STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Oak Grove Academy

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

Review Date(s): December 10-13, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

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

Program Name: Oak Grove Academy
Provider Name: Rite of Passage, Inc.
Location: Hamilton County / Circuit 3
Review Date(s): December 09-13, 2019

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

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Overall Rating Summary for Standard 2

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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

Indicator Ratings

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

Overall Rating Summary for Standard 3

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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

Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

Program Overview

The Oak Grove Academy is a start-up program which 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, Active Parenting, Impact of Crime, Aggression Replacement Therapy (ART), and Seeking Safety. Additional treatment services provided includes family, individual, and group therapy, equine therapy, and 4-H. Program administration is comprised of a program director, an equine program director, a staff development coordinator, and a shift supervisor. Case management and mental health services are provided by the designated mental health clinician authority (DMHCA), two transition service managers, and five clinical counselors. 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, two part-time nurses, and one psychiatrist. Educational services are provided by the program through the use of eight teachers. 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 operating security cameras providing video coverage. At the time of the annual compliance review, the program had three vacant positions including one recreational therapist, one shift supervisor, and one therapeutic manager.

Standard 1: Management Accountability

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

The program 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 employees 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.

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

The program has a policy and procedures related to five-year rescreening. The program does not have any staff eligible for a five-year rescreening.

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

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

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

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 at 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 incidents which involved a complaint related to physical, psychological, or emotional abuse was 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. An interview with the program director revealed the program scheduled a Trauma Responsive and Caring Environment (TRACE) self-assessment for January 2020.

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

The program 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.

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

The program had 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.

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

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 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.

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

The program has a 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. Two One 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.

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

The program has a 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.

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

The program has a 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 were 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.

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

The program 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. the University of Cincinnati Correctional Institute for Substance Abuse (UCCISA). There was no documentation of training for two staff who were facilitating the trainings. One staff was facilitating T4C and the other staff was 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.

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

The program has a policy and procedures 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 programs 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.

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

The program utilizes the Impact of Crime (IOC) curriculum 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.

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

A review of the program's contract 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.

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

The program 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.

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

The program maintains a 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 offence. 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.

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

The program has a formal process to promote constructive input by 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.

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

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.

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

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 has 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.

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

The program has a policy and procedures 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.

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

The program has a policy and procedures 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 apart of each youth's performance or treatment plan. .

Standard 2: Assessment and Performance Plan

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

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.

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

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.

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

The program 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.

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

The program has a 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 dministration 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 form behavior and mental health.

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

The program has a written policy and procedures addressing gang identification. Three of seven youth records was 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.

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

The program 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.

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

The program 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.

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

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.

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

A review of seven youth records found five contained documentation indicating the Individualized Performance Plan (IPP) was developed within thirty days of admission ne 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 ntervention 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 within ten working days of completion of the IPP, 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.

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

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 Plan's (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.

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

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 erformance ummaries 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 were 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.

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

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.

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

The program'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.

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

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.

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

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' 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 were 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 were 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.

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

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.

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

The program 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.

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

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.

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

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.

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

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.

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

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 pending transition goals. The status of transition activities established at the transition conference were 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.

Standard 3: Mental Health and Substance Abuse Services

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

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.

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

The program's only licensed staff is the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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

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.

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

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 procedures (FOPs) 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 never had their MAYSI-2 completed until November 26, 2019. Five of the seven records had a MAYSI-2 completed in full in JJIS. One youth MAYSI-2 was not completed in full and the recommendation was left blank in JJIS, while another youth's MAYSI-2 was enter in 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 and 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.

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

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.

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

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.

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

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 plan was 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 no documentation 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.

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

The program is 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 monthly 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.

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

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 one applicable record with prescribed psychotropic medication. The initial diagnostic psychiatric interview included 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 on all three pages of the CPPN and if there was 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, other week, on Saturdays. The psychiatrist indicated initial psychiatric evaluations and medication management services are provided.

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

The program 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.

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

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 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.

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

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 was with them at all times and was not left alone for any period of time.

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

The program has a policy and procedures in place 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.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program has 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).

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

The program has a policy and procedures 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.

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

The program'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.

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

The program 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.

Standard 4: Health Services

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

The program's designated health authority (DHA) is a licensed physician (MD) who holds an 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 registered nurse practitioner (ARNP) who hold an clear and active license to practice in Florida. The ARNP's clinical specialty is in Family Health and license expires on April 30, 2021. The ARNP 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.

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

The program 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 health care personnel receive a comprehensive clinical orientation to the Department's health care 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	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

The program 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 health care 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.

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

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.

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

The program 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.

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

The program has a 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 health care orientation. Documentation in seven of seven records reviewed reflected youth received health care services orientation on the day of admission to the program. The program's health care orientation included the following: access to medical care, sick call, medication monitoring, what constitutes and "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.

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

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.

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

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).

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

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 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.

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

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.

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

The program has a written policy and procedure in place which provides youth with the opportunity to voice health care 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.

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

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 health care 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.

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

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.

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

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.

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

The program has a written policy and procedures 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.

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

The program 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-health care 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, mediation 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.

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

The program'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.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures addressing youth supervision. The program's youth to staff ratios were one- to- eight during awake time and 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 was observed in proper positioning with one staff in the front and one staff in the back of class. Staff was 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 in orderly fashion and one staff was posted at the front of the line and one staff in the rear.

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

The 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, 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.

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

The program 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 restrictions; 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). Methodics is where the supervisor grade staff throughout the year on their performance leading up to their evaluation. Focus of the weeks is normally based around parts of the BMS.

5.04 Ten-Minute Checks (Critical)	Failed Compliance
A residential commitment program shall ensure staff observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically.	

The program 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.

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

The program has 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.

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

The program 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 pass 10:00 p.m. through approximately 5:00 a.m.. 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.

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

The program has a 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.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program 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 handbookYouth 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 administrative were 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.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

The program 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.

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

The program has 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 unsecureStaff 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.

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

The program has a 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. Transport phone is checked out in the shift supervisor's office prior to a transport.

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

The program has a 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.

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

The program has a written policy and procedures addressing tool inventory and management. Maintenance staff kept 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.

5.14 Youth Tool Handling and Supervision	Satisfactory Compliance
There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.	

The program has a 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 that 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 the are participating in vocational training in which they are allowed to use other tools under adult supervision.

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

The program has a 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.

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

The program 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.

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

The program 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.

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

The program 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).

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

The program has a 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 report they do no use chemicals or cleaning agents.

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

The program has a written policy and procedures which outlines 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.

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

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

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

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

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

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

The program'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	Satisfactory Compliance

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

The program has a written 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. 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.

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

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

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

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

The program's policy, 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	Failed Compliance
A residential program shall conduct an on-going safety planning process for each youth. The safety plan shall be designed to identify stimuli which have both positive and negative effects on the youth.	

The program has a written policy and procedures 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.