreational program was a part of each youth's performance or treatment plan.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place ensuring the program provides a variety of recreation and leisure activities. A review of the activity schedule revealed a range of supervised and structured indoor and outdoor recreation and leisure activities were provided to the youth. The logbook revealed the activities were documented according to the program's activity schedule. Youth are encouraged to explore interests and engage in constructive use of leisure time. Five interviewed staff revealed the youth play basketball, football, volleyball, weightlifting, board games, PlayStation, and Uno for at least one hour a day. Five interviewed youth revealed the program allows the youth the opportunity to exercise, play outside, or down time to read a book or play a board game. These activities promote social and cognitive skill development, creativity, teamwork, health competition, mental stimulation, and physical fitness. Youth were observed playing basketball. The program contract requires a recreational therapist. The recreational therapist meets all requirements. A review of five youth case management records revealed the recreational program is a part of each youth's treatment plan.

## Standard 2: Assessment and Performance Plan

### 2.01 Initial Contacts to Parent/Guardian and Court Notification

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth records were reviewed for initial contact to parent/guardian upon admission to the program. A review of the seven records found each contained documentation reflecting each youth's parent/guardian was notified by telephone on the day of admission to the program. In addition, five of the youth records included a letter to the parent/guardian within forty-hours of admission. Four of the seven records included written notification to the court and juvenile probation officer within five days of admission to the program. One of the letters was twenty days late and the letters were missing.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth records were reviewed for initial contact to parents/guardian upon admission to the program. Each record contained documentation reflecting each youth's parent/guardian was notified by telephone on the day of admission to the program. Each record included a letter sent to the parent/guardian within forty-eight hours of admission. All of the records included written notification to the court and juvenile probation officer within five days of admission to the program.

### 2.02 Youth Orientation

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth records were reviewed to ensure youth are provided an orientation to the program. Four of the seven records contained documentation of completion of orientation to the program on the day of admission. The program's policy indicates upon completion of orientation, the youth and case managers sign and date an orientation checklist form. The program's orientation included services available, daily schedule, expectations and responsibilities of youth, behavior management system, medical and mental health services, Florida Abuse Hotline, zero tolerance for sexual misconduct, contraband policy, performance planning, dress code/hygiene, visitation, mail, telephone use, transition/release process, community access, grievance procedures, emergency procedures, program tour, and assignment to a treatment team. Youth initial by each topic covered on the Orientation Checklist form acknowledging their understanding. Seven youth were interviewed regarding the orientation process. Each youth reported they received orientation to the program within twenty-four hours. All seven youth reported their orientation to the program included program rules, procedures, and schedules. Each of the seven youth were able to explain the orientation process.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth records were reviewed to ensure youth were provided an orientation to the program. Each record contained documentation showing an orientation to the program was conducted on the day of admission. Upon completion of orientation, the youth and therapeutic manager signed and dated the Orientation Checklist form. The program's orientation included services available, daily schedule, expectations and responsibilities of youth, behavior management system, medical and mental health services, Florida Abuse Hotline, zero tolerance for sexual misconduct, contraband policy, performance planning, dress code/hygiene, visitation, mail, telephone use, transition/release process, community access, grievance procedures, emergency procedures, program tour, and assignment to a treatment team. Youth initialed next

to each topic covered on the Orientation Checklist form to acknowledge understanding. Five interviewed youth reported they received orientation to the program within twenty-four hours of admission. An orientation was not observed as no youth were admitted to the program during the week of the annual compliance re-review.

## 2.03 Written Consent of Youth Eighteen or Older

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program obtains written consent for youth eighteen years or older, unless 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. Seven youth records were reviewed for evidence of written consent of youth eighteen years or older. Three of seven youth records were applicable for written consent. Written consent was observed in each of the youth records.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program obtains written consent for youth eighteen years 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. One of the five reviewed youth records was applicable for a youth who was eighteen years of age or older; therefore, two additional records were reviewed. All three applicable records contained a written consent form.

## 2.04 Classification Factors, Procedures, and Reassessment for Activities

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures which clearly outlines the classification process of youth upon admission to the program. Five of the seven youth records contained documentation of screening/assessment classification as a part of the admission process. The history of violence and criminal behavior was not included in four of the records and gang affiliation was not included in two of the applicable records reviewed. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed on the day of admission for all seven youth reviewed; however, it was not entered into the Department's Juvenile Justice Information System (JJIS) prior to the youth's room assignment. None of the seven reviewed records contained all of the required elements of the identified and/or suspected risk factors. One youth did not have their maturity level addressed on the initial classification form. Documentation of reassessments were observed in three applicable youth records found there were no issues. The program has an internal alert system, which is maintained inside a binder located inside the lobby of the administration office. The program also keeps staff updated on youth alerts during shift briefings. One shift briefing was observed, and alerts were discussed during the meeting. An interview with the program director indicated mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a sleeping room. The clinical director and shift supervisor meet to determine the best placement for behavior and mental health.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures which clearly outlines the classification process of youth upon admission to the program. The program's policy and procedures outline the classification process and include a classification system promoting

safety and security, as well as effective delivery of treatment services based on determination of each youth's individual needs and risk factors. A review of five youth records found each record contained documentation indicating the classification factors and procedures were part of the admission process. Classification factors included the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed on the day of admission for all five youth. All VSABs were entered into the Department's Juvenile Justice Information System (JJIS) prior to the youth's room assignment. Each of the youth are also classified by identified/suspected risk factors such as suicide risk, medical risk, escape risk, and security risk. All of the youth were classified for purposes of assigning youth to a living area, sleeping room, and youth groups.

Three of the five reviewed youth records were applicable for and contained reassessments. Reassessments were completed to increase the youth's privileges and freedom of movement. Each of the youth who participated in off-campus activities had a reassessment completed prior to going off campus. All youth who participated in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape, received a reassessment prior to the work projects. According to the program director, everything is taken into account when youth are assigned a room. The program is making adjustments to include a fourteen to sixteen year old cottage and a seventeen to nineteen year old cottage to make programming more relevant to the youth. Youth alerts play the main role in assigning youth to a room. As the program learns the youth's behavior, the youth will be reclassified and moved accordingly.

The program has an internal alert system, which is maintained inside a binder located inside of the lobby of the administration building. The program also keeps staff updated on youth's alert status during shift briefings daily.

**2.05 Gang Identification: Notification of Law Enforcement**

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing gang identification. Three of seven youth records were applicable for gang identification. One of the records reviewed local law enforcement was notified of suspected gang activity, the other two records did not have documentation of the notification. In all three records reviewed, law enforcement was not notified in the youth's home county of residence. The program's education staff were not notified of the youth's gang status. There was no documentation of the youth's juvenile probation officer (JPO) being made aware of the youth's gang status for all three youth.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing the program notifying law enforcement upon identification of a youth's gang affiliation. One of the five youth records reviewed was applicable for gang affiliation; therefore, two additional applicable records were reviewed. Local law enforcement in the county where each youth resides was notified of suspected gang activity for each of the three youth by the program, detention staff, or the youth's juvenile probation officer (JPO). The law enforcement in the home county of the residential facility was notified for all three youth. A review of alerts found each of the youth had a gang alert added in the Department's Juvenile Justice Information System

(JJIS) and the internal alert system. The program's educational staff and the youth's assigned JPOs were notified of the youth's gang status.

**2.06 Gang Identification: Prevention and Intervention Activities**

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program had not implemented gang prevention and intervention strategies as of the date of the annual compliance review. Three applicable youth records were reviewed for gang prevention and intervention strategies. Each of the youth identified as a gang member or a gang affiliate, did not participate in any intervention strategies on a weekly basis. In addition, there were no goals observed on the youth's performance plan pertaining to gang interventions and strategies of gang prevention and intervention.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program implements gang prevention and intervention strategies for each youth identified with gang affiliation. One of the five youth records reviewed was applicable for gang affiliation; therefore, two additional applicable records were reviewed. Each youth participated in gang prevention and intervention strategies on a weekly basis. The youth receive individual counseling form a gang officer from local detention/law enforcement. Each youth's performance plan included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program uses Impact of Crime (IOC) as its gang prevention and intervention curriculum. The program also uses Gang Resistance and Drug Education (GRADE) curriculum from Coral Springs law enforcement as needed. A review of the program's policy revealed each of the youth have the opportunity if they desire to develop a plan to dis-affiliate with a criminal street gang.

**2.07 Residential Assessment for Youth (RAY)**

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program ensures an initial assessment of each youth is conducted. A review of seven youth records found six of seven initial assessments were completed within thirty days of admission. The seventh record was not completed within thirty days of admission and was not yet due as of the date of the annual compliance review. Documentation of the assessments were maintained in the Department's Juvenile Justice Information System (JJIS) as required. A review of seven youth records found six Residential Assessment for Youth reassessment's (RAY) completed as required, and one not yet due. Four of the six applicable youth's RAY reassessments were not completed within ninety days after completion of the initial RAY assessment. Reassessment documentation was maintained in each youth's record as required.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures to ensure an initial assessment of each youth is conducted within thirty days of admission. A review of five youth case management records found there was documentation showing the program completed a Residential Assessment for Youth (RAY) for each youth within thirty days of admission. Each of the assessments were maintained in the Department's Juvenile Justice Information System (JJIS), as required. Two of the five records were applicable for RAY Reassessments. Reassessments were completed within ninety days of the initial RAY assessment. All of the reassessment documentation was maintained in each of the youth's case management record and JJIS.

## 2.08 Youth Needs Assessment Summary (YNAS)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found five contained documentation the Youth Needs Assessment Summary (YNAS) was completed within thirty days of admission. One of the YNAS was not yet due. All records reflected the YNAS was documented in Department's Juvenile Justice Information System (JJIS) as required.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program ensures a Youth Needs Assessment Summary (YNAS) for each youth is conducted within thirty days of admission. A review of five youth records found each contained documentation indicating a YNAS was completed within thirty days of admission. All records reflected the YNAS was documented in the Department's Juvenile Justice Information System (JJIS), as required.

## 2.09 Performance Plan Development, Goals and Transmittal (Critical)

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found five contained documentation indicating the Individualized Performance Plan (IPP) was developed within thirty days of admission, one completed almost ninety days after youth's admission, and one not yet due. All six applicable records reviewed had the IPP developed after the initial assessment. There was no documentation to confirm the treatment team was present during the development of the IPP in any of the six applicable records reviewed. Of the six applicable records reviewed, the IPP was signed by the youth, five were signed by the intervention team leader, and three were mailed to the youth's parent/guardian. One record did not include the top three criminogenic needs of the youth and none contained specific delinquency interventions, targeted court ordered sanctions when applicable, and transition activities. The IPP's contained specified target dates for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal. None of the treatment team members signed the IPPs. There was no documentation in the records to indicate completion of the IPP within ten working days. The program sent a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer, the parent/guardian, and the Department of Children and Families counselor, if applicable. Interviews with seven youth indicated they understood the program's treatment process. Each of the youth stated treatment teams are held monthly.

During the annual compliance re-review, the program received a **Limited Compliance rating** for this indicator. The program has a written policy and procedures regarding the intervention and treatment team, which includes the youth, to meet and develop the youth's performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. A review of five youth records found each contained documentation showing the Individualized Performance Plan (IPP) was developed within thirty days of admission and after the youth's initial assessment. There was no documentation to show the treatment team leader, youth, administrative representative, living unit representative, or educational staff were present during the development of the IPP in two of the five records reviewed. All of the IPPs were signed by the youth, intervention and treatment team leader, and all other treatment team members. There was documentation indicating the IPPs were mailed to the youth's parents/guardians. Each of the IPPs contained individualized goals and the youth's top three criminogenic needs. Four of the five records reviewed did not contain specific delinquency interventions, or targeted court-

ordered sanctions. Four of the five records did not contain transition activities targeted for the last sixty days of the youth's anticipated stay. Each IPP specified the target date for goal completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal. There was documentation in the records to show, within ten working days of completion of the IPP, the program sent a transmittal letter and a copy of the plan to the youth's committing court, juvenile probation officer, and parent/guardian. Interviews with five youth indicated each youth received a copy of the IPP, know their current performance plan goals, and participated in the development of the IPP.

## 2.10 Performance Plan Revisions

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found six applicable for performance plan revisions. Four of the applicable records had documentation of the youth Individualized Performance Plans (IPP) being revised. Three applicable records for transition activities did not include documentation of the program facilitating transition activities during the last sixty days of the youth's stay.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. One of the five reviewed youth records was applicable for performance plan revisions; therefore, two additional applicable records were reviewed. Two of the applicable three records had revisions completed based on RAY Reassessments. None of the records reviewed were applicable for newly acquired/revealed information. Each of the applicable records had documentation indicating the youth demonstrated progress toward completing a goal. Two of the three records reviewed did not have revisions to the Individualized Performance Plan (IPP) pertaining to the facilitation of transition activities during the last sixty days of the youth's stay.

## 2.11 Performance Summaries and Transmittals

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found six applicable for performance summaries and transmittals. A review of the six applicable records found four performance summaries were not completed at ninety-day intervals, and two were not in the records. In the records reviewed, two were prepared prior to the youth's release, discharge, or transfer from the program. Three performance summaries did not include the youth's status on each goal, overall treatment progress, academic status, behavior, behavior adjustment to the program, significant positive and negative events, and interaction with peers and staff. One of the performance summaries contained level of motivation/readiness to change, and justification for release discharge or transfer. There was no documentation of performance transmittals in the records. The original summaries were not consistently signed and dated by the treatment team leader, staff member preparing the summary, program director, and youth. In all records reviewed, there was no documentation copies of summaries were sent within ten working days to the committing court, juvenile probation officer, youth, and parent/guardian. The release summary was not found in three of the records. There was no documentation a copy of the summary was sent within ten working days to the committing court, juvenile probation officer, youth, or parent/guardian. Interviews with seven youth reported four received a copy of the performance summary sent to the court and three did not.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Two of the five reviewed youth records were applicable for performance summaries and transmittals; therefore, one additional applicable record was reviewed. A review of the three applicable youth records found each contained three performance summaries completed at ninety-day intervals. In the three records reviewed, none were applicable to be prepared prior to the youth's release, discharge, or transfer from the program. All three of the performance summaries included the youth's status on each goal, overall treatment progress, academic status, behavior, adjustment to the program, significant positive and negative events, and interaction with peers and staff. None of the performance summaries included level of motivation/readiness to change. Two of the three had documentation of the youth's interaction with peers. One of the three records had documentation of the youth's interaction with staff. There was documentation in the each of the records reviewed indicating the youth's overall behavior adjusting, and signification positive and negative events. There was no documentation of performance summary transmittals in the records. None of the records documented the program provided written notification to the youth's parent/guardian of the planned released. Three of the five interviewed youth received a copy of the performance summary sent to the court, and three did not. None of the records reviewed were indicative of Sexually Violent Predator Program (SVPP) eligible youth.

## 2.12 Parent/Guardian Involvement in Case Management Services

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records indicated all parents/guardians were encouraged to be involved in the case management processes which included assessment, progress reviews, and formal treatment team meetings. The program encourages parental involvement in the case management processes by sending out letters, telephone calls, invitations to family days, and off-site events. Th program director indicated the program is in constant communication with parent/guardians to participate in treatment meetings. Seven youth interviews revealed parent/guardians are involved in their case management.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator.
A review of five youth records indicated parents/guardians were encouraged to be involved in the following case management processes: assessment, progress reviews, formal treatment team meetings. The program encourages parental involvement in the case management processes by sending out letters, phone calls, invitations to family days, & off-site events. Interviews with the five youth reported their parent/ guardian participation in Treatment Team meetings. A treatment team meeting was observed. The program director revealed the program notifies parents/guardians upon intake and update them with treatment team meeting every month. They are encouraged to participate in family counseling and open houses as well. Five youth interviewed stated the parent/guardian are involved during treatment team meetings.

## 2.13 Members of Treatment Team

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's policy indicates each youth must be assigned a treatment team upon admission to the program. The treatment team should consist of the youth's juvenile probation officer (JPO), parent/guardian, administrative representative, living unit representative, treatment staff, educational staff, Department of Children and Families, and gang prevention specialist, if needed. A review of the

seven applicable records found none of the youth had the required treatment team members. One youth did not have any documentation of being part of a treatment team. There was no documentation of the youth's JPO being a part of the treatment for three of the youth. There was not an education representative for three of the youth. There was no living unit representative for three of the youth on the treatment team. There was no documentation of advanced notification to participate in any of the seven youth records.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place in reference to treatment teams. A review of five youth records revealed each youth was a part of a treatment team. The treatment team consisted of the treatment team leader, the youth, representatives from the program's administration, residential living unit, education staff, others directly responsible for providing, or overseeing provision of, intervention and treatment services to the youth, juvenile probation officer (JPO), parent/guardian, and, when applicable, the program's gang coordinator. There was documentation showing the program invited and encouraged participation, through advance notification, and if participation could not be arranged, the opportunity to provide input for the youth's JPO, parent/guardian, and other members of the team.

## 2.14 Incorporation of Other Plans into Performance Plans

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found six were applicable. There was no documentation of the Individualized Performance Plans (IPPs) referencing or incorporating additional plans such as academic, performance, wellness, and safety. In addition, the IPPs referenced mental health and substance abuse needs. One of the records reviewed were applicable for a case plan through the Department of Children and Families, which was not incorporated in the IPP.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place referencing the incorporation of other plans into the youth Individualized Performance Plans. A review of five youth records found all five had additional plans, including academic or treatment, incorporated or referenced in the Individualized Performance Plan.

## 2.15 Treatment Team Meetings (Formal and Informal Reviews)

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of seven youth records found six were applicable. Six applicable records documented formal performance reviews being held at least every thirty days. Two records did not have documentation and one was not due as of the date of the annual compliance review. All reviewed performance reviews included the youth's name and date of review. Of the applicable records reviewed, three were missing comments from treatment team members, two did not include a synopsis of the youth's progress in the program, and four did not have necessary performance plan revisions. Three records contained documentation of the youth's treatment progress and evidence of the youth being provided an opportunity to demonstrate skills acquired in the program. There was no documentation of the Residential Assessment for Youth (RAY) reassessment results. Three of the six records indicated informal biweekly treatment reviews were not held. None of the applicable youth's Individualized Performance Plan information was updated in the Department's Juvenile Justice Information System (JJIS). All seven interviewed youth

responded favorably to being provided the opportunity during treatment team meetings to demonstrate skills learned in the program. All interviewed youth indicated staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. A review of five youth records found the intervention and treatment team met biweekly for formal and informal treatment team meeting reviews. Documentation for the treatment team meetings included youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals. Each youth was provided an opportunity to demonstrate skills acquired in the program. A review of the five youth records revealed biweekly informal treatment team meetings were held each month. Each informal treatment team meeting was documented in the youth's record and included all requirements. During the annual compliance review, a treatment team meeting was observed. All required staff were present. Five youth interviews revealed staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress. All five youth stated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program.

## 2.16 Career Education

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Three closed youth records were reviewed for development and implementation of a vocational competency development program. All records contained a sample résumé. One record contained a completed employment application, local Career Source Center information, and documents essential to obtaining employment. One of the records did not include documentation indicating the location and business hours of a local Career Source Center. One record had documentation the youth's parent/guardian and juvenile probation officer were aware of the vocational plan for the youth. The program provides Type 2 career education programing services appropriate to the age, educational abilities and goals, as well as the length of stay, and custody characteristics of the youth served. All three closed records indicated career education programming included communication, interpersonal, and decision-making skills . An interview with the program director and lead teacher determined culinary arts, Home Builders Institute (HBI), equine, 4-H, masonry, welding, Occupational Safety and Health Administration (OSHA), and Junior Reserve Officers' Training Corps (JROTC) are career education services offered to the youth. Interviews conducted with education staff supported the above noted vocational classes are available. MyCareerShines is the assessment administered. The lead teacher stated the students take Renaissance Star 360 and the Department's Common Assessment to track progress.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. A review of three closed youth records found each contained a sample completed employment application, a résumé, the location and business hours of a local Career Source Center, appropriate documents essential to obtaining employment, and documentation indicating the youth's vocational plans was sent to the youth's parent/guardian and juvenile probation officer (JPO). The vocational program and career education program were found to be appropriate for the age of the youth in the program. The program provides Type 2 career education programing services appropriate to the age, educational abilities and goals, and custody characteristics of the youth served.

An interview with the program director determined equine/4H, Homebuilders Institute (HBI) programs, masonry, culinary arts, and Junior Reserve Officers' Training Corps (JROTC) are career education services offered to the youth. Interviews conducted with education staff revealed the following education services are offered to youth in the program: general education and remediation, General Equivalency Diploma (GED) exam preparation, HBI, Occupational Safety and Health Administration (OSHA) 10-hour training and certification, culinary instruction, first-aid/cardiopulmonary resuscitation (CPR) training and certification, SafeServe food safety training and certification, Microsoft Office Suite training and certification (implemented in 2020), and equine program. The following assessment are offered to youth in the program: Star360 educational survey, the Department's Common Assessment, career cluster and career interest surveys, and MyCareerShines (implemented in 2020). Grades, assessment results, and youth progress and participation are documented in each youth's educational record and, in the case of online assessments, in each youth's online account for the assessment.

## 2.17 Educational Access

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program integrates education instruction into their daily schedule in such a way as to ensure the integrity of required instructional time. Youth participate in educational and career-related programs for 250 days, distributed over twelve months, with a minimum of twenty-five hours weekly of instruction. The youth at the program receive credits for educational experience. The activity schedule and logbook documented minimal interference of educational instruction. A review of the logbook of six randomly selected days reflected youth were attending education according to the schedule. Interviews with seven youth indicated four stated there are minimal interruptions and three reported there were a lot of interruptions. The program director reported the program's instructional schedule is Monday through Friday 8:15 a.m. to 3:05 p.m.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program integrates education instruction into their daily schedule in such a way as to ensure the integrity of required instructional time. Youth participated in educational and career-related programs for 250 days, distributed over twelve months, with a minimum of twenty-five hours of weekly instruction. Youth receive credits for educational and training experience. A review of the activity schedule and logbook documented minimal interference of educational instruction. A review of the logbook of six randomly selected days reflected youth attended educational classes according to the schedule. Interviews with five youth indicated there are no interruptions during educational time. The logbook indicated the youth were late to school on three days The youth were thirteen minutes late, ten minutes late and seven minutes late to school. From May 27, 2020 through June 22, 2020 there was no movement to school as the youth were completing work on the dorm due to the COVID-19 pandemic. The lead teacher reported youth are broken up into four sections by modules, and schedules are staggered to bridge availability of treatment team staffing and educational staff availability. The program's instructional schedule is Monday through Friday 8:15 a.m. to 4:45 p.m.

## 2.18 Education Transition Plan

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of three

closed youth records found each has an individual education transition plan based on the youth's post-release goals, beginning at admission. Key personnel included the youth's parent/guardian, education staff, residential staff, post-release school district, guidance personnel, and personnel in the district with access to management information system. The transition plans addressed services and interventions based on the youth's assessed educational needs, post-release education plans, and education based on individual needs and performance. In two of the reviewed records, there was no documentation of specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services. In all three closed records, transition plans included the provision for continuation of education and/or employment, two had a completed employment application, all had a résumé, local Career Source Center information, and documents essential to obtaining employment. Two of the records reviewed had a completed employment application. None of three records contained a valid State of Florida identification card and there was no evidence the youth's parent/guardian was aware of the plan.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. A review of three closed youth records found each had an individual education transition plan developed based on youth's post-release goals, beginning at admission. Key personnel included were the youth's parent/guardian, education staff, residential staff, post-release school district, guidance personnel, and personnel in the district with access to management information system. The transition plan was developed with the youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. The education transition plans addressed services and interventions based on the youth's assessed educational needs and post-release education plans, recommended education placement for post-release based on individual needs and performance, and specific monitoring responsibilities by individuals with are responsible for the reintegration and coordination of the provision of support services. In all three closed records, the education transition plans included a provision for continuation of education and/or employment, completed employment application, a résumé, valid State of Florida identification card, local Career Source Center information, and documents essential to obtaining employment. There was evidence in two of the three records indicating the youth's parents/guardians were aware of the plan. The remaining record was for  a youth eighteen years of age which did not require the program to notify the parent/guardian.

## 2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Three closed youth records were reviewed to verify transition planning. There was no documentation of a transition conference being held at least sixty days prior to targeted release date. Treatment team members included youth, treatment team leader, and any other necessary members. Two records contained the program director or designee. None of the records contained evidence the youth's juvenile probation officer (JPO), nor the youth's parent/guardian were invited to attend. There was evidence the education staff and other pertinent parties were invited to attend. During the transition conference, participants reviewed transition activities on youth's performance plan, revised performance plans if necessary, identified additional transition activities if needed, identified target completion dates, identified persons responsible for completion, as well as signatures and dates were obtained to acknowledge transition goals and accountability for completion. According to documentation reviewed, a copy of the plan was not sent to the pertinent parties not in attendance who have a responsibility for completion of transition goals. In one record, there was documentation where a Community Re-Entry Team

(CRT) meeting occurred, the meeting was conducted prior to the youth's release with the youth and case manager participation. There was no documentation the intervention and treatment team leader invited and encouraged participation of all pertinent parties through advanced notification of the CRT.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Three closed youth records were reviewed to verify transition planning. All records indicated a transition conference was held at least sixty days prior to the youth's targeted release date. There was documentation indicating all treatment team members were in attendance during the transition conference. All records contained evidence showing the youth's juvenile probation officer (JPO), parent/guardian, education staff, and other pertinent parties were invited to attend. During the transition conference, participants reviewed transition activities on youth's performance plan, revised performance plans, if necessary, identified additional transition activities, as needed, identified target completion dates, and identified persons responsible for completion. Signatures and dates were obtained to acknowledge transition goals and accountability for completion.

A review of the three closed records found there was a Community Re-Entry Team (CRT) meeting conducted prior to the youth's release. There was evidence indicating the youth and therapeutic manager participated in the CRT meeting. Documentation indicated the intervention and treatment team leader invited and encouraged participation of all pertinent parties through advanced notification of the CRT.

## 2.20 Exit Portfolio

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of three closed youth records found all included exit portfolios which were discussed and verified at the exit conference. None of the three exit portfolios contained state issued identification cards and calendars with all upcoming appointments. Each record contained a copy of the youth's transition plan. The records contained all other required items, with the exception of one record missing a birth certificate, and one missing a résumé. There was no documentation the exit portfolio was provided to the youth or sent to the juvenile probation officer. The provider's contract was reviewed and reflected they are not meeting all requirements, in addition to administrative rule requirements.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. A review of three closed youth records found each youth's exit portfolio was discussed and initiated during the transition conferences. Each exit portfolio included a copy of the youth's transition plan, calendar with all dates/times/location of upcoming community appointments, social security card, birth certificate, educational and vocational certificates earned, all educations records, resume, and a completed sample employment application. None of the exit portfolios contained a state-issued identification as the Florida Licensing On Wheels (FLOW) mobile bus was not permitted to come to the facility due to the COVID-19 pandemic. Documentation indicated the youth's exit portfolio was verified at the exit conference. Two of the three youth received the exit portfolio upon release. The exit portfolio information was forwarded to the youth's juvenile probation officer (JPO), and it was documented in the youth records.

## 2.21 Exit Conference

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. A review of three closed youth records found all indicated exit conferences were conducted at least fourteen days prior to the youth's release, and included the conference was conducted after the program notified the juvenile probation officer (JPO) of the release. Documentation in the youth record included the date, signature, and summary of pending transition goals. The status of transition activities established at the transition conference was reviewed and plans for youth's release were finalized. In all records, the date of admission and date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS). Each reviewed record reflected the program director or designee and treatment team leader were in attendance. The three reviewed records reflected it was unable to determine if the youth was present based on documentation and youth. Additional attendees included the youth's JPO and therapist. An education representative did not attend any of the exit conferences, as there was no new or additional education information to add. Two of the three parent/guardians were invited but were unable to participate by telephone or in person. Each of the three records indicated exit conferences were separate from the transition and Community Re-entry Team meetings.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. A review of three closed records revealed the exit conference was conducted after the program notified the juvenile probation officer (JPO) of the youth's pending release. The exit conferences were held at least fourteen days prior to release. The date of admission and the date of termination documented in the youth records correlated with the Department's Juvenile Justice Information System (JJIS).The intervention and treatment team leader, education representative, JPO, youth, and other pertinent parties participated in the exit conferences. The parents/guardians participated in two of the three exit conferences. The remaining youth aged out of foster care. There was evidence showing the exit conferences were held separately from the transition and Community Re-Entry Team meetings.

## Standard 3: Mental Health and Substance Abuse Services

### 3.01 Designated Mental Health Clinician Authority or Clinical Coordinator

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Policy and procedures are in place designating the program director responsible for the administrative oversight and management of the mental health and substance abuse services in the program. The program's operating capacity is fewer than one hundred youth and provides specialized treatment services. The facility employs a designated mental health clinician authority (DMHCA), who is on-site forty hours a week, Monday through Friday as needed, and on call twenty-four hours a day, seven days a week to ensure appropriate implementation of mental health and substance services is taking place. The DMHCA is a licensed mental health counselor (LMHC) under Chapter 491. The DMHCA license expires on March 31, 2021.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The policy makes provisions for administrative oversight and management of mental health and substance abuse services. Along with mental health and substance abuse services, the program provides substance abuse overlay services (SAOS). The program has a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordination and implementation of mental health and substance abuse services.

The DMHCA is a licensed under Chapter 459, and is a licensed mental health counselor. Upon review, it was determined the DMHCA's license expires March 31, 2021. According to a review of sign-in sheets, the DMHCA was on-site forty hours a week, five days a week, eight hours a day. Sign-in logs determined the DMHCA was on-site enough time to provide appropriate services and to implement mental and substance abuse services. The DMHCA reported the role of the DMHCA is to provide direct supervision of all mental health and substance abuse services. The program utilizes the DMHCA and not a clinical coordinator for training in mental health and substance abuse services.

### 3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's only licensed staff is the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. A review of the staff roster found the designated mental health clinician authority is the only licensed staff; therefore, this indicator rates as non-applicable.

### 3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Policy and procedures are in place designating the program director responsible for the administrative oversight and management of the mental health and substance abuse services in the program. The program employs a designated mental health clinician authority (DMHCA), three full-time

therapeutic managers (TMs), one part-time TM, two transitional managers, and a recreational therapist, which is currently vacant. The DMHCA is responsible for providing at least one hour each week of on-site face-face direct supervision with the non-licensed clinical staff. This hour may be conducted individually or in a group format for the purpose of overseeing and directing the mental health services provided in the program as permitted by law within the DMHCAs state licensure. The DMHCA failed to provide an hour of supervision to one TM five times, one TM four times, one TM five times, and the remaining TM missed a total of seven hours of the twenty-three weeks. When the direct supervision occurred between the DMHCA and the TM, documentation was recorded on the correct Department form. The DMHCA assures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training experience, and in accordance with the current contract and 63N-1 F.A.C.

One non-licensed clinical staff holds a Master of Science and Master of Education, the second holds a Master of Science in Human Services, a Master of Social Work for the third, and the fourth holds of Master of Science Forensic Psychology.

The program is licensed in accordance under Chapter 397. The four non-licensed substance abuse TMs work under the direct supervision of a “qualified professional”, the DMHCA as defined in Section 397.311 F.S. Documentation on the correct form was provided for the three non-licensed TMs who conduct Assessment of Suicide Risks (ASRs), indicating they have received twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency health services, which included five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of the DMHCA. The part-time TM has not received this training. The DMHCA indicated when an ASR needs to be administered when the TM is on duty, the TM would contact the DMHCA the facility and complete the ASR, if necessary.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures to address mental health and substance abuse services provided by individuals with appropriate qualifications. A review of the staff roster determined staffing is in accordance with the contract. The program utilizes five non-licensed clinical staff, known as therapeutic managers (TM). A review of educational and training requirements for the TMs determined each of the staff have the appropriate trainings and education. Each TM holds a master’s degree from an accredited university Each TM had twenty hours of training and supervised experience in assessing suicide risk. Each TM completed the required training in accordance with the Rule in order to provide substance abuse services.

The program is licensed under Chapter 397. The license expires March 22, 2021. A review of supervision log from the past six months indicated the non-licensed staff received direct supervision from the designated mental health clinician authority (DMHCA). Documentation included the past six months.
The DMHCA maintained a supervision log with at least one hour a week of on-site face-to-face interactions with the non-licensed mental health professionals. The purpose of the DMHCA’s direct supervision is to provided oversight, as defined in Section 397.311. The direct supervision was recorded on the required Department form. The DMHCA is also responsible for reviewing the Assessment of Suicide Risks, crisis assessments, and follow-up crisis assessments. The DMHCA is responsible for signing each assessment.

## 3.04 Mental Health and Substance Abuse Admission Screening

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Five of the seven reviewed records were screened for mental health and substance abuse needs utilizing the Clinical Mental Health and Substance Abuse Intake Screening form and the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). One youth had the MAYSI-2 completed, while the seventh youth only had the Clinical Mental Health and Substance Abuse Intake Screening form completed. According to the facility operating procedure (FOP) 3.04, initial screening shall be accomplished through administration of the MAYSI-2 and an Assessment of Suicide Risk (ASR). All seven were completed on the date of the youth's arrival by the therapeutic manager (TM). In each of the seven records, the TM reviewed the available information in the commitment packet. Six of the seven records had a MAYSI-2 administered on the day of the youth's admission by a trained staff in the Department's Juvenile Justice Information System (JJIS). One youth arrived at the facility on July 24, 2019, and their MAYSI-2 was not completed until November 26, 2019. Five of the seven records had a MAYSI-2 completed in full in JJIS. One youth's MAYSI-2 was not completed in full and the recommendation was left blank in JJIS, while another youth's MAYSI-2 was entered into JJIS 125 days late. Three records met the criteria for a referral to be made for further evaluation. In two records, the TM completed an override on the MAYSI-2 and made a referral for a further evaluation. The staff did document the reason for the referral in JJIS for both records. The program director (PD) is automatically notified when the MAYSI-2 indicates a need for an assessment and a referral is made.

There were four applicable records for the PD to ensure an ASR is conducted within twenty-four hours when the MAYSI-2 indicates further assessment is needed in the category "suicide ideation". Three of the four records had the ASR completed based on the MAYSI-2, while one youth did not have the MAYSI-2 administered at admission. Three of the four records documented an ASR and comprehensive evaluation was needed. The fourth youth did not have the MAYSI-2 administered at admission.

Six of the seven records had a valid and reliable clinical mental health and substance abuse intake screening completed and signed by a licensed mental health staff. The screening instrument included the youth's mental health/substance abuse history, recent history or trauma of victimization, current medical status, behavioral observations, valid and reliable suicide risk screening instrument, findings and recommendations, and dispositions for all six records. All seven records had a completed "clinical mental health/substance abuse screening" and "clinical substance abuse screening". Based upon the youth's screening instruments, three of the seven records indicated the need for an ASR.

The PD developed written facility operating procedures (FOPs) for the implementation of a standardized admission/intake mental health/substance abuse screening process. The plan includes a review of the commitment packet, administration of the MAYSI-2 on JJIS or clinical mental health screening by a licensed mental health professional, clinical substance abuse screening by a "qualified professional", and the referral process including Baker Act or Marchman Act. The PD indicated, the program review the electronic commitment packet and comprehensive evaluation to see the history of mental health/substance abuse when identifying youth at risk for mental health and substance abuse problems and suicide. The program utilizes the ASR and Suicide Probability Scale (SPS) to screen for suicide, the Beck Depression Inventory (BDI) to screen for depression, and Substance Abuse Subtle Screening Instrument (SASSI) to screen for substance abuse, and the MAYSI-2.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program completes clinical mental health/substance abuse intake forms. Youth needs are identified, and referrals are completed as a part of the screening process. The program utilizes the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) and Assessment of Suicide Risk (ASR). A review of the program's facility operating procedures (FOPs) determined the program has implemented a standardized admission/intake mental health and substance abuse screening process.

Five youth records were reviewed. The program reviewed the commitment packet information, reports, and JJIS' alerts. Any existing mental health or substance abuse problems were documented for each of the five youth records. The MAYSI-2 was administered in the Department's Juvenile Justice Information System (JJIS) on the day of admission, as well as an ASR. Each reviewed MAYSI-2 indicated a need for further assessments, and the program completed a referral. None of the youth were in crisis during the screening process. An ASR was completed for each youth within twenty-four hours because the MAYSI-2 category indicated a need for further assessment or other information obtained indicated a need. Furthermore, it is the practice of the program for each youth to receive and ASR. The clinical mental health/substance abuse intake form was administered upon each of the five youth's admission in the program. All screenings were signed by the designated mental health clinician authority (DMHCA). None of the screenings determined an emergency. The staff documented a consultation with the DMHCA for each of the five youth records.

**3.05 Mental Health and Substance Abuse Assessment/Evaluation**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Six of the seven reviewed records were applicable for mental health and substance abuse assessment/evaluation. All six youth had a new mental health evaluation completed within thirty days of admission. In three of the six records the designated mental health clinician authority (DMHCA) signed the evaluation within ten calendar days after the evaluation was conducted. Two were never signed by the DMHCA, and one was signed two days late. In all six records, the new evaluation included the youth's demographics, reason for the evaluation, relevant background, behavioral observations, mental status examinations, interview or procedures administered, findings, DSM diagnosis, and recommendations. The program is licensed in accordance with Chapter 397 and does not expire until March 23, 2020. All seven records had a signed youth consent obtained for substance abuse services. All seven youth received a new substance abuse evaluation within thirty calendar days of admission. This assessment included the reason, relevant background, behavioral observations, methods of assessment, patterns and impact of alcohol and other drug abuse, risk factors of continued alcohol and other drug abuse, DSM diagnoses, and recommendations for all seven records.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures regarding mental health and substance abuse assessment and evaluation. Youth at the program whom are identified by screenings in need of further evaluations must be referred for a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation. Five youth records were reviewed. Each of the youth were identified at screening as in need of further evaluation. Each of the youth had a new comprehensive evaluation completed by the non-licensed staff, or as the program refers to the as the Therapeutic Manager, within thirty calendar days of admission. Each evaluation was reviewed by the designated mental health clinician authority

(DMHCA) within ten days and the DMHCA is also the licensed staff All the evaluations had new information applicable to each youth, based upon current information provided by the youth, parent/guardian, and youth's records.

**3.06 Mental Health and Substance Abuse Treatment**

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Upon arrival to the program, all seven youth records were assigned a treatment team comprised of the youth, a therapeutic manager (TM), program director (PD), transitional manager, direct care staff, education, and medical as deemed. Only the youth and TM's signatures were obtained all seven initial treatment plans. The PD and transitional manager's signatures were only on two, while the direct care staff's signature was on one of the seven records. There was no documentation of education assisting in the development of any of the seven youths' initial treatment plans. The designated mental health clinician authority (DMHCA), signed off on three of the seven initial treatment plans.

Seven records had a properly executed Authority to Evaluate and Treat (AET) forms, as well as signed substance abuse consent and release forms. All seven records had the mental health and/or substance abuse treatment notes documented on the proper Department form.
The program limits group therapy to ten or fewer for mental health treatment and fifteen or fewer for substance abuse treatment groups. All seven records reflected the youth are receiving individual counseling from a mental health clinical staff professional. All seven records indicated the youth receives psychosocial skills training.

According to the DMHCA, the therapeutic managers who are qualified, provide the substance abuse groups to the youth in the program. The DMHCA indicated Aggression Replacement Training (ART), Seek and Safety, Boys Counsel, Impact of Crime, Thinking for Change (T4C), and the University of Cincinnati Correctional Institute for Substance Abuse are other treatment services provided to the youth in the program.

All seven interviewed youth indicated they participate in group and receive any specialized therapies. During an interview with seven staff, five indicated they or other direct care staff do not facilitate any mental health or substance abuse groups. Five stated no, and one stated staff sit in the groups but do not teach the youth. One staff replied yes and clarified with Positive Skills Develop, Impact of Crime, and Positive Organizational Culture.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Mental health and substance abuse treatment planning is required, as delineated in the program's policy. The policy focuses on providing mental health and/or substance abuse services, interventions, and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse. Treatment teams develop, review, and updates treatment plans.

Five youth records were reviewed. Each youth was assigned to a treatment team upon admission. The teams were comprised of the youth, program administration, living unit representatives, juvenile probation officer (JPO), and the parent/guardian. Each of the youth were determined to need mental health treatment and substance abuse services. Each youth record had documentation the youth received individual and group therapy and family counselling daily, weekly, monthly, or as needed, if a youth expresses wanting to talk to a counselor. Family counseling is conducted monthly. Individual counseling is conducted weekly

for an hour, as indicated on treatment team documentation. Group therapy is conducted daily, as documentation indicates as well.

The program is licensed under Chapter 397. The license expires March 22, 2021. The program has five non-licensed clinical staff. A review of documentation confirmed each non-licensed clinical staff was directly supervised by the designated mental health clinician authority (DMHCA). Each of the five reviewed youth records determined the youth received mental health treatment and substance abuse services in accordance with the youth's treatment plan. Each of the five youth received individual, group, and family counseling by the clinical director or the non-licensed staff. Each of the youth signed consent treatment forms. None of the youth required a court order for substance abuse evaluation and treatment. Each youth had documentation of a properly executed Authority for Evaluation and Treatment (AET). All treatment notes were documented on the counseling/therapy progress notes form. Each youth received dual treatment of mental health and substance abuse services. Each record had signed consents forms for substance abuse treatment and a signed form for youth consent release forms. All consents were on the appropriate forms.

Observations of group therapy for both substance and mental health determined groups were held with fewer than ten participants. The program does not utilize sign-in sheets for groups and individual therapy; however, each youth signature was present on all individual, family, and group documentation. The program utilizes a sign-in sheet for family counseling. Family counseling is conducted monthly. A review of the sign-in sheets for family counseling determined, when the family was available, the program provided family counseling via phone with the parent/guardian

Five staff were interviewed. Each direct care staff reported they do not facilitate any mental health or substance abuse education groups. Each of the five interviewed youth reported participating in counseling weekly. The DMHCA concurred family counseling is conducted monthly. Individual counseling is conducted weekly for an hour, as indicated on treatment team documentation. Group therapy is conducted daily, as documentation indicates as well. individual/group therapy is provided weekly or more, as needed.

**3.07 Treatment and Discharge Planning (Critical)**

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven reviewed records had an initial mental health and/or substance abuse (MHSA) treatment plan developed when treatment was provided. All seven initial MHSA treatment plans are documented on the program's form and included all elements on the Department's Initial Mental Health/Substance Abuse Treatment plan. The initial MHSA treatment plan was developed within seven days of the onset of treatment in six of the seven records. The remaining record was five days late. All seven MHSA initial treatment plans were signed by the therapeutic manager (TM) completing the form. All seven MHSA treatment plans were completed by a non-licensed mental health clinical staff. Two of the seven initial plans were signed by the designated mental health clinician authority (DMHCA) within ten days of completion. One of the plans was signed twenty-two days late and three plans were not signed at all. Only one initial MHSA treatment plan had all the comprised signatures of the treatment team members. One plan did not have any of the treatment team signatures. Two plans comprised of only the youth and TM signatures. One plan had only a TM signature. One initial treatment plan contained signatures from the youth, TM, transitional manager, and DMHCA. One plan contained signatures from the youth, TM, transitional manager, DMHCA, and medical staff. The one youth applicable for psychiatric

needs to be included in their initial MHSA treatment plan failed to have the medication addressed in the plan.

Five of the seven reviewed records had the individualized treatment plan developed within thirty days of initiation of treatment. One youth's individualized plan was developed twenty-five days late, and the remaining youth's plans were twenty-two days late. All seven individualized treatment plans are documented on the program's form but included all elements on the Department's Individualized Mental Health/Substance Abuse Treatment plan. All seven plans are signed by the TM completing the plan. Three of the individualized treatment plans were signed by the DMHCA within the required ten days of completion. One was signed sixty-six days late, and three individualized treatment plans were never signed by the DMHCA. One of the seven individualized treatment plans comprised of all the members of the treatment team. In the remaining six records, there was no documentation the direct care staff participated in the development of the individualized treatment plans. In five records, there was no documentation of the education staff's participation in the development of the individualized treatment plan. The transitional manger and medical staff signatures were also missing in three records. Three records were applicable to include psychotropic medication and frequency of monitoring by psychiatrist for all youth receiving psychotropic medication. This documentation was on page three of the completed Clinical Psychotropic Progress Note (CPPN) for all three records but not attached to the plan.

One of the seven reviewed records completed the individualized treatment plan reviews at a minimum, every thirty days following the development of the plan. Three youth's record had no documentation of one month's formal treatment team meeting. One youth's record was missing documentation for two month's formal treatment team meeting, and one youth was missing documentation for four months. One record had no documentation of a formal treatment team meeting since June 7, 2019.

Seven reviewed records had individualized treatment plan reviews documented on the program's form but included all elements on form MHSA 017. Seven records had the prescribed services outlined in the youth's plan. All seven youth's progress notes reflected each youth received services as stipulated on their treatment plan.

Three additional closed records were requested to review for discharge plans for youth. All three discharge plans were completed on the program's form but were required to be documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three records had documentation of a discussion with the parent/guardian and juvenile probation officer (JPO) of the discharge plan during the exit conference. None of the three records had documentation of a copy of the MHSA treatment discharge summary being provided to the youth, JPO, and parent/guardian. Three discharge summaries considered the services needed for daily maintenance of the positive improvement for the youth.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. According to the program's policy and procedures, youth with mental disorders or substance abuse impairment must have an initial mental health/substance abuse treatment plan. The policy also addresses youth receiving discharge mental health/substance abuse treatment plan, including recommendations.

Five youth records were reviewed. An initial treatment plan was developed within thirty days of each of the youth's admission. An initial treatment plan was developed on the Department's form for each of youth receiving mental health and substance abuse services. Each youth

needed mental health treatment and substance abuse services. Each plan was developed within seven days of the onset of treatment. Three of the five youth were prescribed psychotropic medication. The program provided treatment within seven days of the initial psychiatric diagnostic interview for each of the three applicable youth. Individualized treatment plans were signed by the mental health clinical staff and the appropriate treatment team members. Psychiatric services for the three youth were included in the initial treatment plan. Each youth had their individualized treatment plan completed on the individualized mental health treatment plan form (MHSA 016) and the plan reviews were completed on the individualized mental health treatment plan review form (MHSA 017).

Three closed youth records were reviewed in addition to five open youth records. Each of the youth received mental health/substance abuse services while in the program. Each of the three youth had a discharge plan documented on the mental health/substance abuse treatment discharge plan form (MHSA 011). None of the youth were released with an active suicide risk during the annual compliance review period. The service needs of the youth were documented on the discharge plan. The mental health/substances abuse treatment discharge summary considered services such as therapy and substance abuse therapy. Documentation indicated the summary was provided to the juvenile probation officer (JPO), parent/guardian, and the youth. Exit staffing dates and discharge plan dates determined the summary was available for review. Exit staffing documented the discussion of the mental health treatment discharge summary with all appropriate parties prior to the youth's release date.

**3.08 Specialized Treatment Services (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. All youth admitted to the program are to receive a new comprehensive bio-psychosocial evaluation within thirty days of admission. The program has therapeutic managers to provide individual, group, and family counseling. A psychiatrist is on-site twice a month, every fourteen days, to conduct evaluations, medication management, and provide information for treatment teams. An interview with the program director indicated the program utilizes individualized treatment tools to target the areas identified as high risk, mental health, and substance abuse. All groups are evidence-based and are specific to the needs of the youth.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program director and the designated mental health clinician authority (DMHCA) reported the program provides specialized substances abuse overlay services (SAOS). The program's treatment services were provided in accordance with Florida Statute, Administrative Rule, and the provider's contract.

**3.09 Psychiatric Services (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Psychiatric services at the program are provided by a psychiatrist licensed under Chapter 458. All seven records received an initial diagnostic psychiatric interview within fourteen days of admission; however, only one youth entered the program on psychotropic medication. The initial diagnostic psychiatric interview included the youth's history, mental status examination, DSM diagnosis, and treatment recommendations for all seven records reviewed. This initial diagnostic psychiatric interview was documented on the Department's Clinical Psychotropic Progress Note

(CPPN), all three pages for all seven records.The initial diagnostic psychiatric interview including the medication, the explanation of the need of the medication related to the youth's diagnosis, the frequency of medication, and page three of the CPPN was completed for the one youth. Four of the seven records were applicable for psychiatric services. One youth entered the program on psychotropic medication, while three other youth were subsequently placed on psychotropic medication after admission. All four records indicated the youth was seen by the psychiatrist at a minimum, every thirty days. Documentation was completed on all three pages of the CPPN, and if there were any changes to the medication, page three of the CPPN reflected the changes.

The psychiatrist is available twenty-four hours a day, seven days a week. The psychiatrist briefs a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services, and the evaluation and recommendation are incorporated into the youth's mental health and/or substance abuse treatment plan. A review of the sign-in and sign-out log confirmed the psychiatrist visits are in agreement with the contract. During an interview with the psychiatrist, it was indicated the psychiatrist is on-site, every other week, on Saturdays. The psychiatrist indicated initial psychiatric evaluations and medication management services are provided.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Psychiatric services at the program are provided by a psychiatrist. The psychiatrist is a licensed physician under Chapter 458. A review of the sign-in sheets during the annual compliance re-review period determined the psychiatrist was on-site bi-weekly . This was confirmed by an interview with the psychiatrist. Five youth records were reviewed. Three of the five youth were prescribed psychotropic medication. The three applicable youth entered the program on psychotropic medication. The initial diagnostic interview was completed within fourteen days. The diagnostic interviews contained all the elements specified in Florida Administrative Code. A psychiatric evaluation was conducted within thirty days of intake and included documentation of monthly medication review. The program provided documentation indicating the psychiatrist provided written input during treatment team meetings regarding the psychiatric status for each of the three youth. None of the youth were prescribed a new medication, discontinued a medication, or had a significant change in any medication. Each youth had the required consent forms.

## 3.10 Suicide Prevention Plan (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program currently has a written suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process. The program's suicide prevention plan was signed on March 8, 2019.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written plan delineating the suicide prevention procedures. The plan included all required elements. The program administrator reported drills are conducted quarterly for all staff. The policy includes maintaining one-to-one supervision or constant supervision during suicide precautions. Procedures for the policy includes making a referral, communication with mental health staff, completing notifications to program, updating

and documenting the Juvenile Justice Information System, provisions for immediate staff responses, and a mental health review process

**3.11 Suicide Prevention Services (Critical)**

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Three of the seven reviewed records were applicable for suicide prevention services. One youth was placed on precautionary observation (PO) constant supervision and had an Assessment of Suicide Risk (ASR) completed by a mental health professional within twenty-four hours of being placed on PO. The ASR transitioned the youth to close supervision. There was no documentation removing this youth from close supervision. The second youth was placed on PO constant supervision and had an ASR completed by a mental health professional within twenty-four hours. The ASR transitioned the youth to close supervision until the designated mental health clinician authority (DMHCA) deemed no longer necessary. The second youth also had ASRs completed on June 18, 23, and 28, 2019 placing the youth on standard supervision from PO but there was no documentation the youth was placed on PO. The third youth was placed on precautionary observation (PO) constant supervision and had an ASR completed by a mental health professional within twenty-four hours. The ASR transitioned the youth to close supervision. There was no documentation removing the youth from close supervision. The youth also had ASRs completed forty-seven hours late on October 3, 2019, and forty-three hours late on October 17, 2019. All three records had the PO authorized and the mental health staff provided supportive services. A conference was held between the program director and mental health professional to reduce the level of supervision in all three records. There was also documentation of the date and time the program director and mental health professional conferred the recorded on the ASR in the appropriate section for all three youth. The DMHCA reviewed and signed all ASRs within twenty-four hours or the next time the DMHCA is on-site. One of the three records had documentation of the parent/guardian and juvenile probation officer notification on the ASR of the youth's potential suicide risk. In all three records, the ASR was completed by a mental health professional under the supervision of a licensed mental health professional. All Department's Juvenile Justice Information System (JJIS) suicide alerts were entered, excluding the three ASRs from June 18, 23, and 28, 2019. All three youth placed on PO were allowed to participate in select activities with other youth in designated safe housing areas. Documentation was provided for the three therapeutic managers who completed the ASRs confirming they have completed twenty hours of required training by licensed professional, including five co-assessments. The first youth had one ASR completed within twenty-four hours. The second youth had one ASR completed within twenty-four hours and three additional ASRs completed. The three additional ASRs did not have PO logs; therefore, there was no way to verify if the ASRs was completed within twenty-four hours. The third youth had one ASR completed within twenty-four hours, a second ASR which was forty-seven hours late, and a third ASR which was forty-three hours late. The shift supervisor ensures a listing of youth currently on PO or any concerns is communicated to the next shift during shift debriefing. The program's logbook was inconsistent on documenting when youth were placed on PO or removed from PO. Documentation was only found for one of the three youth being placed on PO.

The program currently has two knife-for-life tools located in each dormitory. The program's multidisciplinary review includes the circumstances surrounding the event, facility procedures relevant to the incident, relevant training receiving by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations. This review was established by the program director for every serious suicide attempt or serious

self-inflicted injury, and a mortality review for a completed suicide. Seven interviewed staff indicated if a youth expresses suicide thoughts, they are to notify the supervisor. Six staff stated they would notify mental health staff, place the youth on constant sight and sound, and document supervision. One staff replied they would place the youth in a locked room. Four of seven interviewed staff stated the knife-for-life, wire cutters, and needle nose pliers are located in the supervisor's office and six staff replied with the dormitory. One staff member stated education, a second staff stated medical, and two staff replied sub control.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Two of the five reviewed youth records were applicable for suicide prevention services; therefore, an additional applicable record was reviewed. Precautionary observation was maintained for each youth until an Assessment of Suicide Risk (ASR). The ASR indicated precautionary observation could be discontinued. The program does not utilize secure observation.

The program has a policy and procedures to address serious suicide attempts or serious self-inflicted injuries to include a mortality review for a completed suicide. Each ASR was documented in real time on the appropriate form. A review of logbooks determined beginning and ending times for youth placed on precautionary observations were documented. The ASR was completed by the non-licensed clinical staff and reviewed by the DMHCA, as required. Youth were not lowered or discontinued until the non-licensed staff conferred with the DMHCA. The program does not utilize secure observations. The parents/guardians were notified in each case. The Department's Juvenile Justice Information System (JJIS) determined alerts were appropriately entered when applicable.

The program utilizes the non-licensed clinical staff. Each of the non-licensed staff completed the required twenty hours of training and five supervised ASRs under the direct supervision of DMHCA. Five interviewed staff reported notifying mental health if a youth expresses suicidal thoughts. Each staff reported if a youth expresses suicidal thoughts it is their responsibility to notify mental health, supervise the youth, and document the supervision of the youth. None of the staff reported putting the youth in a locked room.

## 3.12 Suicide Precaution Observation Logs (Critical)

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Three of the seven reviewed records were applicable for suicide precaution observation (PO) logs. One of the three records maintained suicide PO logs for the duration the youth was on suicide precaution. One youth was missing entire PO logs for June 18, 23, and 28, 2019, and one youth was missing close supervision logs from October 4-5, 2019. In all three records, the PO logs documented the appropriate level of supervision and observations of the youth's behavior in real time, not exceeding thirty minutes. In two of the three records, the PO logs were reviewed and signed by the mental health professional. In the third record, the mental health staff reviewed and signed one of five PO logs. In all three records, the PO logs met safe housing requirements. All three applicable youth were interviewed, and all three stated staff were with them at all times and they were not left alone for any period of time.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Two of the five reviewed records were applicable for suicide precaution observation logs; therefore, one additional applicable record was reviewed. The three applicable youth were not placed in a secure observation room, as the program does not utilize secure

observation rooms. Each record contained completed precaution observation logs. Logs were maintained in real time, not exceeding thirty-minutes , and logs were reviewed and signed by mental health staff and the shift supervisor daily. Each of the three youth were maintained on constant supervision while on suicide precautions. The direct care staff who were supervising the three youth maintained the appropriate level of supervision and recorded the youth's behavior on the logs. Informal interviews with two of the youth determined staff supervised the youth at all times while on suicide precautions.

## 3.13 Suicide Prevention Training (Critical)

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures in place stating 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. Seven staff records were reviewed and all seven received the minimum six hours annually on suicide training. The program failed to complete mock suicide drills quarterly on each shift for all staff who come in contact with youth including kitchen and maintenance staff. The program only completed one mock suicide drill which included cardiopulmonary resuscitation (CPR) and the automated external defibrillator (AED) for the second quarter for both shifts. There was a total of fifteen direct care staff present during this drill, which is half of the program's direct care staff. There was no documentation of a suicide drill during the first and fourth quarters for either shift. The program was not open for the third fiscal quarter. Currently, the program director (PD) is aware there is no process in place for staff members who are not present during a quarterly drill to review each drill scenario. The PD will be moving forward at this time by having the drill videotaped and reviewed by staff not present during a quarterly drill.

During an interview with the PD, it was stated the program provides mock drills for staff which includes emergency response to suicide attempts of self-inflicted injury once quarterly for suicide or injury. The PD also stated the program conducts two mock medical drills a month, such as AED or first aid.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Seven staff training records were reviewed. Each staff received the required six hours of annual training on suicide prevention and implementation of suicide precautions. Training included suicide drills. Suicide drills were held no less than quarterly. Each of the ten staff reviewed were found to have participated in suicide drills quarterly. The program has two shifts. Suicide drills were completed May 21, 2020, February 21, 2020, and February 11, 2020. The program was only required to have two drills for both shifts. An account of the remaining two drills was captured during the program's previous annual compliance review on December 10-13, 2019.

## 3.14 Mental Health Crisis Intervention Services (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a crisis intervention plan detailing how to 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's crisis intervention plan includes notification and alert system, means of referral, communication, supervision, documentation, and review. The plan was signed by the

program director on March 8, 2019, but there was no signature by the designated mental health clinician authority (DMHCA).

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written crisis intervention plan detailing the crisis intervention procedures including notification and alert system; means of referral, including youth self-referral; communication; supervision; and documentation and review.

**3.15 Crisis Assessments (Critical)**

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures in place to prepare them on how to conduct crisis assessments. The program did not have a crisis assessment since opening in March 2019; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. The program policy and procedures delineates a crisis assessment is to be conducted by the licensed mental health professional, by the designated mental health clinician authority (DMHCA), or by a non-licensed mental health clinical staff. The program did not have any crisis assessments since the last annual compliance review. A review of the program's policy, crisis assessment tool, and staff training records determined the program is adequately prepared to conduct crisis assessments.

**3.16 Emergency Mental Health and Substance Abuse Services (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's emergency care plan details how to handle any youth determined to be in imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in the facility. The plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch 397 (Marchman Act), documentation, training, and review.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program's emergency care plan. The plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch. 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 F.S. (Marchman Act), documentation, training, and review.

**3.17 Baker and Marchman Acts (Critical)**

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures in place for youth who require emergency mental health or substance abuse services. The program did not have a Baker Act or Marchman Act since opening in March 2019; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program had documentation of one youth who was believed to be an imminent danger to themselves and others because of mental illness. The youth's record was reviewed and determined a Baker Act was conducted off-site. The youth was placed on constant supervision upon readmission and the program updated the youth's records to reflect a mental health alert. A mental status examination (MSE) was conducted and completed by the licensed mental health professional. The youth was maintained on constant supervision until the ASR was completed. Subsequent to the program completing an Assessment of Suicide Risk, the youth was discontinued from suicide precautions and the suicide risk alert was discontinued. A review of the program's policy determined the program followed all appropriate procedures.

## Standard 4: Health Services

### 4.01 Designated Health Authority/Designee (Critical)

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's designated health authority (DHA) is a licensed physician (MD) who holds a clear and active license and meets all requirements for independent and unsupervised practice in Florida. The DHA's license expires on January 31, 2020 and specialty training is in Family Practice (with experience with adolescents). The DHA designates an advanced practice registered nurse (APRN) who hold a clear and active license to practice in Florida. The APRN's clinical specialty is in Family Health and license expires on April 30, 2021. The APRN has a Collaborative Practice Protocol in place and it states the physician is serving as the program's DHA. The protocol in maintained on-site. A review of the DHA's sign-in and sign-out log for the previous six months reflected the DHA is on-site weekly and no more than nine days pass between on-site visits. The log further reflected the DHA is signing in but not consistently signing out. The DHA is contractually required to be on-site two hours a week. Eleven instances were observed where the DHA did not sign out; therefore, the DHA's time on-site for those eleven days could not be verified. Additionally, there were three days over the previous six months where the DHA was not on-site for the required two hours. During the DHA's absence, a medical doctor (MD) has been designated to perform administrative duties, a copy of their credentials was available for review. The ARNP covers the DHA's clinical duties in the DHA's absence. The DHA is available twenty-four hours a day, seven days a week by telephone and electronically for acute medical concerns, emergency care, and coordination of off-site care. The DHA reported covering Comprehensive Physical Assessments (CPA), sick calls, reviews lab work and test results, health maintenance visits, periodic health reviews of chronic illnesses, and policy reviews. The DHA added they communicates with program staff three to seven times a day in regard to youth medical needs and is available twenty-four hours and day, seven days a week when not on-site.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program's designated health authority (DHA) is a licensed physician (MD) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA's license expires on January 31, 2022 and specialty training is in Family Practice (with experience with adolescents). The program no longer utilizes an advanced practice registered nurse (APRN), and the DHA does not designate a physician's assistant (PA). A review of the DHA's sign-in/out log for the previous six months reflected the DHA is on-site weekly and no more than nine days pass between on-site visits. The sign-in/out logs further reflected the DHA is on-site a minimum of two hours each week, as contractually required. During the DHA's absence, a medical doctor (MD) has been designated to perform administrative duties, and a copy of credentials was available for review. The DHA is responsible for communication with program staff regarding youth medical needs, and is available twenty-four hours a day, seven days a week by phone and electronically for acute medical concerns, emergency care, and coordination of off-site care. Additionally, the program employs three registered nurses (RNs), all of whom have clear and active licenses. Copies of the licenses were provided by the program. The DHA reported visiting the program once a week to provide medical services and policy review and is available for consultation twenty-four hours a day, seven days a week. The DHA added he communicates with the program by text message and phone calls.

## 4.02 Facility Operating Procedures

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and facility administrator signs and dates all respective treatment protocols. Nursing staff have reviewed, signed, and dated a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. The program has been operational since March 2019. In the event new policies are implemented or changes occur, they will be reviewed, signed, and dated by each nurse. At a minimum, an annual review of all FOPs and protocols will be conducted. All newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse. A copy of the orientation and training was available for review. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The designated health authority (DHA) and program director signs and dates all respective treatment protocols. Nursing staff have reviewed, signed, and dated a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. In addition, new policy changes were observed to be reviewed, signed, and dated by nursing staff since the previous annual compliance review. The program completes an annual review of all FOPs and protocols, as required. All newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse. A copy of the orientation and training was available for review. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

## 4.03 Authority for Evaluation and Treatment

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures relating to the Authority for Evaluation and Treatment (AET) of youth in their custody. Seven youth Individual Healthcare Records (IHCRs) were reviewed for an AET. Seven of seven records reviewed contained an AET, each of which were stamped "copy" in red ink. AETs are valid until the youth's eighteenth birthday. In three of the seven records reviewed, youth were observed to be eighteen years old. Each of the three applicable youth had a signed consent form to share information related to their healthcare to their parent/guardian. Copies of parental notifications were maintained behind the AET in the IHCR for all seven youth. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated. According to the nurse, upon admission, the Department's Juvenile Justice Information System (JJIS) is checked for an AET, if there is not one available, the youth's juvenile probation officer (JPO) is contacted.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for an Authority for Evaluation and Treatment (AET). All five records contained an AET and all were

observed to be stamped “copy” in red ink. AETs are valid until the youth’s eighteenth birthday. One of the five reviewed records reflected the youth turned eighteen years old subsequent to his admission to the program. In this record, an Authorization of Release of Information for Youth Eighteen Years Old was observed signed by the youth. Copies of parental notifications were maintained behind the AET in the IHCR for each of the five youth reviewed. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated. According to the nurse, the AETs should come with the youth, but if not, then juvenile probation officer (JPO) is contacted. The nurse added, youth sign a release of medical information if they are eighteen years old.

**4.04 Parental Notification/Consent**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven Individual Healthcare Records (IHCRs) were reviewed for parental consent. Six of seven records reviewed were applicable for parental notification for over-the-counter (OTC) medications beyond those listed on the Authority for Evaluation and Treatment (AET). Documentation reflected all six applicable records contained parental notification. One of the seven records reviewed reflected the youth requested and consented for an immunization not listed on the AET. The youth in this case was observed to be eighteen years old and parental notification/consent was not required, but the program’s practice is to send written notification regardless for those youth (eighteen or older) who consent for their information to be shared. Three of seven records were reviewed reflected notification for changes in existing medication. One record reviewed was applicable for changes in a chronic condition, in which parental notification was observed. Two of seven records reflected parental notification for non-routine dental procedures. Three records reflected notification for off-site medical treatment. Three records reflected notification for new medication. Written notifications are sent regardless of telephone notifications. Documentation in the chronological progress notes reflected staff members witness phone calls and conversations. Three youth applicable for psychotropic medication reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). All three applicable records reflected the CPPN had been mailed out for parent/guardian signature. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated. All youth admitted to the program have their immunization records verified within thirty days of admission through Florida Shots and school records. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According to the registered nurse (RN), immunizations are verified upon admission for each youth through Florida Shots and/or school records.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for parental notification/consent. Two of the five records reviewed were applicable for parental notification for over-the-counter (OTC) medications beyond those listed on the Authority for Evaluation and Treatment (AET). Documentation reflected both applicable records contained parental notification. None of the five youth were applicable for vaccinations/immunizations not consented for on the AET, significant changes to medication, or discontinuation of medication prior to entering the program’s custody. One of the five youth was diagnosed with a chronic condition subsequent to entering the program in which parental notification was observed. Three of the five youth were applicable for off-site emergency care in which notification was observed by phone and letter. One of the five youth was applicable for non-routine dental care in which parental notification was observed. Four of the five records reflected notification for off-site treatment. Three records reflected notification for new medications. Written notifications are

sent regardless of telephone notifications. Documentation in the chronological progress notes reflected staff members witness phone calls and conversations. Two of the five youth were applicable for psychotropic medication. One of the two youth was eighteen years of age when psychotropic medication was prescribed, and the youth consented. Documentation for the second youth reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). For the second applicable record, the CPPN was mailed out for parent/guardian signature. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated. All youth admitted to the program have immunization records verified within thirty days of admission through Florida Shots and school records. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According to the nurse, the youth's immunizations are verified upon admission.

**4.05 Healthcare Admission Screening & Rescreening Form**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedure in place ensuring every youth will receive a screening for health concerns upon admission, or at a minimum each time the physical custody of the youth changes and they are returned or readmitted to the program. Seven Individual Healthcare Records were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS). Documentation in all seven records reflected a FEPHS was completed by a registered nurse (RN) on the day of admission to the program. One of the seven youth records reviewed was applicable for a rescreening. Documentation reflected the rescreening was completed by a RN on the day the youth returned to the program.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS). The completion date on the FEPHS matched the date of admission for all five youth reviewed. The FEPHS was observed to be completed by a registered nurse (RN) in all five records. None of the five youth reviewed were applicable for a change in physical custody. In addition, none of the program's current population were applicable for a change in physical custody.

**4.06 Youth Orientation to Healthcare Services/Health Education**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures to ensure the healthcare admission screening provides health orientation education to each youth admitted to the program. Seven youth Individual Healthcare Records (IHCRs) were reviewed for healthcare orientation. Documentation in seven of seven records reviewed reflected youth received healthcare services orientation on the day of admission to the program. The program's healthcare orientation included the following: access to medical care, sick call, medication monitoring, what constitutes an "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation was observed in all seven records reviewed.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for healthcare orientation. All five records contained documentation which reflected each youth

received a healthcare services orientation on the day of admission to the program. The program's healthcare orientation included access to medical care, sick call, medication monitoring, what constitutes an "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation by both youth and nurse was observed in all five records reviewed.

## 4.07 Designated Health Authority/Designee Admission Notification

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth Individual Healthcare Records (IHCRs) were reviewed for designated health authority (DHA) notification upon admission to the program. One of seven records reviewed was applicable for DHA notification for a chronic condition. None of the seven records reviewed required immediate notification for need of emergency services. The program's practice is to notify the DHA for all admissions to the program. All seven records contained documentation reflecting the DHA was notified by telephone for each youth upon admission to the program. The DHA notification was observed documented in the chronological progress notes for each of the seven youth records reviewed.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for designated health authority (DHA) notification. None of the five records reviewed were applicable for DHA notification upon admission for a chronic condition. None of the five records required immediate notification for need of emergency services. The program's practice is to notify the DHA for all admissions to the program. Each of the five records reviewed contained documentation reflecting the DHA was notified by telephone for all five youth upon admission to the program. The DHA notification was documented in the chronological progress notes for each of the five records reviewed.

## 4.08 Health Related History

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven Individual Healthcare Records (IHCRs) were reviewed for completion of a Health Related History (HRH). Documentation in seven of seven records reviewed reflect a new HRH was completed by a registered nurse (RN) on the day of admission for each youth. Documentation further reflected the designated health authority (DHA) reviewed the HRH for each of the seven youth. All seven HRHs were completed prior to the Comprehensive Physical Assessments (CPAs).

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for completion of a health-related history (HRH). The program's practice is to complete a new HRH on the day of admission for all youth entering the program. Documentation in all five records reflected a new HRH was completed by a registered nurse (RN) on the day of admission for each youth. Additionally, documentation reflected the designated health authority (DHA) reviewed the HRH in each of the five records reviewed. All five HRHs were completed prior to the Comprehensive Physical Assessments (CPAs). According to the nurse, HRHs are completed for each youth upon admission by the admitting nurse.

## 4.09 Comprehensive Physical Assessment/TB Screening

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a Comprehensive Physical Assessment (CPA). The program uses the Department's CPA form. Documentation in seven of seven records reviewed reflect the DHA completed a new CPA on each youth within seven days of admission to the program. Six of seven youth entered the program as a medical grade one, and one youth entered as a medical grade five. Each CPA was observed to be completed in accordance with the Health Services Manual requirements. In six of seven records reviewed, all sections of the CPA were marked with an "O" or an "X". Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. One CPA did not reflect documentation of a refusal or deferment of the Tanner Stage section, but a refusal form corresponding with this section of the examination was observed in the youth's record. All seven youth refused the Tanner Stage portion of the exam, in which corresponding refusal forms were observed in six of seven records reviewed. One record did not contain a corresponding refusal form. The problem list was observed to be updated for all seven youth. All seven youth had at least one verified tuberculin skin test (TST) completed and observed documented within the last year. Each youth was assessed prior to being placed in the general population, as indicated by a Tier I tuberculosis screening completed for each of the seven youth on the day of admission. The results of the TST were observed to be documented on the CPA and Infectious Communicable Disease (ICD) forms in all seven records reviewed. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health Administration standards. According to the registered nurse (RN), the DHA completes a new CPA for each youth upon admission. The RN added, a Tier I screening is completed on the day of admission and annual purified protein derivative (PPD) is completed.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for completion of a Comprehensive Physical Assessment (CPA). The program uses the Department's CPA form. It is the program's practice to complete a new CPA for each youth within seven days of admission regardless of if there is a current CPA on file. Documentation in all of the records reflected each youth had a new CPA completed by the designated health authority (DHA) within seven days of admission to the program. All five youth entered the program classified as a medical grade one. All five CPAs were completed in accordance with Florida Administrative Code. In each of the five records reviewed, all sections of the CPA were marked with an "O" or an "X." Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. All five youth refused the Tanner Stage exam in which the DHA documented "refused" in the corresponding section on the CPA for each youth. In addition, corresponding refusal forms were observed in each youth's record for this portion of the CPA examination. The Department's Problem List was updated for all five youth. All five youth had at least one verified tuberculin skin test (TST) completed and observed documented within the last year. Each youth was assessed prior to placement in general population, as indicated by a Tier I B screening completed for all five youth on the day of admission. The results of the TST were documented on the CPA and infectious communicable disease (ICD) forms in all five records reviewed. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health Administration standards. According to the nurse, a new CPA is completed for each youth within seven days of admission and annually. The nurse added youth are screened for tuberculosis upon admission and annually.

## 4.10 Sexually Transmitted Infection & HIV Screening

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven Individual Healthcare Records (IHCRs) were reviewed for sexually transmitted disease/infection (STI) screenings. Documentation in seven of seven records reviewed reflect all youth received a STI screening upon admission to the program. Two of seven youth consented to testing upon admission to the program, five of seven youth refused testing. One of the five youth who initially refused testing, subsequently requested testing. Testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form. None of the seven youth reviewed were out of the Department's custody where a re-screen would be required. Referrals for each of the three applicable youth were documented on the STI screening form. Additionally, testing for two of three applicable youth was documented in the youth's progress notes upon admission. One youth's testing was documented on an Off-site Site Summary form. Documentation in all seven youth records reviewed reflected youth were offered human immunodeficiency virus (HIV) testing, counseling, and treatment upon admission to the program. Three of seven youth consented to HIV testing. Test results were observed filed in a confidential manner consistent with Florida Statutes 381.004, a certified HIV counselor conducted the testing, and a youth's HIV status is never included on with the internal alerts. HIV testing is completed by the Hamilton County Health Department. Pre and post-test counseling were observed documented in all three applicable youth's Health Education Record within their IHCR. A copy of the Hamilton County Health Department's 500/501 certification was available for review. Seven of seven youth interviewed reported they could ask for an HIV test.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for sexually transmitted infection (STI) screening and human immunodeficiency virus (HIV) screening. Documentation in all five records reflected each youth was screened for STIs upon admission. Two of the five youth were referred and ordered for testing. Referrals for testing were documented on the STI screening form. In both cases, testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form. None of the five youth reviewed were out of the Department's custody where a re-screen would be required. Documentation in all five youth records reflected youth were offered HIV testing, counseling, and treatment (referral) upon admission to the program. Three of the five youth consented to HIV testing and two refused testing. All three applicable youth records reflected consent was received from each youth for testing. HIV testing and counseling is provided by the Hamilton County Health Department. Due to the COVID-19 pandemic, the Hamilton County Health Department is temporarily not providing these services. The health department will notify the program as soon as services can resume. A copy of the Hamilton County Health Department's 500/501 certification was available for review. All five interviewed youth reported they can ask for an HIV test.

## 4.11 Sick Call Process

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedure in place which provides youth with the opportunity to voice healthcare concerns and be evaluated by a nurse to determine the severity of their concerns. Seven Individual Healthcare Records (IHCRs) were reviewed for sick call. Seven of seven youth records reflected all had completed a Sick Call Request. One of seven applicable youth records reviewed reflected the youth presented with a similar sick call three times within a two-week

period, in which case the youth was referred to the DHA. None of the seven youth presented with complaints in which medical staff were unfamiliar with. All seven youth completed Sick Call Request forms which were placed in a locked box and then provided to the nurse. Completed Sick Call Request forms were observed filed with the corresponding progress note for each youth, in reverse chronological order. Sick calls reviewed for all seven youth were completed by a registered nurse (RN) with the exception of one, which was completed by a supervisor after hours. Training was observed for the supervisor completing this sick call. In this case, the RN reviewed the sick call the next morning. The program does not utilize restricted housing. The program conducts sick call twice a day, as contractually required, from 12:15 p.m. to 1:00 p.m. and 5:00 p.m. to 5:30 p.m. Sick call times were observed posted throughout the program. In the event a nurse is not site to conduct sick call, the shift supervisor will review sick call requests within two hours and contact the designated health authority (DHA) if determined urgent in need. Progress notes were observed to be documented in accordance with Health Services Rule 63M-2. Sick calls were observed documented on the youth's Sick Call Index in the IHCR as well as the Sick Call Referral log. Sick Call forms were observed to be available to youth throughout the program. Two sick calls were observed during the annual compliance review. The reviewer obtained both youth's permission to observe the sick call. Both youth were escorted to medical by a Protective Active Response (PAR) certified staff member. The nurse conducting sick call was also PAR certified. The nurse identified themselves and stated why the youth was there, the youth signed they were seen, the youth were seen in a private area, and proper equipment was present. Seven of seven staff interviewed reported the nurse responds to and conducts sick call. Seven youth were interviewed in regard to sick call. Two of seven youth reported they are seen immediately by the nurse once submitting a sick call, four reported they are seen within one day, and one youth reported he was seen within three days.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for sick call. Four of the five records reflected the youth submitted a sick call request. None of the youth were applicable for similar sick call complaint three or more times with a two-week period. None of the four applicable youth complained of pain in which staff were unfamiliar with. Completed sick call request forms for the four applicable youth were observed filed with the corresponding progress note for each youth, in reverse chronological order. Sick calls reviewed for the four applicable youth were completed by a registered nurse (RN). The program does not utilize restricted housing; however, three of the four youth were placed in medical quarantine due to the COVID-19 pandemic. The RN visited the three applicable youth four times a day, as evidenced by a medical quarantine log for each of the three youth. Progress notes were documented in accordance with Florida Administrative Code 63M-2. Sick calls were documented on the youth's sick call index in the IHCR and the Sick Call Referral log. In the event the nursing staff is not on-site, the shift supervisor reviews any submitted sick call requests and contacts for the Health Services Administrator (HSA) or designated health authority (DHA) if determined urgent in need. Sick call is provided twice a day from 7:30 a.m. to 8:00 a.m. and 5:30 p.m. to 6:00 p.m., seven days a week, as contractually required. Sick call hours were observed posted throughout the program. Sick call forms were observed to be available to youth throughout the program. One sick call was observed during the annual compliance re-review with the youth's permission. The youth was escorted to the medical by a Protective Active Response (PAR) certified staff member who positioned himself just outside the clinic door during the youth's exam. The nurse conducting the exam was also PAR certified. The nurse identified themselves and stated why the youth was there, the youth signed he was seen, the youth was seen in a private area, and proper equipment was present. All five interviewed staff reported the nurse reviews and responds to sick calls. Four of five interviewed youth reported they are seen within one day of submitting a sick call, one youth reported immediately.

## 4.12 Episodic/First Aid/Emergency Care

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Two of seven youth reviewed were applicable for episodic care. One additional applicable record was provided by the program for review. One of three applicable youth was referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow up care observed. On-site care provided by licensed healthcare staff and subjective, objective, assessment, and plan (SOAP) format was observed. The Episodic Care Log documents all instances of first aid/emergency care. Logs for the previous six months correspond with all on/off-site events observed in youth records. Emergency medical and dental care, including EMS services are available twenty-four hours a day. The program has seven first aid kits. First aid kits are located in both dorms, education, kitchen, and three are assigned to vehicles used for transport. Six of seven first aid kits were available for review. One first aid kit assigned to a transport vehicle was off-site the week of the annual compliance review. Five of the six first aid kits reviewed were fully stocked with the designated health authority (DHA) approved items. One first aid kit was short two gauze pads (three inch). Medical staff added the two missing gauze pads immediately. First aid kits are inspected weekly by a registered nurse (RN) as indicated by first aid inspection forms. The program has two suicide response kits, one located in each dorm. The program has four automated external defibrillators (AEDs). AEDs are located in both dorms, kitchen, and education building. Instructions are located inside the AED. Instructions are located inside the AED. All four AEDs are brand new. The batteries for all four AEDs expire in March 2028. Three of the AED pads expire January 20, 2024 and one set of pads expires January 27, 2024. The registered nurse (RN) performed a self-test all four AEDs during the annual compliance review, all of which were found to be operational. A review of drill documentation reflected the program has conducted drills monthly and on each shift since the program opened in March of 2019. Additionally, drills included the use of cardiopulmonary resuscitation(CPR)/AED or the administration of first aid quarterly, and on each shift. According to the program director, moving forward, all drills will be videotaped and reviewed during staff meetings to ensure staff who are not present during the drills have an opportunity to review them. The program has a list of emergency numbers, including Poison Control Information Center, which are inaccessible to youth. The program has an approved list of non-licensed healthcare staff who are able to assist youth with medication administration or use of an epinephrine auto-injector. A review of training records for these staff indicated they have completed the required training. The program has a list of emergency numbers, including Poison Control Information Center, and these numbers are inaccessible to youth. Four of seven staff interviewed report they are personally allowed to call 9-1-1 if a youth has a medical emergency. Three of seven staff reported they would contact their supervisor. Seven of seven youth interviewed reported they can see a doctor if needed, and a dentist if they have tooth pain.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for episodic care. Four of the five youth reviewed were applicable for episodic care. One of the four youth was applicable for over-the-counter (OTC) medications. Two of the four youth received treatment on-site while the other two youth were referred for off-site care. Instructions were given to the youth in all four instances. One of the four applicable youth was placed on the alert list, was as required. Progress notes contained all required elements, referral needed, parental notification, and plans for follow-up/future care observed. On-site care provided by licensed

healthcare staff and subjective, objective, assessment, and place (SOAP) format was observed. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months corresponded with all on/off-site events observed in youth records. Emergency medical and dental care, including EMS services are available twenty-four hours a day.

The program has eight first aid kits. First aid kits are located in both dorms, education, kitchen, Home Builders Institute (HBI) classroom, and three are assigned to vehicles used for transport. Three first aid kits were reviewed, as well as each first aid kit used for transport. The first aid kits were observed to be fully stocked with the designated health authority (DHA) approved items. First aid kits are reviewed weekly by the registered nurse (RN). A review of the first aid kits inspections forms for the previous six months reflected the kits were inspected, as required.

The program has two suicide response kits which are located on each dorm. The program has four automated external defibrillators (AEDs). AEDs are located in both dorms, kitchen, and education building. Instructions are located inside the AED. The batteries for all four AEDs expire in March 2028. Three of the AED pads expire January 20, 2024 and one set of pads expires January 27, 2024 (kitchen). The batteries nor pads have been changed, as all four AEDs were brand new when the program became operational. The RN performed a self-test on all four AEDs in the presence of the annual compliance re-review team member, all of which were found to be operational.

A review of drill documentation for the current quarter and previous three quarters reflected the program has conducted drills monthly and on each shift. In addition, the drills included the use of cardiopulmonary resuscitation (CPR)/AED or the administration of first aid quarterly, and on each shift. Drills are videotaped and reviewed during shift change and staff meetings for those staff who are not present during the drill. The program has a list of emergency numbers, including Poison Control Information Center, which are inaccessible to youth. The program has an approved list of supervisory-level, non-licensed healthcare staff who are able to assist youth with medication administration or use of an epinephrine auto-injector. A review of training records for these staff indicated the staff completed the required training. Each of the five interviewed staff reported they are allowed to contact 9-1-1 in case of a medical emergency. All five staff members further reported they would also notify their supervisor and program director. Each of the five interviewed youth reported they can see a doctor and dentist, if needed.

## 4.13 Off-Site Care/Referrals

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth Individual Healthcare Records (IHCRs) were reviewed for off-site care. Seven of seven records reviewed were applicable for non-emergent off-site services. Five of seven records reflected documentation of verbal and written parental notification for off-site care, written notification was sent for the two youth who were eighteen years old. Seven of seven records reflected the completion of the Summary of Off-Site Care form. Discharge documents and instructions were observed in four of seven applicable records. The designated health authority's (DHA) signature was observed on all seven Summary of Off-Site Care forms. Six of seven youth required follow-up appointments. Appointments are tracked by medical staff using an appointment calendar dedicated to youth as well as transport logs which are filed within the appointment calendar.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Five youth individual healthcare records (IHCRs) were reviewed for off-site care. Four of the five youth records were applicable for off-site care. Three of the four youth

were applicable for emergent care and one of the four youth was applicable for non-emergent off-site care. Parental notification was observed in all four applicable records. A Summary of Off-Site Care was observed in each of the four records as well as discharge documents. Documentation in four of four records reflected the designated health authority (DHA) reviewed and signed each of the Summary of Off-Site Care documents. One of the four applicable youth required a follow-up appointment. Youth appointments are tracked in an appointment logbook/calendar by the registered nurse (RN).

## 4.14 Chronic Conditions/Periodic Evaluations

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. Seven youth Individual Healthcare Records (IHCRs) were reviewed for chronic conditions. Two of seven youth were applicable for chronic conditions. The program provided an additional applicable record for review. Two of three records reviewed were identified as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. One youth was identified as having a chronic condition subsequent to admission to the program. None of the three youth reviewed had a communicable disease. All three were taking prescribed medication on an ongoing basis. Two of the youth were classified as a medical grade five and one as a medical grade two. All three youth were observed to be identified as having a chronic illness on the program's internal alert roster. None of the youth reviewed were taking anti-tuberculosis medication. The chronic conditions roster includes the due dates for the youth's next periodic evaluation. Documentation reflected all three youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. None of the periodic evaluations were conducted off-site. The problem list for each youth was updated in accordance with the Health Service Rule 63-M. Periodic evaluation documentation was observed in each youth's IHRC. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff. According to the registered nurse (RN), youth with chronic conditions are monitored by using the Chronic Roster Log. The DHA reported periodic evaluations are conducted every three months or sooner if needed and the nurse tracks the frequency of visits.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. One of the five youth individual healthcare records (IHCR) was applicable for chronic conditions; therefore, two additional applicable records were reviewed. Two of three youth reviewed were identified as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form and one youth was diagnosed with a chronic condition subsequent to admission. None of the three youth reviewed had a communicable disease. All three youth were taking prescribed medication on an ongoing basis. Two of the youth were classified as a medical grade two and one as a five. All three youth were listed on the program's chronic condition roster. One youth has very recently been diagnosed with a chronic condition and has not yet had his first periodic evaluation. Documentation reflected the remaining two youth received periodic evaluations at intervals no greater than three months and there were no instances of lapses in care or missed periodic evaluations. None of the youth reviewed were taking anti-tuberculosis medication. The program's chronic condition roster includes the dates of each youth's next periodic evaluation. None of the periodic evaluation were observed to be conducted off-site. The Department's Problem List for each youth was updated in accordance with Florida Administrative Code. Periodic evaluation documentation was maintained in each youth's IHCR. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff.

According to the designated health authority (DHA), periodic evaluations are conducted every three months or sooner if needed. The DHA added the nurses keep track of when the evaluations are needed. The nurse reported youth with chronic conditions are seen by the DHA every three months and youth are placed on the chronic roster.

## 4.15 Medication Management

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures in place to ensure youth receive medication in a safe, effective and timely manner as ordered. Seven youth Individual Healthcare Records (IHCRs) were reviewed for prescription medication. Two of seven youth were taking prescribed medication upon entry to the program. Three of seven youth were prescribed medication subsequent to admission and two youth reviewed were not applicable for prescribed medication. Prescription verification for both youth taking medication upon entry to the program was observed in the chronological progress notes in the record. Documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and are given pursuant to a current prescription. The program does not utilize restrictive housing. Four of the seven youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). Medication in these four records were observed to be administered in accordance with approved protocols. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Documentation reflected both staff and youth initial each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. Four of five applicable youth's MARs reflected refusals, which were clearly documented on the MAR and had a corresponding refusal form. The Facility Entry Physical Health Screening (FEPHS) indicated two youth were taking prescribed medication upon admission to the program. Appropriate notifications to the parent/guardians were made for both applicable youth. Medications were observed to be in a separate, secure areas inaccessible to youth. All non-controlled medications (prescribed and over-the counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. All expired medication is destroyed once a month using Drug Buster when the pharmacist visits the program. Medication pass was able to be observed during the annual compliance review with no issues noted. Five of seven youth interviewed reported the nurse gives them their medication and two youth reported they do not take medication. Seven of seven interviewed staff reported the nurse give youth their medication. One staff added, a supervisor gives youth their medication.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. One of five youth individual healthcare records (IHCR) reviewed was applicable for taking prescribed medication upon admission to the program. No other youth in the program's current population were taking prescribed medication upon admission to the program. Prescription verification for the applicable youth was documented on the Prescription Medication Verification Checklist (HS025) in the youth's IHCRs. Documentation further reflected the designated health authority (DHA) was contacted on admission to obtain the order to continue the medication prescribed prior to admission. All medications had a current, valid

order, and were given pursuant to a current prescription. The youth's continued medication was observed on a Practitioner Order Form in the youth's IHCRs. The program does not utilize restrictive housing. The youth was not applicable for over-the-counter (OTC) medications not listed on the AET. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). The applicable youth was continued on medication upon admission which was prescribed as "pro re nata" (PRN) in which the youth did not request to take any of the medication and the prescription was subsequently discontinued thirty days after the youth was admitted to the program. The Facility Entry Physical Health Screening (FEPHS) indicated one youth was taking prescribed medication upon admission to the program. Appropriate notifications to the parents/guardian were made for the applicable youth. Medications were observed to be in a separate, secure areas inaccessible to youth. All non-controlled medications (prescribed and OTC) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications were stored behind two locks. There are no youth in the program's current population who were taking controlled medications. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. Non-controlled expired medications are destroyed using Drug Buster on an as-needed basis in the presence of two registered nurses (RNs). All controlled medications are destroyed by the pharmacist in the presence of two witnesses (RNs). Medication pass was able to be observed during the annual compliance review with no issues noted. Five interviewed staff reported the nurses dispense medication to youth. One staff member added a trained supervisor can dispense medication if the nurses are not on-site. Two youth reported the nurse give them medication and three youth reported they do not take medication. Both youth who reported they take medication could described the process.

## 4.16 Medication/Sharps Inventory and Storage Process

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures in place ensuring the appropriate storage of all medication and equipment classified as sharps. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed separated. All controlled substances were observed maintained behind two locks, stored separately from other medications, and had a perpetual inventory. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed documented on the youth's individualized Controlled Medication Inventory Record. A shift-to-shift inventory of all controlled medications was observed. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. The reviewer observed the registered nurse (RN) inventory two youth medications, one being a narcotic/controlled medication, three OTC medications, and three sharps all of which matched the perpetual inventory. Reporting criteria and procedures for inventory discrepancies are in place. Perpetual inventories of medications and sharps for the previous six months were available for review. According to the RN, medication inventory is completed weekly and daily. The RN explained medication is destroyed using Drug Buster in the presence of two nurses, and controlled medication is disposed of in the presence of the

pharmacist and two nurses. The RN added, controlled medication is stored in a locked box within the secure medication cart.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed separated. The program does not currently have any youth taking a controlled substance; however, appropriate storage for controlled substances was observed (two locks and separate). The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed documented on the individualized Controlled Medication Inventory Record for a youth who was previously prescribed a controlled substance. The registered nurses (RNs) complete a shift-to-shift inventory of all controlled medications, documentation from the previous six months was observed. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. The RN completed an inventory of two youth medications in the presence of an annual compliance re-review team member, both matched the inventory. An inventory of controlled medications was not able to be observed as no youth at the program are currently prescribed a controlled substance. In addition, the RN completed an inventory of three sharps and three OTC medications in which both matched the perpetual inventory. Reporting criteria and procedures for inventory discrepancies are in place. Perpetual inventories of medications and sharps for the previous six months were available for review. The RN was able to explain the processes for storage of medications and sharps, as well as inventory and disposal of medications.

## 4.17 Infection Control/Exposure Control

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulation and the Center for Disease Control (CDC) guidelines. The program's infection control procedures include the following: common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. The hepatitis B immunization is available to staff. There have been no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The program director or designee will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's Exposure Control Plan was found to be written in accordance with Occupational Safety and Health Administration (OSHA) standards. The plan is available to all staff. The plan is reviewed and signed annually by the program. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. According to the program director, the plan is located within the facility operating procedures, is covered in pre-service training, and will be reviewed annually. The registered nurse (RN), a copy of the infection control and exposure control plans are located in the medical office and the program director's office.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as according to the Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC) guidelines. The program's infection control procedures include common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. The hepatitis B immunization is available to staff. There have been nine instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified and were notified, as required. All instances were related to the COVID-19 pandemic. The program has a comprehensive process for needle stick post-exposure evaluation. The program director or designee will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with OSHA standards. The plan is available to all staff. The plan is reviewed and signed annually by the program. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. The program has had more than three cases of reportable infectious disease, all of which were reported to the local county health department and CCC, as required, and within the appropriate timeframes. In the previous ninety days, the program has had to quarantine an estimated thirty-five percent of the youth population due to the COVID-19 pandemic. According to the program director, the exposure control plan is located within the facility operating procedures (FOPs) and is reviewed during pre-service and annually with staff.

## 4.18 Prenatal Care/Education

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. This is an all-male program; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. This is an all-male program; therefore, this indicator rates as non-applicable.

## Standard 5: Safety and Security

### 5.01 Youth Supervision (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures addressing youth supervision. The program's youth to staff ratios were one-to-eight during awake time, one-to-twelve during sleep hours, and one-to-five for off-site activities or when youth are working with tools. On the first day of the annual compliance review, youth were observed in education classes and movement between areas. One staff was asked how many youth were in the classroom and responded with the accurate count and could verify where the remainder of the youth who also were assigned to his class. Staff were observed being positive and pro-active by helping a youth with his work. Staff were observed in proper positioning with one staff in the front and one staff in the back of class. Staff were engaged and assisting the youth. On the second day, youth were observed outside having recreation. One staff was seen playing basketball with the youth. On the third day, the staff were observed being in proper positioning while the youth were running laps around A dorm. On the fourth day, staff were observed escorting youth to dinning facility. The youth were orderly, and one staff was posted at the front of the line and one in the rear.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place requiring staff to maintain active supervision of youth. The program's youth to staff ratios are one-to-eight during awake hours, one-to-twelve during sleep hours, and one-to-five for off-site activities or when youth are working with tools. On the first day of the annual compliance re-review, youth were observed on "A" court shooting basketball. One staff was with six youth, and staff were properly positioned to supervise the youth. On the second day, youth were observed leaving school and were searched by staff, in ratio. On the third day, the staff were observed conducting basketball drills with the youth on the basketball court, with one program staff supervising youth and the shift supervisor conducting the drills. On the fourth day of the review, staff were observed supervising seven youth in the classroom.

### 5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The programs written policy and procedures outlines the behavior management strategies designed for youth to comply with daily rules and expectations, as well as offer guidance to change behaviors, thus increasing accountability for the youth. According to the program director, the program's behavior management system (BMS) is clearly written and is in the program's manual and student handbook. The BMS system shows the youth can receive items once a month from the point store, and the youth on the Ram level can go off campus to different events. The BMS was observed posted throughout the program; however, it is clearly written in the youth handbook. All seven youth records were reviewed and reflected documentation of receipt of handbook and orientation, which was signed and dated by staff and youth. Seven interviewed youth were able to explain the program's level system, as well as describe types of rewards and consequences. Seven interviewed youth were able to describe the BMS to include incentives offered to the youth. One reported there are no real rewards, three stated they receive rewards once a month, one stated Ram level youth have outings, one stated staff bring in games for the higher level youth to play. Staff complete point cards weekly and Daily Progress Notes are completed daily.

Seven interviewed staff revealed things such as privileges can be taken away from youth as a consequence. Seven interviewed youth were able to describe the BMS to include incentives offered to the youth. The program director interview revealed the program monitors consequences by incident reports.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures which outlines the behavior management strategies designed for youth to comply with daily rules and expectations, as well as offer guidance to change behaviors, thus increasing accountability for the youth. According to the program director, the program's behavior management system (BMS) is clearly written and is in the program manual and student handbook. Five interviewed staff described the BMS to include incentives offered to the youth, point system, and level system. The BMS shows the youth can receive items once a month from the point store and the youth on the highest level can go off campus to different events; however, due to the COVID-19 pandemic, youth are not able to attend off-site events. The BMS was observed posted throughout the program and is clearly written in the youth handbook. All five youth records were reviewed and reflected documentation of receipt of handbook and orientation, which was signed and dated by staff and youth. Five interviewed youth were able to explain the program's level system, as well as describe types of rewards and consequences. Five interviewed youth describe the BMS to include incentives offered to the youth.

**5.03 Behavior Management System Infractions and System Monitoring**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program policy and procedures to ensure the staff are provided with feedback regarding their implementation of the behavior management system (BMS). The program does not use room restriction; therefore, this was not observed by the annual compliance review team. The BMS allows staff to explain the reason for any sanction imposed on a youth and youth given an opportunity to explain their behavior. A review of a position description for a coach counselor is reflected as an implementation of the BMS as an essential function. A review of the provider's contract reflected all required parties were involved in the development, implementation, and on-going maintenance of the BMS. Seven staff records reflected all completed training, but one still has time to complete it on the BMS. Each of the seven interviewed staff reported youth are informed of consequences immediately and are given an opportunity to explain themselves. Seven youth interviewed, reported youth are not allowed to punish other youth. According to the program director, the BMS can be found in the youth handbook and is monitored through arms distances training, methodic, and focus of the week. The program director (PD) stated arms distance training is where a supervisor is on the floor working hand in hand with staff to ensure they are properly utilizing the behavior management system (BMS). Methodic is where the supervisor grade staff throughout the year on their performance leading up to their evaluation. Focus of the week is normally based around parts of the BMS.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures to ensure the 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. The program does not utilize room restriction; therefore, this was not observed by the annual compliance re-review team. The BMS allows staff to explain the reason for any sanction imposed on a youth, and the youth is given an

opportunity to explain their behavior. A review of the program's contract reflected all required parties were involved in the development, implementation, and on-going maintenance of the BMS. According to the program director, the BMS can be found in the youth handbook. Five staff records reflected all staff received training on the BMS. Each of the five interviewed staff reported youth are informed of consequences immediately and are given an opportunity to explain themselves. Five interviewed youth reported youth are not allowed to punish other youth. The youth reported rewards include food, point store, and trips outside of the facility. Each of the youth explained each level of the BMS. The youth reported all staff use rewards the same. Three of the youth rated the BMS as fair, the remaining two rated the BMS as good.

**5.04 Ten-Minute Checks (Critical)**

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures to address ten-minute checks. The program has a total of fifty-eight cameras of which all are currently operational. The video recording is stored for thirty days. Three sample dates for two separate dorms were reviewed for ten-minute checks. A review of the check sheets revealed checks were not completed in real time. The sheets were not filled out completely. A review of the video coverage and check sheet revealed staff on two occasions documented a check which was not observed on the video. The Department's Central Communication Center was contacted by the program for falsification and a report was taken. Seven interviewed staff revealed room checks are conducted when a youth is placed in their room for sleeping or non-punishment reasons every ten minutes.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has fifty-eight cameras and all fifty-eight were operational at the time of the annual compliance re-review. The program director stated the digital video recording (DVR) system holds thirty days of recordings. A sample of five random ten-minute checks dates on various shifts and times were observed and compared with the ten minute check form. The ten minute check form and the camera times for each check matched. Ten-minute checks were conducted by staff and each were ten minutes apart between room checks. The actual time of the check was logged on the check form as opposed to a check mark. The staff conducting the check initialed beside the time. Each staff initials next to each time entered on the ten-minute check form. A total of six different staff were observed during the ten-minute check review. Each staff used flashlights when looking into the youths' rooms. Five staff were interviewed, and each staff stated youth checks must be conducted every ten minutes or less.

**5.05 Census, Counts, and Tracking**

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures outlining census, counts, and tracking. According to the procedures, the shift supervisor is responsible for all counts which includes formal, informal, and emergency counts. Counts were observed taking place throughout the annual compliance review. Counts were observed to be documented in the logbook. Logbook documentation also reflected daily census counts, head counts, youth movements, new admissions, releases, transfers, and youth off-site. Additionally, counts are conducted at the beginning of each shift, after each outdoor activity, and during mock drills. Four log books were reviewed and did not indicate or display the counts were being conducted at the beginning or the end of the shift. Random counts were completed and documented. An interview with the shift supervisor stated

headcounts are conducted at the beginning of each shift, randomly, and at the end of the shift. The program was using two logbooks but only one was being utilized for the entire program.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures outlining counts and daily census. According to the procedures, the shift supervisor is responsible for all counts including formal, informal, and emergency counts. Counts were observed during the annual compliance re-review. Counts were documented in the master control logbook. Logbook documentation also reflected daily census counts, head counts, youth movements, new admissions, releases, transfers, and youth off-site. Additionally, counts were conducted at the beginning of each shift, after each outdoor activity, and during drills. Logbooks from January to June 2020 were reviewed and indicated counts were conducted at the beginning and the end of A-Shift and B-shift. Random counts were completed and documented. The shift supervisor was interviewed and stated headcounts are conducted at the beginning of each shift, randomly, and at the end of the shift. The program uses one logbook and it is kept in master control.

**5.06 Logbook Entries and Shift Report Review**

The program originally received a **Limited Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing logbooks and shifts reports. Four logbooks were observed to be bound with numbered pages, not falling apart or missing any pages, and one was in a binder. Logbooks for the previous six months were reviewed. The program documents emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts, transports away from the program, youth placed on observation, admissions, and releases. Logbook entries were made with black/blue ink. According to the policy any errors are to be struck through with a single line, dated, and initialed by the person correcting the error. There were no errors observed. Observation of each entry included the time of event but not specifying if it was am or pm. B-Shift logbooks indicated there were no documents past 10:00 pm through approximately 5:00 am. The program documents specific entries with colors such as yellow for head counts, admissions, and releases. The program does not maintain living unit logbooks. Shift reports are completed by each shift supervisor and include a summary of events, incidents, activities, and alerts. Staff members signatures were missing on several shift reports, indicating they have reviewed the shift report before exiting master control. Shift reports were missing and there were no signatures starting until December 10, 2019. Internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center(CCC) were not documented in the logbook on a separate log labeled internal incidents.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing logbooks and shifts reports. Logbooks from January to June 2020 were observed to be bound with numbered pages, not falling apart, or missing any pages. The program documents emergency situations, incidents, special instructions for supervision and monitoring of youth, population counts, transports away from the program, youth placed on observation, admissions, and releases. Logbook entries were made with black/blue ink. No errors were observed. Each observed entry included the time of event. The program highlights specific entries in colors, such as yellow, for head counts, admissions, and releases. The program does not maintain living unit logbooks; however, one main logbook is located in master control. Shift reports are completed by each shift supervisor and include a summary of events, incidents, activities, and alerts. A review of seven shift reports found staff signatures were missing from two of reports Shift reports were accounted for starting from January to June of 2020. Additionally, the shift

supervisor will verbally brief staff about the contents of the reports. A review of the logbooks revealed internal incidents reported to the Florida Abuse Hotline and/or the Central Communications Center (CCC) were documented.

**5.07 Key Control (Critical)**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing key control. The program's key control system is as follows: all staff and visitors turn in their personal keys at the entrance of the administration building at the front desk and receive a chit to get their keys when leaving. Observations of distribution and the collection of keys was conducted during the annual compliance review. A review was completed of the daily inventory of all keys and were examined by the reviewer. Keys are stored in a locked cabinet in the shift supervisor's office when not in use and only the shift supervisor has access to the key cabinet during the shift. Youth do not have access to this area. The key assignments are made by the shift supervisor and staff must sign in and sign out for their keys. Certain areas have limited or restricted access (medical, food storage, youth records, staff records) and are, therefore, only assigned to staff which require access to these areas. In the event a key is lost, the program's procedure states it is reported immediately to the shift supervisor, the program director will be notified, a search will be conducted, and an incident report will be completed. If a key is damaged and needs replacing, staff will notify their supervisor and a Maintenance Request form will be completed. The program reported it has not had an incident of lost or missing keys in the past six months. According to the shift supervisor, restricted keys are kept in the director's office secured in a box, signed for and no other staff can utilize these keys. A random check of three staff members was conducted and all had program keys and stated their keys were in a secure box in the shift supervisor office. The shift supervisor was able to explain the key control process and what to do in the event of a lost or damaged key. Seven staff were interviewed, and they were all able to explain the key control process.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing key control. All staff and visitors turn in personal car keys at the entrance of the administration building at the front desk. Staff are assigned keys to their assigned mod and must return the keys in order to receive their personal keys when leaving. Observations of the distribution and the collection of keys was observed during the annual compliance re-review. A review was completed of the daily inventory of all keys and were examined by the reviewer. Keys are stored in a locked cabinet in master control when not in use and only the shift supervisor has access to the key cabinet during the shift. Youth do not have access to this area. The key assignments are made by the shift supervisor and staff must sign in and sign out keys. Certain areas of the program have limited or restricted access (medical, food storage, youth records, and staff records); therefore, keys are assigned to staff which require access to these areas. In the event a key is lost, the program's procedures state the missing keys shall be reported immediately to the shift supervisor and the program director will be notified. A search will be conducted, and an incident report will be completed. If a key is damaged and needs replacing, staff will notify the supervisor and a maintenance request form will be completed. The program reported there has not been any incidents of lost or missing keys in the past six months. According to the shift supervisor, restricted keys are kept in the program director's office secured in a box, signed for, and no other staff can utilize these keys. A random check of three staff members found each staff had program keys with personal keys located in a secure box in the shift supervisor's

office. The shift supervisor explained the key control process and what to do in the event of a lost or damaged key.

## 5.08 Contraband Procedure

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a policy and procedures to address illegal contraband and prohibited items. The program's policy also incorporated the Department of Juvenile Justice Guidelines Relating to Contraband in Residential Facilities. The program defines items and materials considered as contraband. Youth are provided with a list of contraband within their youth handbook. Youth are informed of search procedures. The program's policy includes searches of the youth dorms, program grounds, before and after visitation and home visits, and searches of incoming and outgoing mail. Program administration was interviewed and confirmed all youth items are searched in the youth's presence. The policy indicated any illegal contraband which should be discovered will be turned over the law enforcement. The program's policy, employee handbook, and staff's list of contraband items address violations of work standards and disciplinary action to include unbecoming conduct and willful violation of laws and program rules. The shift supervisor conducts the program searches of randomly selected program areas for each shift daily. The completed search forms were maintained in binders. Contraband forms where missing for A-mod from October to March and for B-mod from March to June. There were dates and signatures missing. The shift supervisor was interviewed and stated if contraband is discovered, a contraband report is submitted.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing the prevention of and searching for contraband within the facility grounds. The program's policy also incorporates the Department's \ Guidelines Relating to Contraband in Residential Facilities. The program defines items and materials considered as contraband. Youth are provided with a list of contraband within the youth handbook and are informed of search procedures. The program's policy includes searches of the youth dorms, program grounds, before and after visitation, home visits, and searches of incoming and outgoing mail. The program director was interviewed and confirmed all youth correspondence is searched in the youth's presence. The policy indicated any illegal contraband which should be discovered will be turned over the law enforcement. The program's policy, employee handbook, and staff list of contraband items address violations of work standards and disciplinary action to include unbecoming conduct and willful violation of laws and program rules. The shift supervisor revealed the program searches randomly selected program areas for each shift daily. The completed search forms are maintained in binders. All contraband forms from January to June 2020 were reviewed. There were two forms with no dates and signatures. The shift supervisor was interviewed and stated if contraband is discovered, a contraband report is submitted, the contraband is retrieved, disposed, and documented as needed.

## 5.09 Searches and Full Body Visual Searches

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing youth searches. During the annual compliance review, youth were observed being searched exiting the dorms and cafeteria, to education and vocational classes. Two staff were observed conducting searches and one was done correctly and one was not. Each youth was observed being searched by a staff member of the same sex

and was treated with dignity and respect. Neither an admission or visitation was able to be observed but a new intake search was observed being conduct by two staff of the same sex and staff failed to check youth clothing during the intake process. According to procedures, all new admissions and youth returning from a home visit participate in a full body visual search by two staff members of the same sex. The purpose of the search is explained to the youth and searches are conducted in accordance to the Protective Action Response (PAR) training manual. All seven interviewed youth reported searches are conducted when returning after visitation. Three of the seven interviewed staff reported searches were also conducted after returning from any off-campus activity and after meals and four reported during every movement. Seven staff reported youth are searched during all movement, leaving and returning to campus, going inside and outside, and after vocational activities. Searches are also outlined in the student handbook.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing youth searches. During the annual compliance re-review, observations found youth were searched exiting the basketball court, cafeteria, and education. Staff were observed conducting searches correctly. Each youth was searched by a staff member of the same gender and was treated with dignity and respect. Neither an admission or visitation were able to be observed during the annual compliance re-review. According to procedures, all new admissions and youth returning from a home visit participate in a full body visual search by two staff members of the same gender. The purpose of the search is explained to the youth and searches are conducted in accordance to the Protective Action Response (PAR) training manual. Five interviewed youth reported searches are conducted when youth return after meals and four reported during every movement. Five interviewed staff reported youth are searched during all movement, leaving and returning to campus, going inside and outside, and after vocational activities. Searches are also outlined in the student handbook and documented in the logbook.

## 5.10 Vehicles and Maintenance

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures ensuring all vehicles which transport youth are appropriately maintained and operational. The program utilizes two vehicles to transport youth. A maintenance binder is kept for each vehicle. Documentation reflected each vehicle had an annual safety inspection completed, as required. The two vans were equipped with the appropriate number of seatbelts, a seatbelt cutter, and window punch. One of the vans was missing a fire extinguisher and window punch during an inspection of the vehicle. The missing items were added to the van prior to the end of the annual compliance review. First aid kits are not stored in the vehicle and must be signed out for transport from the program director's office. First aid kits designated for transport were observed and contained all approved items. A random check of personal vehicles in the parking lot was completed during the annual compliance review, in which the vehicles checked were found to have one vehicle unsecure. Staff and youth were both observed wearing seatbelts. At no time during the observation was the youth attached to any part of the vehicle by any means other than a seatbelt.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures ensuring all vehicles which transport youth are appropriately maintained and operational. The program utilizes two vehicles to transport youth. One was available for review due to transports conducted. A maintenance binder is kept for each vehicle. Documentation reflected each vehicle had an

annual safety inspection completed, as required. The one van reviewed was equipped with the appropriate number of seatbelts, a seatbelt cutter, window punch, and fire extinguisher. First aid kits are not stored in the vehicle and must be signed out for transport from the program director's office. First aid kits designated for transport were observed and contained all approved items. A random check of personal vehicles in the parking lot was completed during the annual compliance review, all vehicles were found secured.

## 5.11 Transportation of Youth

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing youth transports and ensures compliance of all requirements outlined by the Department relating to the transportation of youth and driver eligibility. According to the program's written policy and procedures, staff to youth ratio for youth transport is one-to-five and requires two staff members for youth who pose a high security risk. A new intake transport was observed during the annual compliance review. The youth was searched by a staff member of the same gender. One of the two vehicles utilized for transport did not have youth passenger doors which can be opened from the inside. Youth do not operate vehicles and are not left unsupervised in the vehicles. The program staff with valid driver's license are approved drivers in which a driver's license check is conducted annually by the program's human resource specialist, through Florida Department of Highway Safety and Motor Vehicles, for each of those staff members. A transport phone is checked out in the shift supervisor's office prior to a transport.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing transportation of youth. According to the program's policy and procedures, the staff to youth ratio for youth transport is one-to-five and requires two staff members for youth who pose a high security risk. Two transports returning from the dentist's office were observed during the annual compliance review. The youth were searched by a staff member of the same gender. One of the two vehicles utilized for transport were checked and met policy requirements with items listed. Youth do not operate vehicles and are not left unsupervised in the vehicles. The program staff with valid driver's licenses are approved drivers. A driver's license check is conducted annually by the program's human resource specialist, through Florida Department of Highway Safety and Motor Vehicles (FDHSMV), for each of those staff members. A transport phone is checked out in the shift supervisor's office prior to a transport. Five interviewed staff revealed transport vehicles are searched for contraband prior to and after each use.

## 5.12 Weekly Safety and Security Audit

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures outlining the weekly safety and security auditing process. The program director is the staff designated to complete these checks as required. The program was missing copies of Weekly Safety and Security Audit check sheets. A review of these documents found the program has not been consistent with logging the checks every seven days. The program was missing logs from June to September and from September to December. The program director revealed the program conducts week safety and security audit. Safety and security deficiencies are prioritized based on importance and fixed as soon as possible.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures outlining the weekly safety and security auditing process to include who is responsible for conducting the audits, the development of any corrective actions needed, and an internal system to verify the deficiencies are corrected, and existing systems improved to maintain compliance. The program director completes the weekly safety and security checks, as required. A review of weekly safety and audit documents revealed the checks were completed every seven days, as required. The program director revealed weekly safety/security inspections are conducted and documentation is sent over to the department. If issues are found, the maintenance department of the program or and outside vendor completes the issue.

## 5.13 Tool Inventory and Management

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing tool inventory and management. Maintenance staff keep tools on-site and secured in the maintenance building. A maintenance tool binder was available for review in which maintenance staff signs tools in and out, as needed. Tools which are utilized in the kitchen and in culinary class were kept in a secure storage box with a shadow board. These items are inventoried daily and monthly but was not consistently completed, as well as signed in and out as they are used. Inventory and sign in/out sheets were available for review. Each dorm has two brooms, one mop, one mop bucket, and one dust pan assigned. Inventories for these items were also available for review and matched the items in each of these areas. All tools were stored when not in use, in an area not accessible to youth. Tools were found clearly marked for easy identification. Documentation reflected staff were trained on the intended and safe use of tools. Based on the interviews of the seven youth, they are only allowed to use the mops and brooms. In the event a tool is lost or missing, a search of the program and the youth will be conducted until the item is located. If the item cannot be located, and is determined linked to another reportable incident, the Department's Central Communications Center (CCC) will be notified within the required timeframe.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures addressing tool inventory and management. Maintenance staff keep tools on-site, secured in the maintenance building. A maintenance tool binder was available for review in which maintenance staff sign tools in and out, as needed. Tools utilized in the kitchen and in culinary class are kept in a secure storage box with a shadow board. A review of inventories and sign-in/out sheets revealed tools are inventoried daily and monthly, as well as signed in and out as they are used. Each dorm has two brooms, one mop, one mop bucket, and one dust pan assigned. Inventories for these items were reviewed and matched the items in each of these areas. All tools are stored when not in use in an area inaccessible to youth. Tools are clearly marked for easy identification. A review of five staff records determined each staff received training on the intended and safe use of tools. Five interviewed youth reported only using mops and brooms. In the event a tool is lost or missing, a search of the program and the youth will be conducted until the item is located. If the item cannot be located, and is determined linked to another reportable incident, the Department's Central Communications Center (CCC) will be notified within the required timeframe of two hours.

## 5.14 Youth Tool Handling and Supervision

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing youth handling tools. According to the written policy and procedures, when using tools, the staff to youth ratio is one-to-three during work activities or vocational training. At the time of the annual compliance review, no youth were observed using any tools. Kitchen staff stated no youth has access to the knives, and they are secured in a lock box when not being used. Risk assessments are completed for all youth in the program. The risk assessment indicates if youth are authorized to work with tools. Youth were observed throughout the annual compliance review week being searched upon entering and exiting education and vocational classes. Seven interviewed staff reported youth use mops, and brooms. Youth interviews revealed youth are allowed to use mops and brooms unless they are participating in vocational training in which they are allowed to use other tools under adult supervision.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place addressing youth handling tools. According to the policy, when using tools, the staff to youth ratio is one-to-three during work activities or vocational training. Youth were observed using tools and the program was in compliance with the ratio. Kitchen staff stated no youth has access to the knives, and the knives are secured in a locked box when not in use. Risk assessments are completed for all youth in the program. The risk assessment indicates if youth are authorized to work with tools. Risk assessments for each of the five selected youth were reviewed and determined reassessments were completed, as required. Observations determined youth were searched upon entering and exiting education and vocational classes. Staff from the Home Builders Institute at the program was interviewed explained the search procedures, ratios, and tools distribution and collection during a work project. Five interviewed staff reported youth are allowed to use mops and brooms. Five youth interviewed revealed they are only allowed to use brooms and mops.

## 5.15 Outside Contractors

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures outlining the process for outside contractors. A binder for outside contractors was available for review. All outside contractors are required to sign a vendor agreement prior to entering program which includes: all tools are inventoried prior to entering and exiting the program, what tools are restricted by the program, youth restriction from the work area, and missing tool procedures. The vendor agreement is signed and dated by the contractor and witnessed by a staff member. Additionally, the contractor then completes a tool inventory sign in and out form which is also verified/witness by the administrative staff. A review of project invoice was conducted and the date the project was being worked on matched the sign-in-sheet of the outside workers.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures outlining the process for outside contractors. The program has separate binder for outside contractors to sign in and out. All outside contractors are required to sign a vendor agreement prior to entering the program which includes: all tools are inventoried prior to entering and exiting the program, what tools are restricted by the program, youth restriction from the work area, and missing tool procedures.

The vendor agreement is signed and dated by the contractor and witnessed by a staff member. Additionally, the contractor then completes a tool inventory sign in and out form which is also verified and witnessed by the administrative staff. A review of project invoices submitted to the program by the vendors was conducted and the dates the project was being worked on and/or completed matches the sign-in sheets of the outside workers. There was documentation of the program conducting inventory on the tools and other equipment when the vendor leaving. According to the written policy and procedures, the program director may authorize the introduction of an electronic device into the secure area by a visitor if the device is issued by the visitor's employer for conducting official business.

## 5.16 Fire, Safety, and Evacuation Drills

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures ensuring fire, safety, and evacuation drills are conducted to ensure the youth and staff are prepared for immediate implementation in the event of an emergency or disaster. According to policy, the program conducts fire drills monthly and on each shift. There was no documentation of six drills of the required drills for B-shift. Drill documentation includes the type of drill, date, and time. Drills for the previous six months included monthly fire drills and two evacuation drills. Fire evacuation route and plans were observed to be posted throughout the program. According to the program director, all shifts are required to conduct drills and these drills include, but are not limited to, fire, severe weather, program disturbances, bomb threats, hostage situation, chemical spills and flooding. Seven interviewed youth report they participate in fire drills and could explain what to do during the drill. Seven interviewed staff report they have participated in fire drills. All fire extinguishers were serviced and up to code.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures ensuring fire, safety, and evacuation drills are conducted to ensure the youth and staff are prepared in the event of an emergency or disaster. The program conducts fire drills monthly and on each shift. Drill documentation included the types of drill, dates, and times. Drills from January to June 2020 included monthly fire drills and two evacuation drills (bomb and weather). Fire evacuation route and plans were observed posted throughout the program. According to the program director, all shifts are required to conduct drills, these drills include, but are not limited to, fire, severe weather, program disturbances, bomb threats, hostage situation, chemical spills, and flooding. Five interviewed youth reported participating in fire drills and could explain what to do during the drill. Five interviewed staff report they have participated in fire drills. All fire extinguishers were found to be inspected annually.

## 5.17 Disaster and Continuity of Operations Planning (COOP)

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a Continuity of Operations Plan (COOP) located on each module and in administration. The plan is readily available to staff. There was documentation of the COOP being submitted to the Department for approval. The plan found it was reviewed on April 9, 2019. A review of the plan found it addressed alternative housing plans approved by the applicable Department's regional director or designee.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program's written disaster and Continuity of Operations Plan

(COOP) was easily accessible and is readily available to staff in the program's trainer's office. The COOP was updated and submitted on February 27, 2020 to the Department's residential regional director. The COOP was reviewed and signed by the regional director or April 3, 2020. Provision of equipment and supplies required for continuous operation and services were observed. The program director stated the COOP was in the master control room. The COOP contains fire and fire prevention, evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff rolls and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions of continuity of care and custody of youth, and provisions for public protection. Staff contact information was also listed with the COOP Plan.

## 5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing flammable, poisonous, and toxic control. According to the procedures, a current list of staff authorized to handle chemicals is maintained at each location in which chemicals are stored. Flammable, poisonous, and toxic items are secured always in areas inaccessible to youth. Chemicals used in the kitchen were observed to be stored in a locked closet. Chemicals used on the dorm are stored in a closet behind locked doors. Chemicals were not properly being signed in and out. The sign-in and sign-out sheets only indicated date but no signatures. Inventories matched the items on hand and included corresponding Safety Data Sheets (SDS).

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing flammable, poisonous, and toxic control. According to the policy, a current list of staff authorized to handle chemicals is maintained at each location in which chemicals are stored. A tour of the program found flammable, poisonous, and toxic items were secured in areas inaccessible to youth. Chemicals used in the kitchen were observed to be stored in a locked closet. Chemicals used on the dorm are stored in a secured office. All chemicals were properly being signed in and out. A review of the inventories of the flammable, poisonous, toxic items found there were no missing or additional items not on the inventories. Inventories matched the items on hand and included corresponding Safety Data Sheets (SDS).

## 5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing youth handling and supervision for flammable, poisonous, toxic items and materials. The program maintains strict control of all flammable, poisonous, toxic items, and materials is secured in the maintenance room at all times. Youth do not use, handle, or clean up dangerous or hazardous materials. Youth do not clean, handle, or dispose of any person's biohazardous material, bodily fluids, or human waste. Flammable, poisonous, and toxic items are always secured in areas inaccessible to youth. Seven interviewed youth reported they do no use chemicals or cleaning agents.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing youth handling

and supervision for flammable, poisonous, and toxic items and materials. The program maintains strict control of all flammable, poisonous, and toxic items and materials and is secured in the maintenance room at all times. Youth do not use, handle, or clean up dangerous or hazardous materials. Youth do not clean, handle, or dispose of any person's biohazardous material, bodily fluids, or human waste. Flammable, poisonous, and toxic items are always secured in areas inaccessible to youth. Youth were not observed during cleaning activities. Five interviewed youth reported they do no use chemicals or cleaning agents.

**5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures which outline the process for disposal of flammable, toxic, caustic, and poisonous items. Disposal procedures are completed in accordance with Occupational Safety and Health Administration (OSHA) Standards. A review of the program's chemical storage found a supply of cleaning products. According to the maintenance staff, all hazardous materials are disposed of in accordance with state and local regulations and removed by the Hamilton County Waste Management. The program director interview revealed the program follows OSHA protocols and contacts a local agency to dispose flammable, toxic, caustic, and poisonous items.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures which outline the process for disposal of flammable, toxic, caustic, and poisonous items. Disposal procedures are completed in accordance with Occupational Safety and Health Administration (OSHA) Standards. A review the program's disposal log determined these items are disposed of as needed through the Hamilton County Waste Center. According to the maintenance staff, all hazardous materials are disposed of in accordance with state and local regulations and removed by the Hamilton County Waste Management. The program director revealed the maintenance staff disposes flammable, toxic, caustic, and poisonous items at the Hamilton County hazardous waste center.

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

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's policy and procedure confirm the program does not participate in water activities; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. The program's policy and procedure confirm the program does not participate in water activities; therefore, this indicator rates as non-applicable.

**5.22 Visitation and Communication**

The program originally received a **Satisfactory Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures which outline the visitation schedule for youth. Visitation is conducted on Sundays from 1:00 p.m. until 4:00 p.m. The visitation schedule was observed posted within various program areas. Procedures for visitation, as well as telephone and mail procedures were also noted within the youth handbook. A review of seven youth case management records revealed each youth received and signed for a youth handbook upon their

admission. The program allows youth the opportunity to participate in home visits, when they are on the appropriate level in accordance with the behavior management system, and if they are within the transition phase of their commitment. In addition to visitation, youth are afforded the opportunity to communicate with family through mail and telephone. Youth are also given the opportunity to make a call home once a week. All incoming and outgoing mail is checked by the assigned case manager for contraband. This was also confirmed through an interview conducted with the program director. Seven youth interviews were conducted, and all confirmed they are given the opportunity to speak with family on a regular basis.

During the annual compliance re-review, the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures which outlined the visitation schedule for youth. Visitation is conducted on Sundays from 1:00 p.m. until 4:00 p.m., however since the COVID-19 pandemic, there has been no in-person visitation. The program utilizes FaceTime and Zoom to conduct visitation as of the date of the annual compliance review. The visitation schedule was observed posted in various areas throughout the facility. Procedures for visitation, as well as telephone and mail procedures were also noted within the youth handbook. A review of five youth case management records revealed each youth received and signed for a youth handbook upon admission. The program allows youth the opportunity to participate in home visits when they are on the appropriate level in accordance with the behavior management system, and if are in the transition phase. However, due to the COVID-19 pandemic, home visits have been canceled. In addition to visitation, youth are afforded the opportunity to communicate with family through mail and telephone. Youth are also given the opportunity to make a call to their families once a week. All incoming and outgoing mail is checked by the assigned case manager for contraband. This was also confirmed through an interview conducted with the Program Director. Five youth interviews were conducted, and all confirmed they are given the opportunity to call or send a letter to their parent/guardian on a regular basis.

## 5.23 Search and Inspection of Controlled Observation Room

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

## 5.24 Controlled Observation

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. The program's 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 and Release Procedures

The program originally received a **Non-Applicable Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the annual compliance re-review, the program received a **Non-Applicable Compliance rating** for this indicator. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

## 5.26 Safety Planning Process for Youth

The program originally received a **Failed Compliance rating** for this indicator during the 2019-2020 annual compliance review, conducted December 10-13, 2019. The program has a written policy and procedures addressing youth safety plans. A review of five youth records found all had a safety plan, but were missing dates and signatures, and one was missing an admission card. Four of the safety plans were not completed within fourteen days of admission. The safety plans were only developed with the youth and clinical staff. The youth parent/guardians were not involved in the development of the youth plans. A review of five safety plans found none had been updated every thirty days. The was no documentation of the safety plans incorporating any recommendations from previous or current clinical assessments or screening instruments. The youth safety plan binder is located in the case management's office.

During the annual compliance re-review, the program received a **Limited Compliance rating** for this indicator. The program has a policy and procedures addressing youth safety plans. A review of five youth records found all youth had a safety plan. Four of the five youth showed safety plans were not completed within the fourteen-day time frame after the youth enter the program. Three of the plans were forty-two days late and the other plan was fifteen days late. There was no therapist signature in four of the five safety plans. A review of five safety plans found four of the plans were not updated every thirty days. The youth safety plan binder was located in the case management office.