STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Okaloosa Youth Academy

Gulf Coast Youth Services

(Contract Provider)
4555 Straightline Road
Crestview, Florida 32539

Review Date(s): April 30 - May 3, 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 that do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator that result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

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

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1)
Geneva Davis, DJJ Probation, Circuit One, Senior Juvenile Probation Officer, (Interviews)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Jessica Gibson, Office of Program Accountability, Technical Assistance
Specialist (SPEP)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 3)
Genie Omel, Twin Oaks Juvenile Development, Case Manager, (Standard 2)
Courtney Preston, Okaloosa Regional Juvenile Detention Center, Superintendent, (Standard 5)

Program Name: Okaloosa Youth Academy
Provider Name: Gulf Coast Youth Services
Location: Okaloosa County / Circuit 1
Review Date(s): April 30 - May 3, 2019

MQI Program Code: 830
Contract Number: 10288
Number of Beds: 60
Lead Reviewer Code: 144

Methodology

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.

Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
1 # Case Managers

1 # Clinical Staff
_____ # Food Service Personnel
2 # Healthcare Staff
1 # Maintenance Personnel
2 # Program Supervisors

3 # Staff
7 # Youth
_____ # Other (listed by title): _____

Documents Reviewed

☒ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☒ Egress Plans
☐ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☐ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
7 # Health Records
7 # MH/SA Records
37 # Personnel Records
7 # Training Records/CORE
3 # Youth Records (Closed)
7 # Youth Records (Open)
X # Other: **JJIS**

Observations During Review

☒ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☒ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☒ Transition/Exit Conferences
☒ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

	Standard 4 - Health Services	
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Satisfactory
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Okaloosa Youth Academy is a non-secure residential commitment facility which serves sixty male youth between the ages of thirteen and nineteen years old. The program is contracted through the Department with Gulf Coast Youth Services, Inc., located in Crestview, Florida. The program is co-located with Crestview Sex Offender Program. During the annual compliance review, there were a total of fifty-one youth on-site. The Okaloosa Youth Academy management team, which is shared with Crestview Sex Offender Program, consists of a program director, two assistant program directors, food service manager, five dietary workers, one maintenance personnel, a recreation specialist, a transition specialist, four case managers, director of nursing, two registered nurses (RN), a nursing director, clinical coordinator (referred to as the designated mental health clinical authority), seven therapists, and two juvenile sex offender therapists. The provider also has an agreement with a designated health authority (DHA) and a psychiatrist. The DHA is contracted to be on-site for two hours weekly on Mondays and is on-call twenty-four hours a day, seven days each week. The psychiatrist is required to be on-site twice a month and is also available twenty-four hours a day. The program had two vacancies for youth care workers and an RN vacancy at time of the annual compliance review. The program offers substance abuse overlay services (SAOS) and mental health overlay services (MHOS) for those youth diagnosed in need. The youth at the program participate in a variety of delinquency intervention groups scheduled throughout the week such as Impact of Crime (IOC), Thinking for Change (T4C), and ARISE. In addition, gender specific programming, which included Boys Council and Fathers in Training (FIT). Educational services are provided by the Okaloosa County School Department. Youth attend school five days a week and have the opportunity to earn credits as well as certifications within the vocational component, Home Builder's Institute, Inc. (HBI). The program is comprised of three youth housing units in which two are designated to house the Okaloosa Youth Academy population. The remaining housing unit is designated for the Crestview Sex Offender Program youth. The program has a master control room, which is operated by a master control operator who is responsible for documenting daily events within the logbook and reviewing the video surveillance system. The program has sixteen total cameras and fifteen were operational at the time of the annual compliance review. Gulf Coast Youth Services, Inc. employs a full-time training manager to coordinate training activities and develop training calendars and plans to meet pre-service and in-service training requirements for all staff.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

A total of thirty-six staff personnel records were reviewed for an initial background screening. Each of the thirty-six initial background screenings were completed prior to each staff's hire date. Additionally, a criminal history report was reviewed prior to each staff's hire date. Five of the thirty-six staff background screenings required an exemption prior to working with youth. Twenty-eight staff had a pre-employment assessment tool administered. Positions requiring a professional license, certification, or degree do not require a pre-employment assessment tool; therefore, six of the remaining eight staff were not applicable for the assessment. The remaining two staff were hired in 2017, prior to the revision of the Department's written policy on background screening and hiring procedures for contract provider employees and volunteers; therefore, a pre-employment assessment tool was not required for the remaining two employees. The program utilizes the assessment of care effectiveness as their pre-employment assessment tool. Each of the staff administered a pre-employment assessment had a passing score in their respective personnel record. The provider added each reviewed employee/volunteer to the clearinghouse employment roster. The provider reviews each potential hire for the program, by reviewing the Central Communication Center (CCC) person involvement history report, staff verification system (SVS) module, and Florida Department of Law Enforcement (FDLE) automated training management system (ATMS) results. There was no need for a background screening to be completed for a Department employee hired by the provider or when a provider employee is hired by another contracted provider. The program's practice for a volunteer, mentor, and or intern who assists or interacts with the youth on an intermittent basis for less than ten hours a month, is for an employee who has been background screened to always be present. The program currently does not have individuals who assist or interact with youth on an intermittent basis for less than ten hours and may have access to confidential information. An Annual Affidavit of Compliance with Level 2 Screening Standards, was completed, sent, and signed to the Department's Background Screening Unit on January 4, 2019. Teachers who are funded by the school board or Department of Education received an annual screening, which was completed and signed on January 18, 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 written policy and procedures which addresses practices for five-year rescreening. The program had one staff applicable for a five-year background rescreening. The staff member's five-year rescreening was calculated from the staff member's agency hire date. The five-year background rescreening was completed and submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the staff member's five-year anniversary date. The program reported there were no volunteers, mentors, and/or interns who required a five-year rescreening since the last annual compliance review.

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. • *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse are 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.* • *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.*	

The program had a total of fifty-nine Central Communications Center (CCC) calls since the last annual compliance review.. A review of the CCC calls found five were allegedly related to physical, psychological, or emotional abuse. Three of the five incidents were applicable for contact to the Florida Abuse Hotline and the remaining two were regarding youth over the age of eighteen. Two of the five CCC incidents reviewed were determined to have substantiated findings related to physical, psychological, or emotional abuse. Both incident reports identified a corrective action was administered as a result of findings. During a tour of the program and on-site observations made during the annual compliance review, postings of telephone numbers for the Florida Abuse Hotline and CCC for youth eighteen years of age and older were found throughout the facility. Seven staff personnel records were reviewed for adherence to the code of conduct. Each of the reviewed personnel records contained a signed code of conduct. Additionally, each staff signed an employee acknowledgement for receiving a copy of the program's employee handbook. The program has a written policy and procedures which

address incident reporting requirements and child abuse reporting procedures. Should a youth make a request to a staff member to make an abuse call, the staff will immediately inform the shift supervisor of the youth's request. For youth eighteen years of age or older, the shift supervisor escorts the youth to a private area and grants the youth access to a phone to contact the CCC. For those youth under eighteen years of age, the shift supervisor will afford the youth the opportunity to contact the Florida Abuse Hotline. Upon completion of the youth's call, the youth will be returned to the designated location of the scheduled activity and shall not suffer any consequence or reprisal for making the allegations. The shift supervisor will complete an entry in the program's abuse log. The program's written policy indicates youth have unimpeded access to the CCC or Florida Abuse Hotline.

Interviews were conducted with seven youth during the annual compliance review. All seven youth stated they felt safe in the program. All seven youth stated they have never been stopped from reporting abuse to the Florida Abuse Hotline or CCC, if eighteen years of age or older, while at the program. Each of the seven youth were questioned if staff are respectful when talking with them and other youth. Six youth reported staff are respectful when talking with them or other youth. The remaining one youth reported half of the staff are respectful. Six of the seven interviewed youth reported they have never heard staff use curse words when speaking with them or other youth. The remaining youth reported hearing staff use profanity often when staff get irritated. A meeting was held between the program and lead reviewer of the review team. The concerns identified from youth responses pertaining to an abuse-free environment were openly discussed, such as respect and use of profanity. The program reported they will address these areas of concerns during staff meetings and maintain these items of concern as on-going agenda items. Interviews were conducted with three staff. Staff were asked to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All three staff were able to articulate the process as outlined within the program's written policy for making contact to either the Florida Abuse Hotline or CCC. All three interviewed staff denied ever observing a co-worker tell a youth they could not contact the Florida Abuse Hotline. In addition, each of the three interviewed staff denied ever observing a co-worker use profanity, threats, intimidation, or humiliation when speaking or interacting with youth.

The program director (PD) was interviewed and reported any reports of physical abuse, threats or profanity toward youth will be investigated by management staff, and based upon findings discplinary action up to and including termination will be taken. The PD stated any reports of abuse or suspected abuse will be immediately reported to the Florida Abuse Hotline and CCC. Youth will receive phone calls to the Florida Abuse Hotline as requested and any youth reports to the Florida Abuse Hotline will be reported to the CCC.

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 fifty-nine Central Communication Center (CCC) calls since the last annual compliance review. Five CCC's were reviewed which related to physical, psychological, or emotional abuse. Two of the five incidents reviewed were later determined to have substantiated findings related to physical, psychological, or emotional abuse. In both incidents, there was evidence management took immediate action to address findings related to the

physical, psychological, or emotional abuse. In one incident a staff member was terminated and the other the staff was given counseling and provided with additional training. An interview with the program director (PD) revealed youth and staff are knowledgeable of their ability to contact the CCC or the Florida Abuse Hotline. This information is discussed with the youth during their admission and is included in each student handbook. Documentation of the Florida Abuse Hotline and CCC numbers are also posted within program areas which were observed during the program tour. Staff also are trained during the new hire process regarding child abuse reporting. Staff complete annual training regarding child abuse reporting and are trained periodically during staff meetings. The PD further indicated all calls to the Florida Abuse Hotline are documented on the program's abuse call log.

1.05 Incident Reporting (CCC) (Critical)	**Satisfactory Compliance**
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program has a written policy and procedures which addresses practices for reporting to the Central Communication Center (CCC). The program had a total of six CCC calls in the past six months. There were no incidents discovered and or reported during the current annual compliance review. A sample size of five CCC reports were reviewed. In all five reports, the CCC was notified within two hours of the program becoming aware of the incident. A review of the program's logbooks revealed each of the five CCC incidents was documented. There were no indications of internal incident reports or grievances which should have been reported to the CCC. The program had a decrease in the total number of reportable incidents to the CCC since the last annual compliance review. The program director indicated any reports of abuse or suspected abuse will be reported to the Florida Abuse Hotline and CCC, immediately. Youth will receive phone calls to the Florida Abuse Hotline as requested and any youth reports to the Florida Abuse Hotline will be reported to the CCC.

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

The program had a total of six Protective Action Response (PAR) interventions within the past six months. Five PAR interventions were reviewed. Each of the five PAR intervention reports were completed by the end of the staff member's workday. All PAR intervention reports included statements from all staff involved. None of the PAR interventions required the use of mechanical restraints. There were no PAR interventions which resulted in an injury to a youth. Subsequently, there were no allegations of abuse by the youth involved. The review by a PAR certified instructor or supervisory staff was completed for each of the PAR interventions. One of the five incidents indicated a PAR medical review was necessary in which the youth denied any injury as a result of the PAR intervention. Each of the PAR interventions contained a post-PAR interview with the youth which was conducted by the program director (PD) or designee. The post-PAR interview was conducted no longer than thirty-minutes after the PAR intervention. The PAR intervention reports were reviewed by the PD or designee within seventy-two hours of the

reported incident. The program's PAR intervention reports and applicable attachments were placed in a central file within forty-eight hours of being signed by the PD. The program submits a monthly summary of all PAR reports to the Department by the fifteenth of each month. The program's PAR plan was approved and signed by the Department on April 19, 2019. A review of PAR interventions since last annual compliance review found the program had a decrease in incidents. The PD reported PAR incidents are documented and reported to Department and program management. Program management conducts camera reviews of all PAR incidents. The program's PAR rate during the annual compliance review period was 0.76 which is below the statewide residential PAR rate of 1.51.

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

A review of seven staff training records was conducted in order to verify pre-service training requirements. Each of the seven staff were certified within 180 days of their respective hire dates. All staff completed at least 120 hours of pre-service training. Each of the reviewed staff completed training in cardio pulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) training. All staff received passing scores on their respective PAR written examinations. The staff also completed professionalism and ethics (to include standards of conduct), suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training. Each of the reviewed staff training records also included evidence of completion of contract-specified training in the areas of restorative justice programming, gender specific services, stress management, post-traumatic stress disorder (PTSD), and emergency evacuation procedures. The program also provided enhanced training in the specialized services offered to the specific population of youth at the program, which includes mental health overlay services and substance abuse overlay services. Each of the reviewed staff training records indicated completion of training requirements within the Department's Learning Management System (SkillPro). The program did not have all training documented within SkillPro;, however, there was on-site documentation of staff having completed training. The instructors providing training are qualified and each instructor certification was provided for review. The program submitted in writing, a list of pre-service training to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training. The pre-service training plan was submitted and signed by the Office of Staff Development and Training, on October 2, 2018.

1.08 In-Service Training	Satisfactory Compliance
Residential 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.*	

A review of seven staff training records was conducted in order to verify in-service training requirements. Three of the seven records were supervisory staff. All staff received more than the required twenty-four annual training hours in cardio pulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and refresher in Protective Action Response (PAR)

training. In addition, staff received training in professionalism and ethics (to include standards of conduct) and suicide prevention. Each of the staff were also provided with program-specific specialized training for mental health overlay services and substance abuse overlay services. One staff was applicable for having received training in life skills and social skills group implementation for the ARISE curriculum. In addition, the staff member was trained in Impact of Crime (IOC) curriculum. The three reviewed supervisory training records included at a minimum eight hours of additional training in areas specific to management, leadership, personal accountability, employee relations, communication skills, and or fiscal training. A review of two nursing staff training records found each had a current certification in CPR and AED training. Staff records reviewed for completion of in-service training found each was documented within the Department's Learning Management System (SkillPro). A review of the instructor certifications documented each are qualified to deliver training provided. The program submitted in writing, a list of in-service training to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training. The in-service training plan was submitted and signed by the Department's Office of Staff Development and Training, on October 2, 2018. The program has an annual in-service training calendar which is updated as changes occur. The program's training manager was interviewed and stated all training is monitored quarterly for staff to ensure each staff receive all training, as required. An interview with the program director (PD) revealed the program considers positions for youth care worker and youth care worker II, as direct care positions and are primarily responsible for youth supervision. The PD also indicated the maintenance manager is PAR certified and may at times supervise youth if performing tasks outside of regular job duties.

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 written policy and procedures which addresses the grievance process. The written grievance policy identifies training requirements for the grievance process, which was evident upon reviewing seven staff training records. All staff received training in the grievance process. The grievance process is divided into three phases. The initial phase or phase one is called the informal phase. In phase one, if a youth decides they would like to grieve a situation, the youth may approach any staff on duty and informally attempt to resolve the grievance. The second phase is called the supervisory or formal phase . Should a youth determine the resolution from the informal phase was unsatisfactory, the youth would indicate this on the grievance form and drop it in one of the locked drop boxes, which are available throughout the program. The locked grievance box is checked by program administration, five days a week. The grievance is logged and the supervisor has seventy-two hours to respond after receiving the grievance. In the event the youth is not satisfied with the outcome in the formal phase, the youth may move to the third phase of the process, the administration or appeal phase . The grievance is reviewed by the program director (PD) or designee, who has seventy-two hours to respond after receiving the grievance. Each youth receives a copy of the program's student handbook upon admission. A review of the handbook found the grievance process as outlined. A review of the program's grievance log binder found the program maintains all grievance forms, as required. The program had one grievance in the past six months. A review of the grievance was conducted and found the situation was resolved at the program's formal phase.

The grievance was resolved within the required time frames in accordance with the program's written grievance policy and procedures. In addition to grievances, youth are also provided with youth special request forms which are site specific forms for youth to request a consultation with administration. These forms may be completed and placed in a locked drop box.

Seven youth were interviewed and each were familiar with and able to summarize the grievance process. Three of the seven interviewed youth stated they never completed a grievance. All seven youth reported they can ask staff for assistance when completing a grievance. Three staff were interviewed in regard to the program's grievance process for youth. Each staff was able to provide insight into the practices necessary for conducting the grievance process. The PD was interviewed and provided a breakdown of the process where the youth writes and submits a grievance. Staff respond to the grievance and the grievance is escalated to the supervisor or PD, if necessary.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

A review of the provider's contractual agreement revealed the required delinquency intervention services are Thinking for a Change (T4C) and Impact of Crime (IOC). The program's written description addresses the delinquency intervention strategies utilized. The T4C curriculum is evidenced-based. The IOC curriculum is considered a promising practice. A review of the program's activity schedule determined the program provides structured, planned programming or activities at least sixty-percent of the youths' awake hoursThe two youth in attendance to T4C were involved in a delinquency intervention which addressed an identified need.
Three staff were reviewed whose regularly assigned job duties include the delivery of delinquency intervention models. Each staff was reviewed for training, education level, and years working with adult or juvenile offenders. All three staff received certifications for the respective delinquency interventions they delivered to youth. All staff had the required education and years of experience. Education and work experience were considered by the program director (PD) when determining staff delivery of delinquency intervention services at the program. The PD reported staff members are selected for delivery of life skills training or groups based upon their background of facilitating training, group, or mentoring sessions. The presentation of staff skills and youth interactions are evaluated to determine appropriate selection for facilitation and delivery of training and groups. The PD further reported youth are assigned to specialized case managers and counselors based upon their commitment packet and program assignment. Consideration is made when assigning youth based upon their individual background. The Residential Positive Achievement Change Tool (R-PACT) is also reviewed and utilized to determine appropriate intervention groups.

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

A review of the provider's contractual agreement found the program provides the ARISE curriculum as their intervention and instruction focusing on developing life and social skill competencies in youth. The ARISE curriculum addresses communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking which includes problem solving and decision making type skills. The determination for youth eligibility for life skills training is achieved through the completion of the Residential Positive Achievement Change Tool (R-PACT). A review of the program's written policy and procedures identifies and addresses the need for all youth to receive life skills training. A review of ARISE groups sign-in sheets and the program's activity schedule confirmed groups were being facilitated, as required. The program employs seven therapeutic staff. A review of all seven staff training records found each received training to facilitate the ARISE curriculum. Seven youth records were reviewed to determine if they are in receipt of the ARISE curriculum. A review of three youth records determined they were not in receipt of services as outlined within their respective treatment and or performance plan. The remaining four youth did receive or were currently receiving services. Seven youth interviews were conducted. Each of the youth were able to share what groups and activities they participated in while at the program. Each youth were able to describe some type of skill they were taught while in groups. The youth were also able to share what or how they have practiced the skills in and outside of groups.

1.12 Restorative Justice Awareness for Youth	Failed 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.	

A review of the provider's contract revealed the program will facilitate the Impact of Crime (IOC) curriculum as a delinquency intervention for enhancing restorative justice awareness for youth. Seven youth records were reviewed for receipt of services to increase their accountability for criminal actions and harm to others. None of the seven youth participated in an IOC group. Each of the seven youth reviewed were not receiving any type of services to increase accountability for criminal actions and harm to others. The youth were not receiving contractual service delivery of IOC which would assist each youth to accept responsibility for the harm they have caused by their past criminal actions. In addition, the services challenge the youth to recognize and modify their irresponsible thinking of denying, minimizing, rationalizing, and victim blaming. There were no efforts to teach youth about the impact of crime on victims, their families, and communities. There were no discussions held with community members, exposing the youth to the victim perspectives which allows youth to process reactions to each victim's account of how crime impacted his or her life.

The program's efforts of conducting IOC groups had gaps of service delivery. A review of the attendance records demonstrated there were two cohorts held from July 2018 through September 2018 and January 2019 through April 2019. The group prior to July 2018 was held from February 2018 through May 2018. During this group five of the seven youth were released from the program prior to completing the group. The group conducted from July 2018 to September 2018 had attendance records through chapter four. There were no record of the

seven youth in this group completing IOC. The group held from January 2019 to April 2019 ended after chapter six and did not complete chapter seven. Service delivery for IOC groups when conducted are scheduled for an hour each session, during the youth's lunch time. The program director was interviewed and stated youth not only participate in the IOC groups as scheduled but are also able to complete community service activities. There was no evidence of youth having participated regularly in restorative justice or IOC type group activities.

1.13 Gender-Specific Programming	**Satisfactory Compliance**
The program provides delinquency intervention and gender-specific treatment services.	

A review of the provider's contract found the program provide Fathers in Training and Boys Council as gender-specific programming. The program designs its services based on the common characteristics of its male population. The program's activity schedule did offer gender-specific programming. The groups, Fathers in Training and Boys Council are offered during the youth's lunch time. Both curriculums utilized for gender-specific programming were reviewed as well as sign-in sheets to determine consistency with group facilitation. An interview with the program director confirmed each curriculum are used for gender-specific programming. A review of seven staff training records were reviewed and found each staff were trained in gender responsive services.

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

The program has a written policy and procedures addressing an internal alert system. The written policy provides direction on how alerts are identified, documented, updated, and communicated to staff. The program utilizes the Department's Juvenile Justice Information System (JJIS) for entering and removing alerts on identified youth. A review of alerts contained within JJIS and the program's internal alerts were consistent with one another. Each team member for mental health, medical, case management, and safety and security were asked if there were any issues and there were no issues found. There was evidence all youth were placed within the program's internal alert system, as specified within the programs written policy and procedures. A review of the program's logbook found youth were removed or downgraded from alert status by appropriate staff. There were no noted inconsistencies. Informal interviews were conducted with two staff members who were observed supervising youth assigned to the program. Each staff reported they were aware of the alert information for the youth they were supervising. Each staff was able to identify all youth who were receiving prescribed medication. The staff were questioned on their response in the event a youth had abnormal behavioral issues possibly associated with their medication or medication side effects. The staff responded they would immediately inform the nurse and their supervisor.

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 separates the youth record into three separate records which includes an individual management record, individual healthcare record, and mental health and substance abuse record. All youth records are marked 'confidential.' Each of the youth records are maintained in locked cabinets within the responsible program area's office. There were no records observed to be accessible to youth. Office area doors are also marked 'confidential'. A review of seven individual management records found each record had a file tab which included the youth name, Department identification number, date of birth, county of residence, and committing offense. Each record was divided into sections by legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All records were neat and well organized.

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 from all youth. An interview with the program's transitional specialist found customer satisfaction surveys are given to the youth and the parent/guardian by the transition specialist prior to each youth leaving the program. All information is shared with program administration and the overall satisfaction rate is given in numerical form and tracked. Samples of the youth and parent/guardian satisfaction surveys were provided. In addition, youth grievances and special request forms are provided. The special request forms are available throughout the program. Youth can complete the forms in order to request consultation with a member of administration. The formal process to promote constructive input from youth includes a youth assembly meeting, which are conducted monthly and facilitated by the assistant program director (APD). All youth may participate in these meetings. In addition, the APD meets weekly on Fridays with members of the peer advisory committee which is comprised of youth. The youth for the peer advisory committee are selected from each living area to represent their peers and discuss program issues and requests. Documentation of peer advisory committee meetings were reviewed, as well as youth sign-in sheets. The program also provides youth and parent/guardians with satisfaction surveys. The surveys are given to youth and parent/guardians after a youths' initial thirty-days at the program. The program director (PD) was interviewed and stated the formal processes the program utilizes to solicit youth input include grievances, request forms, town hall meetings, and peer advisory meetings, as well as open access to the PD. Seven youth interviews were conducted and each of the youth agreed the program had a process for them to provide input about what happens at the program.

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

The program maintains community advisory board meeting sign-in sheets, minutes, and agenda topics in a community advisory binder. The meetings are facilitated quarterly by the program

director. Community advisory board meetings were held in June 2018, September 2018, December 2018, and March 2019. There was evidence the program solicits information from law enforcement, victim advocates, and parent/guardian of a youth previously involved in the juvenile justice system, judiciary staff, community partners, business community, school board, and the faith community. The program director (PD) was interviewed and stated community advisory boards convene quarterly and are scheduled based upon the availability of board members. The board members also provide various opportunities for youth in the community. The PD further indicated the program works with the community to enhance youth opportunities for community involvement and employment through board members. Telephone contact was made with two community members to confirm their participation in the meetings. Each of the members stated they continue to participate in meetings as scheduled. The board members stated they are informed of meetings through email notification, as well as telephone contact made by the program. One member who works for the local Habitat for Humanity, stated the program's vocational class has worked with her to help construct wooden steps for entrance ways into new homes constructed by youth through Habitat for Humanity. Each of the members contacted also stated they felt the program is doing a good job. They have enjoyed their participation within the community advisory board committee.

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

The program has a written policy and procedures which are utilized to determine the system of staff communication, opportunities for providing input, and feedback on program operations. The program director (PD) provided documentation of meeting minutes and agendas to show the consistency of meetings facilitated within the program. In addition to all meetings facilitated, the program facilitates youth and parent/guardian surveys to determine further youth program status information. The surveys are compiled into Trauma Responsive and Caring Environment (TRACE) documentation and shared during treatment team meetings. Examples of meeting agendas found the TRACE information was a topic for discussion during the meetings conducted. The PD was interviewed and stated shift briefings are held to discuss program status information and plan for improving day to day operations. Shift briefings are held daily and facilitated by the direct care supervisor or assistant program director (APD). All oncoming staff participate and sign they attended these briefings. In addition, shift debriefings are also completed as needed in the event of major issues encountered during a shift. Debriefings are facilitated by the APD. The program also conducts team meetings which are monthly and involve all staff. These meetings are facilitated by the PD. Supervisor meetings are also held monthly and are facilitated by the PD. These meetings are primarily for all direct care supervisor staff. Management meetings are also held monthly and are facilitated by the program's clinical director. These meetings are attended by the PD, APD, case management supervisor, nursing director, and an education representative. In addition, the PD stated staff are provided with monetary bonuses for employee recognition such as employee of the quarter and catching staff doing good. The PD reported when a staff is caught doing good during an interaction with youth, the staff may receive a monetary gift such as a gift card. Two staff who received this recognition were informally interviewed during the annual compliance review and both confirmed this practice. An interview with the program's human resources manager revealed the program also conducts a bi-annual survey with staff and coordinates an associate council team to discuss holiday activities and employee recognition for staff. A review of previous Commission Accreditation Report (CAR) information, youth, and parent/guardian surveys were completed to confirm this practice. Three staff interviews were conducted and staff reported meetings were conducted bi-weekly and monthly. The staff reported the topics of discussion included making

sure staff are doing their job, youth information, what needs to be done on the dorms, and safety and security items. One of the three interviewed staff reported they were briefed on the CAR report information. The staff responded not knowing what CAR reports were. All three staff indicated they felt the communication at the program was good overall.

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

Four samples of job descriptions were reviewed for determining the program's system for evaluating staff, performance standards, and frequency of evaluations. The samples included the assistant director of programming, dietary worker, transition coordinator, and nurse. Each of the jobs descriptions reviewed had a position description which included clearly identified performance standards. Performance standards matched job descriptions for each staff position. In addition, a review of the program's written policy and procedures was conducted. The program's written policy addresses staff evaluations and performance standards, along with completing employee evaluations. The written policy indicated evaluations for staff are completed initially after ninety-days from the date of hire, and annually thereafter. A review of four staff personnel records found each had a completed annual evaluation in their record. The evaluations were completed as outlined within the program's written policy. The program reported having only one key position vacancy, which was one registered nurse. The program director was interviewed and stated all staff members receive an annual evaluation from the appropriate supervising staff member. These evaluations assess areas of strength and for improvement of each staff member and allow the supervisor and staff to set goals for the coming year. Three staff were interviewed and two staff reported they receive an evaluation annually. The remaining one staff was not aware when they receive a performance evaluation.

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 case management records were reviewed for initial contact with the parent/guardian upon a youth's admission to the program within twenty-four hours. In all cases, youth contacted their parent/guardian by telephone on their admission dates. The parent/guardian was also mailed an admission notification letter within forty-eight hours of each youth's admission to the program. Each youth record had notification to the committing courts and juvenile probation officer (JPO) within five working days of the youth's admission.

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

Seven youth case management records were reviewed for orientation of the youth at admission to the program. Orientation commenced for each youth upon their admission to the program. Orientation addressed all required elements Including the grievance process, access to mental health, medical, behavior management system, performance planning process, dress code, personal hygiene practices, contraband, procedures on visitation, mail, use of the telephone, anticipated length of stay, community access, grievance procedures, emergency procedures, assignment to living unit, and access to the Florida Abuse Hotline. A youth admission was observed during the annual compliance review. During the admission, the case manager addressed the length of stay by reviewing with the youth the level process and what stages needed to be attained for youth to be released and all other elements outlined within the program's written policy. A review of the program logbook revealed orientation for youth is documented, which also included any safety precautions necessary. Seven youth were interviewed and each youth stated orientation commenced within twenty-four hours of their admission to the program.

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

Seven youth case management records were reviewed and three were applicable for written consent of youth eighteen years of age or older. In each of the applicable records, written consent was obtained for youth ages eighteen years of age or older before providing or discussing with the parent/guardian information related to physical or mental health screening, assessment, or treatment.

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

Seven youth case management records were reviewed. In all seven records, youth were classified on their admission dates. The program completed several instruments to address all classification requirements as outlined within the program's written policy and procedures including escape risk, gang membership, level of maturity, physical characteristics, criminal history, special needs, and medical needs. The case managers also completed the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) instrument for each youth. A program director (PD) interview was conducted. The PD stated several instruments were used to assign youth to living quarters based on prior victimization, mental health status, physical health status, cognitive performance, and age. During admission the program administered the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2), VSAB, and completed an admission classification form. Classification documentation screened for mental health, medical, safety, security, and special needs issues. Each of the records contained classification documentation. Staff completed an initial risk assessment and a gang assessment. The program has a process of entering alerts on an internal system. The program has a board located in the control room which lists all youth on alerts. the program requires one to one supervision for youth placed on close supervision. Program staff radios alerts every thirty minutes and security alerts every hour. All youth were classified based on the assessment information and placed in appropriate dormitories. Seven youth case management records were reviewed for reassessments prior to an increase in the youth's privileges or freedom of movement. In each record, youth were assessed on their admission date for risk and later reassessed and reclassified during each formal staffing. Each youth record contained risk assessments for off-campus activities and increase in privileges. The risk assessments identified the off-campus activity each youth participated in.

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

The program has policy and procedures to address the identification of gang members and notification to law enforcement of potential gang members. Three youth were applicable and identified as gang members. Staff completed a gang assessment on each youth at admission to the program. Staff notified the youth's juvenile probation officer (JPO), local school district, law enforcement in the youth's home county, post residential counselor, and local law enforcement agency of the youth's gang identification.

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

The program has a written policy and procedures addressing gang intervention. The program's written policy addresses notification to law enforcement of suspected gang members. Once a youth is identified as a gang member or a suspected gang member, the youth will participate in Impact of Crime (IOC) and group discussions. The youth will complete worksheets out of a gang workbook and are also assigned performance plan goals. Three records were identified as gang members. Case managers incorporated gang intervention strategies into all performance plans. Youth receive intervention strategies through groups such as IOC and group discussions.

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

Seven youth case management records were reviewed for the Residential Positive Achievement Change Tool (R-PACT) instrument. Each record contained a R-PACT assessment which was completed within thirty days of the youth's admission to the program. The R-PACT assessment was maintained within the Department's Juvenile Justice Information System (JJIS). Seven youth case management records were reviewed for completion of a R-PACT re-assessment. Each of the records reviewed were applicable for a R-PACT re-assessment. The R-PACT re-assessments were completed within the ninety-day required time frame. When applicable, other updates or re-assessments were completed when deemed necessary. The program maintained all re-assessment documentation within each youth's official case management record.

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

Seven youth case management records were reviewed for the completion of a Youth Needs Assessment Summary (YNAS). Six youth case management records contained a YNAS which was completed within the required thirty-day time frame. The one remaining record had a YNAS which was two days late. All YNAS were maintained within the Department's Juvenile Justice Information System (JJIS).

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Satisfactory Compliance

The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission.

For each goal, the performance plan shall specify its target date for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal.

Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.

Seven youth case management records were reviewed for the development of performance plans. Each record contained a performance plan which was developed within thirty days of the youth's admission to the program. All performance plans were developed after the completion of the Residential Positive Achievement Change Tool (R-PACT). Each treatment team member was present during the development of the youth's individualized performance plan. The treatment team was comprised of the treatment team leader, youth, administrative representative, direct care staff, treatment staff, medical staff, and education staff. None of the youth reviewed were applicable for Department of Children and Families (DCF) involvement. All performance plans reviewed were signed by all involved parties to include the youth, treatment team leader, and educational staff. The performance plans in each of the seven records did not contain a parent/guardian signature sheet which was to be mailed back to the program; however, each of the seven records did contain a form requesting the parent/guardian to aid in the completion of the performance plan. The plan was also reviewed with the parent/guardians during treatment team.

All seven performance plans were reviewed for goals. In all seven records, goals were based on prioritized needs which reflected the risk and protective factors identified during the initial assessment process. In each of the seven records, the top three criminogenic needs were addressed on the youth's performance plans. Each of the seven records contained performance plans which did not contain specific delinquency interventions. The interventions which were present had a target completion date. Seven records had transition activities targeted for the last sixty days of each youth's anticipated stay. Seven records contained youth and staff responsibilities towards the completion of goals and interventions. Seven records were reviewed for transmittal of performance plans to the committing court, juvenile probation officers (JPOs), and parent/guardians. All performance plans were forwarded to the committing courts and juvenile probation officers (JPOs) within twenty-four hours of treatment team members signing the performance plans. Seven records contained documentation showing parent/guardians were sent copies of the performance plans within the same time frame. The performance plans were signed by all required parties. Seven youth were interviewed and each provided input into the program's treatment process, which included the development of their performance plan, treatment team meetings, and goals. Additionally, four of the seven youth stated they had copies of their performance plan and the remaining three youth replied they did not have a copy of their performance plan.

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

Seven youth case management records were reviewed for revisions to performance plans. All seven records reviewed were applicable. Revisions completed were made based upon the Residential Positive Achievement Change Tools (R-PACT) results, demonstrated progress, or lack of progress toward completing a goal. In addition, a revision was warranted to the youth's individualized performance plan when it was necessary to facilitate transition activities during the youth's last sixty days of stay at the program.

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

Seven youth case management records were reviewed for performance summaries and transmittals. Five youth case management records were applicable for the completion of a performance summary. In each record, a performance summary was completed within the required ninety calendar day time frame. A performance summary was completed prior to the youth's release, discharge, or transfer from the program. Each of the performance summaries included youth status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, significant positive and negative events, and justification for release, discharge, or transfer from the program. For each of the performance transmittals, youth could read and add comments to their summaries prior to signing. The youth were also provided a copy of the summary. The original summary was filed in each of the youth's case management record. The performance transmittals were each signed and dated by the treatment team leader, staff member preparing the summary, program director or designee, and the youth. A copy of the summary was sent within ten working days to the committing court, juvenile probation officer (JPO), parent/guardian, and youth.

Six of seven youth case management records reviewed were applicable for a release summary. Each record contained the original summary along with justification for release and was sent with the pre-release notification (PRN) to the JPO. The release summary and PRN were sent at least forty-five days prior to the youth's planned release date. A signed copy is retained in each of the youth's case management record. There was no indication of incidents where the court objected to any of the youth release date. In each of the reviewed records, once approved, the program provided written notification to the youth's parent/guardian of the planned release. There were no indications of those youth reviewed requiring notification of sexually violent predator program (SVPP) notification. The youth's JPO was notified of pending release from the program, as needed. In addition, a performance summary, transition plan, and any psychological/psychiatric reports were sent to the JPO while the youth was in the program.

None of the reviewed youth required a victim notice. Seven youth were interviewed and four stated they had attained copies of their completed performance summaries.

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

The program encourages and facilitates involvement of parent/guardian into their youth's case management process, which includes an assessment process, participation in the development of the youth's performance plan, along with progress reviews. In addition, parent/guardians are provided with advanced notice of meeting dates and times for their attendance to formal treatment team meetings. Parent/guardians are encouraged to participate in the youth's transition planning. If a parent/guardian is unable to attend a meeting, they are allowed to participate by telephone, video conference, or give verbal/written input prior to the meeting. A review of the provider's contract was conducted and determined the outlined performance expectations were being met. A treatment team was observed during the annual compliance review. During the treatment team, it was noted the parent/guardian participated in the meeting. The program communicates to parent/guardians by contacting each parent/guardian at admission to advise them of the youth's safe arrival to the program. In addition, the parent/guardian is sent an admission notification letter within forty-eight hours of each youth's admission to the program. A review of case management records contained forms which were mailed to the parent/guardians to encourage performance plan involvement. The program case managers mail completed copies of performance plans for parent/guardian review. An interview with the program director revealed, parental involvement is encouraged through telephone calls and letters, along with family day activities. Seven youth were interviewed and each confirmed their parent/guardian was involved in their case management, treatment plans, and treatment team process.

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

Seven youth case management records were reviewed for the composition of treatment teams. Prior to each youth's admission to the program, key staff meet to plan for initial treatment and academic needs. Treatment team members were identified during this process. Upon admission to the program, the youth is introduced to treatment team members. Treatment team members included the youth, an administrative representative, a living unit representative, educational staff, treatment staff, and case management staff. Parent/guardians and juvenile probation officers (JPO) are invited to participate in treatment team meetings. All treatment team members attended meetings, as required.

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

Seven performance plans were reviewed for the incorporation of academic and treatment plans. In each case, case managers incorporated youth treatment plans into their performance plans.

Seven case management records indicated academic plans were incorporated into the performance plans. In addition, if a youth had a separate treatment plan, the youth's performance plan incorporated the treatment plan. There was no indication of youth reviewed requiring a plan from the Department of Children and Families (DCF) or Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

Seven youth case management records were reviewed for documentation of treatment team meetings; informal and formal. All case management records contained formal reviews which occurred at least every thirty days and were documented in each record. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged through advanced notification to participate. All formal reviews included the youth's name, date of review, meeting attendee's, comments from treatment team members, a brief synopsis of youth progress, progress on goals, and positive and negative behaviors. Each youth was able to self-report on progress in treatment groups, academics, and their relationships with their peers.

Seven youth case management records were reviewed for documentation of informal treatment team meetings. All records contained documentation showing informal reviews occurred bi-weekly each month. All informal reviews included youth's name, date of review, meeting attendee's, comments from treatment team members, brief synopsis of youth progress, progress on goals, and positive and negative behaviors.

Treatment team was observed during the annual compliance review where the discussion was centered around the youth's performance plan goals. All required staff were present at the meeting and all members actively participated. Treatment team documented and actively discussed the youth's progress on performance goals, positive and negative behaviors, and treatment progress. The youth were allowed to demonstrate any skills acquired while in the program. A review of each youth's treatment plan demonstrated the youth had an anticipated release date. The release date corresponded with information entered into the Department's Juvenile Justice Information System (JJIS). Seven youth were interviewed and six stated they were able to demonstrate the skills they had learned at treatment team meetings. The remaining one youth stated youth just say hello during treatment team meetings.

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

Seven youth case management records were reviewed for implementation of career education. Each of the records contained a sample of a completed employment application, a résumé, and appropriate documents for attaining employment. The program indicates the career source center no longer allows appointments to be made due to the constant no-shows. There were no calendars with appointments in any records. There was documentation to support the youth's parent/guardian and juvenile probation officer (JPO) are aware of the vocational plan for the youth.

The program provides appropriate educational programming based on each youth's age. The program career education is appropriate for the educational abilities and goals of youth in the program. In addition, the career education program is appropriate for the length of stay and custody characteristics of the youth in the program. The program provides Type-2 vocational competency programming. According to the program educational director, the program provides My Career Shines, Home Builders Institute (HBI), and Safe Serve certifications. The interview with the program director and lead teacher confirmed the career and vocational services offered at the program are HBI, carpentry, woodshop, credit recovery, opportunities for outside employment, and employability skills training.

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.	

An interview with the educational director indicated all youth participate in educational and career related programs for 250 days of instruction a minimum of twenty-five hours weekly. The program utilizes ten or less of the 250 days of instruction for teacher planning and training. All youth receive credits for educational and training experience. Upon review of the activity schedule and the logbook, there are minimal interferences during educational instruction. The logbook also documents education classes are taking place as scheduled. The logbook did reveal due to scheduling some students were getting to school a few minutes late. An interview with the program director ensured all youth will be in their appropriate classes by 7:25 a.m. in order for school to start at 7:30 a.m.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

Seven youth case management records were reviewed for education transition planning. Each youth had an individual education transition plan developed based upon the youth's post release goals, beginning at admission. Transition plans were developed with the youth, program staff, education staff, and other pertinent individuals. The youth's education transition plan addressed at a minimum those services and interventions based on the youth's assessed educational needs and post release education plans. In addition, recommended educational placement for post release based upon the youth's need and performance. Education transition plans also included specific monitoring responsibilities by individuals who are responsible for the

reintegration and coordination of support services for the youth. Each of the reviewed records contained language for employability as a transition goal within their respective education transition plans. The plans provided provisions for continuation of education and/or employment as well as a completed sample of an employment application. Five of seven youth had a completed résumé contained within their records. Four of the seven youth reviewed had a valid Florida identification card. The remaining three youth did not; however, there was documentation supporting a request was made for an identification card. Youth were able to make an appointment with Career Source Center within the youth's home vicinity. Each of the seven youth records had evidence the youth's case manager and parent/guardian are aware of the education transition plan, documents, and post release discharge plans.

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

The program has a written policy and procedures addressing transition planning, conference and Community Re-entry Team (CRT) meeting activities. Seven youth case management records were reviewed for transition planning and CRT activities. Each of the records contained transition planning meetings which were held within the required sixty-day time frame. The transition conference meeting included the youth, treatment team leader, program director or designee, and other team members. Input was also solicited from parent/guardians, juvenile probation officers (JPO), education staff, and any other pertinent parties. During the transition conference, the participants reviewed transition activities based on the youth's performance plan. In addition, the performance plan was revised, when necessary. The team identified additional transition activities as needed and identified target completion dates, as well as those individuals responsible for completion. The treatment team leader obtained attendees signature for participation in the transition planning. Six of the seven youth records reviewed were applicable for a CRT meeting. The CRT meeting was conducted prior to each of the youth's release from the program. In each record, the youth and case manager participated in the CRT meeting. In addition, there was evidence of an invitation for individuals to participate in the youth's CRT meeting.

2.20 Exit Portfolio	Limited 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.	

Seven youth case management records were reviewed for inclusion of exit portfolio during the youth's transition conference. Six records were missing documentation to support the discussion of the exit portfolio during the transition conference. Three records included a state issued identification card within the exit portfolio. All seven exit portfolio's had a copy of the youth's transition plan. Six of the seven exit portfolios contained a calendar with dates, times, and locations of follow-up appointments within the community. Seven records reviewed were applicable for a youth fifteen years of age or older. None of the seven youth contained a social security card or birth certificate in their respective exit portfolios. All seven records contained the necessary vocational certificates earned while in the program. Three of the seven youth records reviewed were applicable for having completed educational records and documents contained within the exit portfolio. All seven youth had a completed sample job application. Two youth were applicable for having an exit conference conducted. There was no documentation to support the two youth exit portfolios were discussed during the exit conference; however, the youth was provided with a copy of their completed exit portfolio upon release from the program. Additionally, the program staff forwarded the exit portfolio information to the youth's juvenile probation officer (JPO) which was documented in the youth's case management record. An exit conference was observed where discussion was held concerning the youth's exit portfolio. A review of the provider's contract revealed the program is meeting all requirements in addition to administrative rule requirements.

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

Seven youth case management records were reviewed for exit conferences. In all records, an exit conference was conducted after the program notified the juvenile probation officer (JPO). The exit conference was conducted at least fourteen days prior to release in each of the seven youth records reviewed. The exit conference was documented in each of the youth's case record which included the date, signatures, and a summary pending transition goals. Exit conference documentation included the participants and other pertinent information related to discharge plans. In each record, the youth's admission and release dates were entered in the Department's Juvenile Justice Information System (JJIS), as required.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA), licensed under Chapter 491, Florida Statute. A copy of the license and position description were available and reviewed. The DMHCA is on-site forty hours a week and on-call on the weekends to provide oversight of mental health and substance abuse treatment. A review of the DMHCA's license through the Florida Department of Health (DOH), Division of Quality Assurance revealed the license is clear and active through March 31, 2021. The DMHCA interview addressed their role in the coordination and implementation of treatment services. The DMHCA provides complete oversight to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place. An interview with the DMHCA revealed their role is to provide oversite to all therapists delivering mental health and substance abuse services. The DMHCA provides weekly clinical supervision to all therapists and supervises six non-licensed mental health professionals.

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

A review of the program's contract found staffing was in accordance with contract and Rule 63N-1, F.A.C. An interview with the designated mental health clinical authority (DMHCA) revealed a licensed clinical staff is working under the supervision of the DMHCA. The licensed clinical staff performs services in which they are qualified to provide based on education, training, and experience. The program has one licensed mental health professional. The license of the mental health professional was reviewed and found to be current with an expiration date of March 31, 2021.

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

The program has six non-licensed mental health and substance abuse therapists working at the program. An interview with the designated mental health clinical authority (DMHCA) assured the non-licensed clinical staff working under the DMHCA's supervision are performing services they are qualified to provide based on education, training, and experience. Each of the non-licensed clinical staff hold a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. Clinical supervision from August 2018 to April 2019 was reviewed. Documentation was found each non-licensed mental health and substance abuse clinical staff received at least one hour a week of on-site face-to-face direct supervision by the licensed clinical supervisor. The program provided documentation of the of the non-licensed mental health staff who conducted Assessments of Suicide Risk (ASR) receiving twenty hours of training and supervised experience in the ASR. The training included administration of at a minimum, five assessments of the ASR or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The training was documented on the Non-Licensed Mental Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 002).

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

The program has a written policy and procedures identifying a mental health and substance abuse comprehensive screening process. The written policy and procedures identifies the practices for referrals, when necessary for youth who have an identified mental health and/or substance abuse need or identified as a possible suicide risk. A review of seven youth mental health records revealed each youth was screened using the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). The MAYSI-2 was administered on the day of each youth's admission and in a confidential manner. The screenings were completed by trained staff and documented in the Department's Juvenile Justice Information System (JJIS). All seven records documented the review of the youth's commitment packet. All seven records reflected the youth was admitted to the program on precautionary observation supervision from detention, requiring a referral for further assessment. The youth was admitted on precautionary observation, the program continued new precautionary observation logs while admitting the youth, and the youth was stepped down to standard supervision. As a result of staff referral, an Assessment of Suicide Risk (ASR) was conducted in all seven records. The executive director was notified of the youth's need for an ASR. Each ASR was completed within twenty-four-hours of the referral and reason for the referral was documented.

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

The program has a written policy and procedures pertaining to mental health and substance abuse assessment/evaluation. A review of the seven youth mental health records found each of the youth was referred for mental health and substance abuse assessments. Each assessment was a new assessment completed within thirty days of each youth's admission date. Three of the seven youth records included the substance abuse component of the assessment for youth with a history of substance abuse. The substance abuse assessment included patterns of alcohol and other drug use, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol and other drug abuse. The remaining four records included the mental health assessment. All substance abuse and mental health assessments included the youth's identifying information, reason for evaluation, relevant background, behavioral observations, mental status examinations, diagnostic impression/formulation including the diagnostic and statistical manual of mental disorders (DSM) diagnosis, discussion of findings, and recommendations. All seven youth records documented youth consent for substance abuse release of information, substance abuse evaluation and treatment, and urinalysis.

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

The program has a written policy and procedures pertaining to mental health and substance abuse treatment. A review of seven youth mental health records found each youth was assigned to a multidisciplinary treatment team upon arrival to the program. The treatment team consists of the youth, assigned therapist, the designated mental health clinical authority (DMHCA) who also serves as the program's administration, and the registered nurse for youth on medication. A letter to the youth's parent/guardian was found with all youth's treatment plans and reviews. In accordance with the youth's initial or individualized treatment plan, all youth records included treatment types for individual, group, or family counseling by a licensed or non-licensed mental health professional. There were no treatment team meetings held during the annual compliance review; however, a review of progress notes found each of the youth were receiving treatment services as stipulated on their treatment plan. Each youth had a properly executed Authority for Evaluation and Treatment (AET) form. All applicable youth had a signed Substance Abuse Consent and Release on the correct Department's Youth Consent for Substance Abuse Treatment form (MHSA 012) and Youth Consent for Release of Substance Abuse Treatment Record form . Mental health and/or substance abuse treatment notes were found in each youth's record and documented on the provider's form, which contained all the information noted on the Department's form. Treatment services were provided by the assigned non-licensed mental health clinicians and licensed mental health counselor (LMHC). The program is certified under Chapter 397, Florida Statute to provide substance abuse treatment. Observation of groups and review of youth sign-in sheets for mental health overlay services

(MHOS) and substance abuse overlay services (SAOS) treatment groups were completed during the review. Groups did not exceed ten participants for MHOS treatment groups and fifteen participants for SAOS treatment groups.

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

The program has a written policy and procedures outlining service delivery for treatment and discharge planning. A review of seven youth mental health records contained documentation of an initial treatment plan and contained all elements of the Department form. Each of the initial treatment plans was developed on the same day of the youth's admission. Four of the seven youth entered the program on psychotropic medications and the youth's initial treatment plan included the youth's psychiatric needs, including medication and frequency of monitoring medications. All seven plans were signed by the youth's assigned mental health clinical staff I and were reviewed and signed by the designated mental health clinician authority (DMHCA) within ten days of completion. All seven initial treatment plans were signed by treatment team members who participated in the development of the initial treatment plan, as well as the youth. Each record contained an individualized treatment plan developed for each youth within thirty days of admission. The individualized treatment plans were signed by the youth's assigned mental health clinical staff completing the plan and were reviewed and signed by the DMHCA within ten days. The individualized treatment plans were signed by the treatment team members who participated in the development of the plan and the youth. Copies of parent/guardian letters regarding the youth's treatment plan confirmed parent/guardian involvement. All seven records were applicable for an individualized treatment review. All seven youth had an individualized treatment plan review conducted every thirty days. Each individualized treatment review was completed on a site-specific form, which contained all required information contained within the Department's form.

Three closed youth records were reviewed for discharge plans. Each youth had a discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Summary form. There was documentation of each discharge plan being discussed with the youth, parent/guardian (when available), and juvenile probation officer (JPO) during the exit conference. A copy of the discharge plan was provided to the youth, parent/guardian, and JPO.

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

The program has a written policy and procedures outlining service delivery for specialized treatment services conducted. The program provides mental health overlay services (MHOS) and intensive substance abuse treatment overlay services (SAOS) to youth in the program. The program provides either MHOS or SAOS groups to youth seven days a week. Of the seven youth records reviewed, three youth received SAOS services and four youth received MHOS services. An interview with the designated mental health clinician authority (DMHCA) confirmed the youth received individual, group, and family therapy as prescribed as part of the youth's treatment plan. Services are provided by a master's-level therapist under the supervision of the DMHCA. An interview with the DMHCA confirmed mental health clinical staff provide MHOS and SAOS groups seven days a week. Youth with co-occurring substance abuse disorders receive SAOS group therapy twice a week. According to the DMHCA, therapists for MHOS and SAOS treatment do not exceed a caseload of ten youth. All youth admitted to the program receive a urinalysis upon entry to the program and upon return to the program from any home visit.

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.	

The program has a written policy and procedures outlining service delivery for psychiatric services. Psychiatric services are provided by a psychiatrist licensed under Chapter 485 or 459. Four of the seven youth records reviewed were applicable for psychiatric services. All youth who meet with the psychiatrist receive an initial diagnostic psychiatric interview documented on the Department's Clinical Psychotropic Progress Note (CPPN) form and designated as "initial diagnostic psychiatric evaluation". Each of the four initial diagnostic psychiatric evaluations included the youth's history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) mental disorder, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. All four youth records reflected the youth entered the program on a prescribed psychotropic medication and the initial diagnostic psychiatric evaluation was completed within fourteen days of admission. Three of the four youth on psychotropic medication did not have changes to medications. One youth had medication discontinued five months after entering the program and the parent/guardian consent was documented on the CPPN. All four youth on psychotropic medications included the CPPN with all treatment plans and reviews, despite any change in medication. Psychiatric services were documented by the psychiatrist on a psychiatric evaluation form every thirty days for youth on psychotropic medications. An interview with the designated mental health clinical authority (DMHCA) also confirmed the psychiatrist was on-site biweekly, available to evaluate and monitor youth, as needed. Psychiatric youth treatment was relayed to the multi-disciplinary team through the nurse. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week.

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 has a written plan detailing suicide prevention procedures. The plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was reviewed on March 3, 2019. The program director revealed the program conducts mock drills quarterly.

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

A review of seven youth mental health records found all records were applicable for suicide prevention services. All seven youth were admitted to the program under precautionary observation (PO). Each of the youth were placed on PO and the Assessment of Suicide Risk (ASR) was completed on the required Department form within twenty-four hours. There was a suicide precautionary observation log completed for all youth with no documented time lapse. In six of the seven youth records reviewed, an ASR was completed on the same date as the youth's admission and before each youth was removed from PO to standard supervision. One youth record documented the youth remained on PO until the follow-up ASR was complete and was stepped down to close supervision. Six of the seven ASRs were completed by clinical staff, and reviewed and signed by a licensed mental health clinician (LMHC). One ASR was completed by the supervising designated mental health clinician authority (DMHCA). Six of the seven records included the DMHCA's review and signature on the same day the ASR was complete. One record noted a telephone conversation with the DMHCA and verbal approval to move the youth to standard supervision within twenty-four hours of the youth being placed on PO. The DMHCA signed the ASR the next day on-site. The Department's Juvenile Justice Information System (JJIS) suicide alerts were reviewed and all youth placed on suicide precautions were removed immediately after the youth was removed from PO. Documentation on the ASR confirmed a conference was conducted by the program director and licensed mental health professional in order to reduce the level of supervision. Discontinuation of PO was documented in accordance with the suicide prevention plan. PO does not limit a youth's activity to the youth's sleeping room. The program does not use secure observation which was verified by the program's facility operating procedures and observation. Three staff were interviewed and questioned if a youth expressed suicidal thoughts, what steps are the responsibility of the staff.. Three staff reported they would notify mental health, place the youth on constant sight and sound, and document supervision. Two staff reported searching the youth and room for

sharp objects. Three staff were questioned on the location of the suicide response kits. All staff responded the kit is kept in master control.

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

A review of the seven youth mental health records found each record was applicable for suicide precaution observation logs. All seven youth were admitted on precautionary observation (PO) at the time of admission when transported from the detention center and continued on PO at the program. Each of the seven youth's PO logs were documented on the Department's Suicide Precautions Observation Log form and was maintained for the duration the youth was on suicide precautions. All reviewed PO logs documented the appropriate level of supervision and observations of the youth's behavior. One of seven reviewed records included a PO log with the youth's name but no other identifying information. In all PO logs reviewed, staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals and five-minute intervals for the youth on close watch. There were no warning signs required to be noted on the logs. All PO logs included specific language documenting safe housing areas within the program. All PO logs were reviewed and signed off by a shift supervisor. All PO logs were reviewed and signed off by the mental health clinical staff. Two of the reviewed youth placed on PO were interviewed regarding their experience on PO. The two youth reported they were with staff at all times while on PO and 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.	

A review of seven staff in-service training records was conducted. Each of the staff completed the required six hours of suicide prevention training. The program has a written suicide prevention plan which includes suicide prevention training to include mock suicide drills for staff. A review of the program's last four quarters of mental health mock drills found drills were conducted in June 2018 through December 2018 and March 2019. Documentation for the last four quarters revealed the program conducted mock drills with scenarios which did not meet required criteria, which includes a response to a suicide attempt and/or incident of serious self-injury. Three of the four drills did not record a time of the mock drill to further validate the mock drills being conducted on a designated shift. The program has three shifts which only one out of the four drills noted a time frame.

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 written crisis intervention plan. The plan included all of the required information including notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review.

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

The program has not had any crisis assessments during the annual compliance review period. The program has a written policy and procedures in place for crisis assessments. The mental health clinical staff person performing the crisis assessment will provide information such as a clear description of the crisis situation or event, a description of any events or circumstances which appeared related to the crisis, action taken to intervene, and the youth's symptoms or behavior, relevant medical or mental health history, and current behavioral observation. Once the crisis assessment is completed, the program director and the designated mental health clinician authority (DMHCA) are notified of any findings and special instructions. The program director then notifies the supervisor on duty and it is documented on the shift pass on report. The control room is notified, and the alert is posted on the dry erase board in the control room. A level of supervision is then recommended for the youth. A mental health clinical staff continues to follow-up with the youth in accordance with the follow-up plan on the Crisis Assessment until which time a mental status examination has been completed by a mental health clinical staff and it is determined the youth's crisis has been resolved.

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 has an integrated emergency mental health and substance abuse services and crisis intervention plan. The plan includes the following: 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 , transport for emergency substance abuse assessment and treatment, 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 did not utilize a Baker Act or Marchman Act procedure during this annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program's designated health authority (DHA) is a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA's license expires on January 31, 2020. The DHA's specialty training is in internal medicine with experience with adolescents. The provider does not employ a physician's assistant (PA) or advanced registered nurse practitioner (ARNP) as it is not contractually required. The DHA is on-site at least once a week and documentation reflected no more than nine days passed between on-site visits. Evidence of the DHA's weekly visits were reflected in documentation on the program's weekly program complaint log, in which the DHA signs and/or initials by each youth seen each week. In the event of the DHA's absence, the program utilizes the Fort Walton Medical Center for any medical needs. The DHA is available twenty-four hours a day, seven days a week by phone for acute medical concerns, emergency care, and coordination of off-site care. An interview confirmed the DHA is on-call, twenty-four hours a day. The DHA responsibilities include performing Comprehensive Physical Assessments (CPA), sick call, and periodic evaluations.

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 program director signs and dates all respective treatment protocols and facility operating procedures (FOPs). Nursing staff reviews, signs, and dates a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by nursing staff for changes which occur between annual compliance reviews. An annual review of all FOPs and protocols is completed by the program as reflected by the signatures of the program director, DHA, and nursing staff on the cover pages of the protocols and FOPs. 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. 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 ensuring the program provides informed consent to each youth admitted to the program in which the general authorization for healthcare is present and parent/guardians are notified of healthcare. Seven youth individual healthcare records (IHCRs) were reviewed and reflected an Authority for Evaluation and Treatment (AET),

each of which were stamped "copy" in red ink, was included in each IHCR. AETs are valid until the youth's eighteenth birthday. Copies of parental notifications were observed to be maintained behind the AET in each seven IHCRs. A review of three IHCRs reflected the youth turned eighteen while in the program, in which a new AET was signed by the youth.

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

The program has a written policy and procedures ensuring the program provides informed consent to each youth admitted to the program in which the general authorization for healthcare is present and the parent/guardian are notified of healthcare. Seven youth individual healthcare records (IHCRs) were reviewed for parental notification. Two IHCRs reflected documentation of parental notification for over-the-counter medications beyond what is covered in the Authorization for Evaluation and Treatment (AET). A review of two records reflected documentation of significant changes in medication. One youth reflected notification for a change in chronic condition or change in medication for youth with chronic conditions. One youth required emergency off-site care and documentation of parental notification was present. Two youth reflected parental notification for non-routine dental procedures. Four youth IHCRs reflected parental notification for off-site care. The program sends written notification in addition to telephone notifications. Documentation reflected staff members witnessed telephone attempts or contacts in four of seven youth IHCRs. There were no youth reviewed which were applicable for involvement with the Department of Children and Families.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

Four of seven youth individual healthcare records (IHCRs) reviewed were applicable for notification by Clinical Psychotropic Progress Note (CPPN). In all four applicable IHCRs, documentation for parental notification of prescribed, discontinued, or dosage adjustments was present. The notification for four youth was sent by certified mail along with the CPPN (page three) to include explanatory information for the initiation of psychotropic medication. Additionally, notification was observed to be sent when changes in medication occurred for all four applicable youth. Documentation in four youth IHCRs reflected verbal consent was obtained for the CPPN, in which a staff member signed indicating they witnessed the call. The parent/guardian signatures were observed in three IHCRs for consent. One CPPN did not reflect the parent signature.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

The program has a written policy and procedures ensuring immunization histories of each youth admitted to the program are obtained, evaluated, updated, and if necessary immunizations are administered following written consent by the parent/guardian. Seven youth individual healthcare records (IHCRs) reflected immunizations were verified within thirty days of the

youth's admission. Immunizations for the seven youth reviewed were found to be up to date upon admission to the program. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. Immunizations are verified by the program's registered nurse (RN) through the youth's school immunization records and by Florida Shots.

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

The program has a written policy and procedures to ensure all youth are screened for health-related conditions upon admission to the program utilizing the Facility Entry Physical Health Screening (FEPHS) form. Seven youth individual healthcare records (IHCRs) were reviewed for healthcare admission screening. Seven IHCRs reflected a FEPHS was completed on the day of admission by a registered nurse (RN) for each youth.

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

The program has a written policy and procedures in place to identify youth who have medical problems or conditions which may affect the health and safety of the youth, their peers, the staff or the program. Seven youth individual healthcare records (IHCRs) were reviewed for medical alerts. Three youth were applicable for medical related alerts. Four youth were applicable for mental health related alerts. Alerts were observed and posted in the kitchen, nurses' station, control room, and the bulletin board in administration. Medical staff updates the internal alert roster when there is a new admission to the program and when changes occur which require the alert roster to be updated. The internal alert roster matched the alerts identified in seven IHCRs reviewed. However, two alerts which were no longer applicable were observed to be open in the Department's Juvenile Justice Information System (JJIS). Once identified during the annual compliance review, the alerts were closed by medical staff. Three staff were interviewed and each reported they are informed of youth alerts by taking a youth to medical, by other staff, and information passed along through the intake process.

4.09 Youth Orientation to Healthcare Services	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 ensuring all youth admitted to the program are provided with healthcare orientation and education. Seven youth individual healthcare records (IHCRs) were reviewed for orientation to healthcare services. All seven IHCRs contained documentation each youth received healthcare orientation upon their admission to the program. The program's healthcare orientation included access to medical care, sick call, what constitutes an "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. A review of the healthcare contacts reflected they were accurate.

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

The program has a written policy and procedures ensuring the designated health authority (DHA) is notified of all youth admitted with certain conditions. Seven youth individual healthcare records were reviewed for DHA notification. Three youth entered the program with an existing chronic condition which required DHA notification. There was documentation in the progress notes which reflected the DHA was notified in all three applicable youth. There were no youth admitted in need of an emergency response. Documentation reflected the notification for the three applicable youth was made by telephone.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

The program has a written policy and procedures in place ensuring if there is a change in the physical custody of a youth while in the program, a Facility Entry Physical Health Screening (FEPHS) form will be completed upon the youth's return to the program. Seven youth individual healthcare records (IHCRs) were reviewed for a healthcare rescreening. One IHCR reviewed was applicable for a rescreening. The program provided two additional applicable records for review. In all three applicable IHCRs reviewed, documentation reflected a FEPHS was completed within twenty-four hours of the youth's return to the program. Documentation further reflected a registered nurse (RN) completed all three re-screenings.

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

The program has a written policy and procedures in place ensuring all youth admitted to the program receive healthcare screenings and evaluations which include a Health-Related History (HRH). Seven youth individual healthcare records (IHCRs) were reviewed for a HRH. Seven youth IHCRs reflected documentation a HRH was completed by a registered nurse (RN) on the date of admission for each youth. All seven HRHs were new and not updated. Documentation reflected all seven HRHs were reviewed by the designated health authority (DHA). Six IHCRs reflected the HRH was completed prior to the Comprehensive Physical Assessment (CPA). One record reflected the HRH was completed at the same time as the CPA.

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

The program has a written policy and procedures in place ensuring each youth admitted to the program receives a Comprehensive Physical Assessment (CPA) within seven days of admission to the program. The program uses the Department's CPA form. Seven youth individual healthcare records (IHCRs) were reviewed for a CPA. A review of five IHCRs reflected the youth had a current CPA upon admission to the program and two youth did not.. It

is the program's practice to complete a new CPA for each youth admitted to the program regardless if there is a current one on file. Seven IHCRs reflected a CPA completed by the designated health authority (DHA) within seven days of admission to the program. Four youth reflected a medical grade of five, two youth reflected a medical grade of one, and one youth reflected a medical grade of two. The CPA was observed to be completed in accordance with Health Services Manual requirements. All sections of the CPA were marked with an "O" or an "X". Sections marked with an "X" reflected comments by the DHA in the comments section of the form. Seven youth refused the gender specific genital exam, in which all seven youth signed a refusal. The problem list was observed to be updated in all seven IHCRs reviewed.

4.14 Female-Specific Screening/Examination	Non-Applicable
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

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

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

The program has a written policy and procedures to ensure all youth receive an evaluation of tuberculosis status and risk upon admission to the program. Seven individual healthcare records (IHCRs) were reviewed for tuberculin skin test (TST) screening. Seven IHCRs reflected documentation of at least one TST in the past year. Seven IHCRs reflected each youth receive Tier I B screening on the day of admission to the program. Each youth was assessed prior to placement in the general population. The results of the TST were observed to be documented on the Comprehensive Physical Assessment (CPA) as well as the Infectious and Communicable Disease (ICD) form. 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.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

The program has a written policy and procedures in place ensuring all youth entering the program are evaluated and treated, if necessary for sexually transmitted infections (STIs). Seven youth individual healthcare records (IHCRs) were reviewed for STI screening. Seven IHCRs reflected documentation of a completed STI screening form. Seven youth were referred for testing. Observations of referrals were documented on the STI screening forms for all seven youth. Results of the tests were documented on the Infectious and Communicable Disease (ICD) form in all seven IHCRs. Additionally, the lab results for seven youth were observed to be filed in the lab section of the youth's IHCR.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

The program has a written policy and procedures in place to address human immunodeficiency virus (HIV) testing which also includes education and counseling. A review of seven youth individual healthcare records (IHCRs)reflected all seven youth were offered testing, counseling, and treatment upon their admission to the program. Documentation reflected four youth refused testing and three youth consented. the IHCRs of the three youth who consented to testing contained results which were observed and filed in a confidential manner consistent with Florida Statute 381.004. HIV testing and counseling is provided by the Okaloosa AIDS Support and Information Services (OASIS). Documentation of the three youth's consent to testing was observed in each IHCR. The program provided a copy of the 500/501 certification. Pre-test and post-test counseling provided by OASIS for the three applicable youth was documented in the health education section of each youth's record. In the event the youth wants to release the results of the testing to other parties, the program's practice is to have the youth sign a consent specifying whom the information can be released to. No consents of release were observed in the three applicable youth IHCRs. Seven youth were interviewed and each reported they can ask for HIV testing.

4.18 Sick Call Process – Requests/Complaints	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 has a written policy and procedures in place ensuring a system of response to complaints of illness or injury of a non-emergent nature to the youth. Seven youth individual healthcare records (IHCRs) were reviewed for sick call. None of the seven IHCRs reflected documentation any of the youth presented with similar complaints three or more times within a two-week period. Three of the reviewed youth IHCRs reflected documentation of a sick call. Two of the three applicable records for sick call reflected a referral was made to the designated health authority (DHA) who is a licensed physician . None of the youth complained of severe pain in which staff was unfamiliar. The sick call was completed by the registered nurse (RN) for all three youth reviewed. Sick call is conducted seven days a week at 11:00 a.m. and 2:00 p.m. Additionally, the nurse reported youth can submit a sick call form at any time. The sick call box is checked every four hours and youth can also have the youth care worker radio medical at any time with issues. Observation reflected the sick call hours were posted in the dining hall, in the youth handbook, and in the dorms, in addition to forms being available in these areas. In the event a licensed nurse is not on-site, the supervisor will review the sick call form and call the RN or DHA for consult. The program does not utilize a computerized system for sick call. Seven youth were interviewed in regard to the sick call process. Five youth reported they are seen for sick call immediately and two youth reported they are seen by the nurse within a day.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

The program has a written policy and procedures in place ensuring a system of response to complaints of illness or injury of a non-emergent nature to the youth. Seven youth individual

healthcare records (IHCRs) were reviewed for sick call. Three applicable youth IHCRs reflected the youth placed a sick call. Each sick call reviewed was completed by the registered nurse (RN). Sick call forms and progress notes were observed to be documented in accordance with the Health Services Rule. Sick calls were observed documented in the sick call log. Youth signatures for all three applicable youth were observed on the sick call form. Sick calls were observed filed with the progress notes for each of the three youth. Youth privacy is ensured during sick call encounters. An exam chair and equipment are used to perform sick call. A sick call was observed during the annual compliance review in which the youth's consent was obtained prior to observing. The youth was escorted to medical by a youth care worker who is Protective Action Response (PAR) certified. The youth was seen in the nurse's station in which the youth care worker remained in the doorway within sight and sound of the youth. The youth was examined by a RN who identified themselves and obtained the youth's signature on the sick call form. Seven youth were interviewed in regard to the sick call process. Five youth reported they are seen for sick call immediately and two youth reported they are seen by the nurse within the day. An interview with three staff reported the nurse conducts sick call.

4.20 Restricted Housing	**Satisfactory Compliance**
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program ensures youth who have been placed in controlled observation have timely access to medical care. One of the seven youth individual healthcare records (IHCRs) was applicable for controlled observation. The program was able to provide three additional examples for review. Documentation in three of the four IHCRs reflected the Health Status Checklist form was completed by the registered nurse (RN). Three of the four IHCRs reflected additional documentation of the youth's placement in controlled observation in the progress notes. None of the four youth required prescribed medication during their placement in controlled observation. One youth record did not reflect completion of the Health Status Checklist nor any notes of placement in controlled observation in the progress notes. Three of the four applicable youth for controlled observation were available for interview. One youth was not available due to recently being released from the program. Two youth reported they were seen by medical upon placement in controlled observation. One youth reported they were not seen by medical, which was consistent with the lack of documentation in the youth's record.

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

The program has a written policy and procedures in place to ensure the program maintains written healthcare practices for on-site episodic care, first aid, and emergency care by staff. Three youth individual healthcare records (IHCRs) reviewed were applicable for episodic care. One of the three youth reviewed was referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow-up/future care. On-site care provided by licensed healthcare staff was documented in subjective, objective, assessment, and place (SOAP) format. Emergency medical and dental care, including emergency medical services are available twenty-four hours a day. The program has eight first aid kits on-site. Four are located in control, one in the dining hall, two in the vocational classroom, and one in the nurse's station. All first aid kits contained the approved contents and are inspected monthly by the registered nurse. 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 IHCRs. Seven youth were interviewed and reported they can see a dentist if experiencing tooth pain and a doctor, if needed.

4.22 Emergency Care	**Satisfactory Compliance**
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The program has a written policy and procedures in place to ensure the program maintains written healthcare practices for on-site episodic care, first aid, and emergency care by staff. The program has one automated external defibrillator (AED) located in master control. Instructions are located inside the AED. The registered nurse (RN) performed a self-test of the AED during the annual compliance review. The batteries in the AED had an expiration date of May 2024. The pads in the AED expire in May 2019 and a new set was observed ready for installation. The AED batteries were last changed in February 2019 and the pads were last changed in May of 2014. AED checks were observed to be consistently completed by the RN for the previous six months. According to the written policy and procedure, medical drills are conducted quarterly on each shift simulating events which require emergency care and first aid. The use of cardiopulmonary resuscitation (CPR) will be included in at least one drill a calendar year. A review of drill documentation reflected the program has conducted drills quarterly and on each shift since the last annual compliance review. The program has a list of emergency numbers including Poison Control Information Center located on the bulletin board in the front lobby area, which is inaccessible to youth. The program's healthcare and direct care supervisory level staff are trained in the administration of an Epinephrine Auto-Injector. Three staff were interviewed and reported they can call 9-1-1 if a youth has a medical emergency.

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

The program has a written policy and procedures ensuring the program will provide timely referrals and coordination of medical services to an off-site health care provider, emergent and non-emergent. Four of seven youth individual healthcare records (IHCRs) were applicable for off-site care. Three IHCRs reflected documentation of parental notification. Four (IHCRs) reflected completion of the Summary of Off-Site Care form. Discharge documents were filed in four applicable records. The designated health authority's (DHA) signature was observed on all four off-site care findings, instructions, and information. An interview with three youth reflected documentation in which follow-up or additional appointments were necessary. The medical staff utilizes an appointment calendar to track referrals and additional appointments youth may have to ensure youth received appropriate and timely follow-up care as needed.

4.24 Chronic Illness/Periodic Evaluations	**Satisfactory Compliance**
The facility shall ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-up.	

The program has a written policy and procedures to ensure the program is proactive in providing care for chronically ill and developmentally disabled youth. Seven youth individual healthcare records (IHCRs) were reviewed for chronic conditions. Three youth reviewed were

applicable for chronic conditions. Each of the three youth was identified as having a chronic condition on the program's internal alert roster. All three youth were classified as a medical grade two to five. None of the youth were applicable for a communicable disease. Documentation in all three IHCRs reflected each youth received a periodic evaluation at no greater than three month intervals. There were no observed lapses or missed periodic evaluations. None of the youth were taking anti-tuberculosis medication. Periodic evaluations are tracked through a chronic conditions roster. All three youth received their periodic evaluations on-site. Treatment orders were observed to be written in a clearly distinguishable manner. The problem list for each youth was updated in accordance with the Health Service Rule 63-M. According to the program director, upon youth admission appropriate staff are notified of health-related issues with the youth. The designated health authority (DHA) reported youth with chronic conditions are evaluated every ninety days and the nurse tracks periodic evaluations by using a chronic condition roster.

4.25 Medication Management – Verification	**Satisfactory Compliance**
A youth's medication regimen shall be ascertained upon admission to the facility.	

The program has a written policy and procedures to ensure a system is in place to verify the authenticity of all medications brought into the facility, to verify the actual medication regimen of all youth admitted, and to establish a system of timely procurement of medications. Four of seven youth individual healthcare records (IHCRs) reflected youth were taking prescribed medication at the time of their admission to the program. Each of the four applicable youth were admitted to the program from detention in which each youth had a Non-Licensed Staff Medication Record which reflected the prescriptions and transfer of medication from the detention center to the program. Documentation in all four IHCRs reflected the prescription verification in the progress note and contact with the psychiatrist. All four youth were admitted with psychotropic medication. None of the seven youth reviewed were admitted to the program when nursing staff was not available. Two of the four applicable youth required notification to the designated health authority (DHA). A review of the Facility Entry Physical Health Screening (FEPHS) form reflected documentation of all four youth being admitted with medication and subsequent verification.

4.26 Medication Management – Orders/Prescriptions	**Satisfactory Compliance**
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

The program has a written policy and procedures requiring the program maintain a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. According to the written policy, all medications which are administered must have a physician's order which specifies the name of the medication, dosage, frequency, and mode of administration. Four of the seven youth individual healthcare records (IHCRs) reviewed were applicable for prescription medication. All medications were observed to have a current valid order. Current medications prescribed prior to admission were renewed or refilled for the life of the prescription as long as there were no changes in the total dosage or route. When current medications are continued, discontinued, changed, or new ones are orders, the designated health authority (DHA) placed a practitioner order in the progress notes. Two of the seven youth reviewed were administered over-the-counter (OTC) medications which are not listed on the Authorization for Evaluation and Treatment (AET) in which they were

administered in accordance with approved protocols. None of the parent/guardians prohibited the administration of OTCs by way of the AET.

4.27 Medication Management – Storage	**Satisfactory Compliance**
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

The program has a written policy and procedures to ensure all medications will be stored in a safe and secure manner consistent with State and Federal Law and the highest standards of professional practice. All medications were observed to be in separate, secure areas inaccessible to youth. All non-controlled medications 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. The program uses RX Destroyer for the disposal of non-controlled medications. The pharmacist comes to the program once a month and with two licensed nurses uses the RX Destroyer to dispose of controlled medications.

4.28 Medication Management – Medication and Sharps Inventory	**Satisfactory Compliance**
All medications and sharps shall be inventoried as per department requirements.	

The program has a written policy and procedures to ensure all medications will be stored in a safe and secure manner consistent with State and Federal Law and the highest standards of professional practice which includes sharps, syringes, or any other medical tool(s). All over-the-counter (OTC) medications are inventoried weekly. The program maintains a perpetual inventory with running balances maintained on all controlled substances with a shift-to-shift inventory. Syringes and sharps inventoried weekly by nursing staff. In the event there is a discrepancy in sharps or medications, the program director and director of nursing is immediately notified, and a search is conducted. An inventory of three youth medications was conducted during the annual compliance review. Two of which were controlled medications and the medication on hand matched the inventory. An inventory of three OTC medications was conducted during the annual compliance review and the medication count matched the inventory. An inventory of three sharps was conducted during the annual compliance review and the sharps counts matched the sharp inventories. Inventories for medications and sharps were available for review for the previous six months. The program has a contract with Stericycle in for the disposal of biohazardous waste.

4.29 Medication Management – Controlled Medications	**Satisfactory Compliance**
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a written policy and procedures in place which require the program to have a system in place to ensure proper distribution and administration of controlled substances to include adequate documentation and record keeping. The program's written policy and procedures articulate a shift-to-shift inventory with running balances with two signatures

observed. According to the registered nurse (RN) and written policy, non-licensed staff do not have authorization to administer controlled medication to youth. An observation of counts of three controlled medications were observed during the annual compliance review and the counts matched the corresponding inventory. Controlled medication was observed to be stored in the secure medication cart inside a separate locked box from all other medication. Inventories from the previous six months were available for review.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

The program has a written policy and procedures requiring the program to maintain a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Each youth in the program has a MAR regardless of being prescribed medications. Seven youth individual healthcare records were reviewed for a MAR. The MAR for each youth included the youth's name, Department of Juvenile Justice (DJJ) ID number, date of birth, allergies, precautions, and medical grade. Photographs of each youth were attached to their corresponding MAR in the MAR binder. The MAR indicated the youth received medications as prescribed, including start and stop dates. Over-the-counter (OTC) medications were also documented on the MARs. There was one instance of missed non-controlled medication for one youth. Documentation for this youth reflected the youth was off campus during the time scheduled to receive this medication. The registered nurse (RN) initialed the MAR for each medication entry. There are non-licensed supervisory level staff trained to assist youth in medication administration; however, there were no observed instances of non-licensed staff administering medication for any of the seven youth reviewed. Nursing staff documents weekly side effect monitoring on the MAR. Refusals of medication are clearly documented on the MAR. There were no instances of missed psychotropic medication. Four of the seven youth reviewed were admitted to the program with prescription medication. The progress notes and orders corresponded with the administration of medication on the MAR.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

The program has a written policy and procedures requiring the program to maintain a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. None of the seven youth individual healthcare records reviewed were applicable for parenteral medication. Medication administration occurs daily at the program at 7:10 a.m., 12:20 p.m., and 5:00 p.m. Medication administration procedures are clearly posted for youth outside of the nurse's station. Medication administration was observed during the annual compliance review. The nurse's station was observed to be clean and organized. The nurse had control of the medication cart. There is a structured process by which youth approach the nurse. During the observation, each youth approached the cart, stated their name, date of birth, and confirmed their medication. Youth were observed taking their medication with a small cup of water, the nurse then swabbed their mouth, and youth ate a handful of crackers and drank more water if needed. The Five Rights of Medication Administration were verified. Verification of the Medication Administration Record (MAR) was observed. Allergy and alert

status was verified by the nurse. The nurse did not pre-pour any of the of the medications. None of the youth refused their medication. Three staff were interviewed and reported the nurse gives youth their medication. Seven youth were interviewed and reported the nurse gives them their medication.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program has a written policy and procedures requiring the program to maintain a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. None of the seven youth individual healthcare records reflected youth received medication from non-licensed staff. The program does have a list of approved supervisory level staff trained to assisted youth in the administration of medication; however, the registered nurse (RN) reported the administration of medication by non-licensed staff is extremely rare. Non-licensed staff are only trained and authorized to assist youth in self-administration of oral, topical, or inhaled prescribed medication. Three staff were interviewed and each reported the nurse gives youth their medication. Seven youth were interviewed and each reported the nurse gives them their medication.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

The program has written policy and procedures requiring the program to maintain a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. Seven youth individual healthcare records (IHCRs) were reviewed for the administration of psychotropic medication. Four youth IHCRs reflected youth were prescribed psychotropic medication upon admission to the program. Progress notes reflected the psychiatrist was notified of admission for all four youth. The psychotropic medication the four youth were receiving prior to admission was continued until an initial diagnostic psychiatric review was conducted. An initial psychiatric interview was conducted for all four applicable youth within fourteen days. Documentation reflected the youth received medication monitoring by the program's psychiatrist. There were no examples of youth being prescribed psychotropic medication subsequent to admission during the annual compliance review period. The program uses the Department's Clinical Psychotropic Progress Note (CPPN). The prescription of new or changes in the existing medication were documented on the CPPN for all four applicable youth. The CPPN included each youth's diagnosis, target symptoms of medication, evaluation and description of the effect of prescribed medication on target symptoms, side effects, youth's adherence to the medication regimen, laboratory findings, and telephone contact with the parent/guardian to discuss the medication. The psychiatrist's signature and date were observed on the CPPN in all four applicable records. Monthly monitoring for Tardive Dyskinesia was observed. There were no standing orders for psychotropic medication. There were no emergency treatment orders for psychotropic medications or pro re nata (PRN) orders for psychotropic medication.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility 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 program has written policy and procedures to document the system in place which provides for control of infectious and communicable diseases. The program's infection control procedures in place includes 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 includes 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, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. There were no instances in which the local health department, CDC, or the Central Communications Center (CCC) were notified of an infectious disease.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

The program has written policy and procedures to document the system in place which provides for control of infectious and communicable diseases. The program's comprehensive infection control education plan includes pre-service and in-service training for all staff according to the Center for Disease Control (CDC) guidelines. A review of seven staff pre-service and seven staff in-service training records reflected staff completed training on infection control. Seven youth individual healthcare records reflected each youth received infection control education.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program's exposure control plan was found to be written in accordance with Occupational Safety and Health Administration standards. The plan is available to all staff. The plan is reviewed and signed annually by the program director (PD). The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. In the event youth or employees experience an occupational exposure, the PD establishes a separate file and records are maintained for ten years. The program did not have instances of reportable infectious disease which needed to be reported to the local county health department during the scope of the annual compliance review. The PD reported the exposure control plan is located in the control room and is reviewed yearly with all staff.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

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

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

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

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

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.	

Program staff maintained active supervision of all youth including interacting positively with each of them and keeping a one to eight ratio. Youth were engaged in a full schedule of constructive activities daily while staff closely observed behavior of each youth and looked for changes in behavior. The implementation of the program's behavior modification system was consistently observed while on-site during the annual compliance review. Program staff were able to account for all of the youth under their supervision at all times during the review period. The youth to staff ratio during daytime activity hours is one to eight and one to twelve during night time hours. On the first day of the review, youth were observed in physical education with twelve youth and five staff. The assistant director was present. All of the youth were playing basketball or sitting in the shade, the staff was standing at each corner of the basketball court, and the assistant program director (APD) was walking around the perimeter of the recreation area. On the second day of the review, youth were observed in recreation with fifteen youth on the basketball court and four youth care workers, recreation therapist, and the APD. A youth was observed prior to a transport. Two staff took one youth off campus for a doctor appointment. The vehicle was inspected and the youth was searched. Both the youth and staff wore seatbelts before the driver started the vehicle. On the third day of the review, youth were observed going to class with one staff in front of the line and one staff in the back of the line with eight youth in transition. The youth were searched before transition and before entering the classroom. Staff members were questioned on five different occasions of their youth count. Each time the count was correct without the staff having to recount. The program's written policy and procedures defines active supervision as staff being within sight and/or sound of youth at all times. The activity schedule is planned for each day. Current daily schedule is posted in the dayroom of each dorm. During all observations of the programming, the youth were busy and did not have any unstructured time. The staff were observed closely monitoring the youths' behavior and changes of behavior. The behavior modification system was observed throughout the review. The youths' points were discussed with youth by the youth care workers and or the assistant director and point deductions with reason were called over the radio to control. Staff was able to account for the youth under their supervision at all times. Youth were accounted for and accompanied at all times. the youth were not permitted to roam freely.

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) employed at the program.*	

The program's behavior management system (BMS) was reviewed. There was an agreement between the program and the school related to the BMS. The BMS is clearly written and is in the youth's handbook. Seven youth case management records had a signed document by the youth indicating the youth received a copy of the student handbook at intake. Rules governing conduct and positive and negative consequences for behaviors are posted in the youths' handbook. The program's BMS has not changed since the last annual compliance review period. The BMS was posted in an area conspicuous for youth to observe. Three staff were interviewed and each understood the BMS. Seven youth were interviewed and each understood the BMS.

The program director (PD) was interviewed and was able to describe how the program's BMS is monitored and addressed by management, if necessary. The program's written BMS included provisions to maintain order and security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions which are non-punitive, opportunities for a positive reinforcement, recognition of accomplishments, and positive behavior at a four to one ratio. The BMS also promotes socially acceptable means for youth to meet their needs, a process for explaining to each youth the reason for any sanction imposed, opportunities to explain their behavior, and opportunities for staff and youth to discuss impact of behaviors on others. Youth and staff discuss alternate behavior through referring to the treatment plan and identifying coping skills. The BMS promotes positive dialogue and peaceful conflict resolution. Separation of youth from population is minimized and rare with the population who is served. Coordination of individual behavior plans are completed. There is consistent implementation and treatment through oversight.

Staff and youth interactions were observed for adherence to the BMS implementation. Staff to youth supervision ratio remained at a minimum of one staff to eight youth. The positive reinforcement to negative consequences were observed to occur in a four to one ratio. There were zero negative consequences observed during the annual compliance review. The program's written behavior management system policy and procedures state there is a required ratio of positive to negative consequence of four to one. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited. There is a variety of rewards and incentives offered through the BMS. The BMS includes special provisions in the provider's contract including but not limited to nightly incentives, off campus trips once youth have reached the appropriate level, token economy store, thirty minutes of video games, and a movie night. Three staff and seven youth were interviewed and indicated youth have a variety of incentives including token economy store, video game time, playing cards, off-campus trips, and other daily incentives. The PD stated the shift supervisor and the assistant program director review the point card daily.

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's written policy and procedures were reviewed to ensure there is a protocol in place where staff are able to provide feedback regarding implementation of the behavior management system (BMS). The youth care worker job description outlines specific qualifications of staff whose job function includes implementation of the program's BMS. The provider contract was reviewed and all required parties were involved in the development, implementation, and on-going maintenance of the applicable BMS. Three staff were interviewed and staff stated there is an annual review completed in December of the BMS. Staff utilizes a point card and discipline report court along with treatment teams to address youth behaviors. The program director stated the youth care workers tally points on the point cards and the assistant program director ensures each card is correctly tabulated. Three staff were interviewed and all three indicated supervisors monitor staff use of the BMS and provide feedback through reviews and staff incentives.

The program's BMS includes a process where staff explain to the youth the reason for any sanction imposed. Each youth is given an opportunity to explain their behavior. Both the staff and the youth discuss the behavior's impact on others. The discussion includes reasonable reparations for harm caused to others and alternate acceptable behavior. There were no room restriction or controlled observation utilized during the on-site review period. The BMS does not include any increased length of stay for youth, denial of basic rights, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement.

Three staff were interviewed and each reported they talk with youth and discuss with them if they have a sanction imposed through a meeting with the assistant director, case manager, and therapist. Three indicated they never been on room restriction. Seven staff training records were reviewed and each were trained in the program's BMS. The BMS includes special provisions outlined in the provider's contract. Staff are trained in the combined BMS plan to include use of the BMS during school. The program director (PD) trains education staff in the combined BMS plan to include use of the BMS during school. The PD stated the assistant director review point sheets and referral forms to monitor how consequences and or punishment are monitored within the program. The program does not utilize room restriction.

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

The program has sixteen cameras and fifteen cameras were operating. The assistant program director stated the cameras digital video recording (DVR) system holds thirty days of recordings. A copy of a work order was provided showing repair for the one camera noted as not functioning. A sample of ten random ten-minute checks where observed and compared with the program's logbook for the month of April. Second and third shift operations were reviewed between 8:00 p.m. and 5:00 a.m. timeframes. The logbook and the camera times for each check matched. Ten-minute checks were conducted by staff and each were less than eight minutes apart between room checks. After a ten-minute check was conducted, each staff initials next to each time entered on the ten-minute check form. A total of five different staff were observed during the ten-minute check review. Each staff used flashlights when looking into the youths' rooms. Three staff were interviewed and each staff stated youth checks must be conducted every eight minutes or less.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. *The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.* *The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable 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's written policy and procedures were reviewed for practice involving youth census, counts, and tracking. On-site observations demonstrated staff are conducting census, counts, and tracking of youth under the program's supervision. The counts are conducted at the beginning of each shift and after each movement. A review of the program's logbook indicates counts are being conducted at the beginning of each shift, after each outdoor activity, and during emergency drills. The program's continuity of operations plan (COOP) was reviewed and outlines when drills will be conducted. The program only has one logbook in the control room. The logbook contains the total daily census count, headcounts, youth movements, new admissions, releases, alerts, and youth temporarily away from the program. The logbook was reviewed and counts are conducted at the beginning of each shift, after each outdoor activity, and after youth are temporarily away from the program. There were no emergency counts noted during this review period. Three staff were interviewed. One staff stated youth counts are

conducted at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:30 p.m. One staff stated youth counts are conducted at 10:00 a.m. and 2:00 p.m. Another staff stated youth counts are conducted seven times a day. All movements are stopped and a recount is conducted.

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

The program's logbook was reviewed and is bound with numbered pages without any pages missing or falling apart. All entries are made in ink without erasure marks or whited out areas. There were no logbook entries obliterated or removed. All errors are struck through with a single line, dated, and initialed by the person correcting the error. All entries include the date, time of the event, with the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry. The program does not utilize a living unit logbook. The program summarizes in shift reports the event, incidences, and activities which are documented on a pass on sheet which is kept by the timesheet. All staff initial the pass on report when they begin their shift for the day. The program supervisor verbally briefs incoming staff about the contents of the shift reports and all incoming staff will review the shift reports. Incoming staff sign and date the shift report from the previous shift to document they reviewed or been verbally briefed about the contents. A copy of the shift report is located next to the time clock. The program documents incidents and activities in a central logbook which is located in master control. Color codes are utilized to highlight any events staff should be cognizant of such as security risk, etc. Special instructions from supervisors about monitoring of youth were noted. Population counts at the beginning and end of each shift are recorded in the logbook at 6:30 a.m., 8:00 a.m., 2:00 p.m., 6:00 p.m., 10:30 p.m., and 2:00 a.m. The perimeter security checks and other security checks conducted by maintenance are documented in the logbook and on daily sheets by all three shift supervisors. Transports away from the program including the names of the staff and youth involved, and the destination are documented in the logbook. Request by law enforcement to access any youth is documented in the logbook. A youth removal from the mainstream population is documented within the logbook. Admissions and releases including the name date and time of anticipated arrival or departure and mode of transportation is noted in the logbook. There were no attempted escapes noted during the review period. No Central Communication Center (CCC) calls were noted during the on-site review period.

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's written policy and procedures on key control which were reviewed outlines key assignment and usage. The policy includes restrictions on usage, inventory and tracking of

keys, and secure storage of keys not in use. In addition, procedures are in place which address missing or lost keys and practices to report and replace damaged keys. The distribution and collection of keys were observed. Keys are collected in the front lobby by master control. There are no personal keys permitted to enter the building. The building keys are located behind a secured area where each staff must enter an assigned number to obtain and return the program's keys. The key inventory was reviewed and the key inventory matches the actual keys in use. The key storage area was observed. Keys are locked up and only given out in exchange for personal keys along with the key log sheet. Keys must be returned to master control to obtain personal keys. Damaged keys are logged into a report and replaced by maintenance. The procedure to report a lost or missing key is to inform the program director or designee, lock down movement of the program, and inform Central Communication Center (CCC). The assistant program director stated special area keys are assigned to individuals for their specific program roles such as medical, case management, youth care, mental health, and maintenance. The program's method for the daily tracking and reconciliation of keys is to collect keys each shift and daily logs are reviewed by master control. Three staff were checked for personal keys and each of the staff did not have their personal keys on them. Three staff were interviewed and each staff stated they are given a number to check assigned keys in and out of the key control box located in master control.

5.08 Contraband Procedure	Satisfactory Compliance

The program shall develop and implement a system to prevent the introduction of contraband into the program.

A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.

The program shall document the confiscation of any 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.

The program's written policy and procedures on contraband were reviewed. The program's policy and procedures address the Department's recommended guidelines for contraband. The program conducts searches of every individual entering the program. Each individual enters through a metal detector and is scanned by a wand as they enter the building. The program's staff handbook defines what contraband is and the student handbook indicates the only items youth are allowed to have in the program. The youth are provided with a list of items which they are permitted to have at the program and are told if an item is not on the list, it is considered contraband. All common areas and rooms are searched and noted in the program's logbook. The program grounds are searched and noted in the program's logbook. Each youth is searched as they leave the dining hall, dorm, classrooms, group rooms, and recreation. Incoming mail is opened by the case managers while the youth are present. All outgoing mail must remain open until the case manager seals the outgoing letter. The program's policy for staff introducing contraband is clear. If a staff member brings contraband into the program, the

staff will be subject to disciplinary action up to and including dismissal which may involve law enforcement, if necessary. The program's standard of conduct stated all employees who are found in possession of contraband within the program will be subject to disciplinary action, up to and including dismissal which includes administrative staff. The program clearly delineates items considered contraband to include but not limited to the following illegal items such as sharps, escape paraphernalia, drugs, to include prescription or over the counter medications, tobacco products, electric or vapor less cigarettes, non-program Department issued program equipment, unauthorized food or beverage, cell phones, cash, keys, or any item not deemed safe to security. The program documents confiscation and disposition of contraband on discipline reports. There were no illegal contraband items discovered during the annual compliance review period. Searches are documented in the program's logbook. The youth's student handbook includes items considered contraband and list the consequences. An interview with the program director determined searches are conducted daily, contraband is discarded, if necessary law enforcement is contacted and contraband is turned over, and if reportable; the Central Communications Center (CCC) is contacted.

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.	

Youth searches were observed throughout the annual compliance review period, including before and after groups and before and after transport. There were no intake or visitation searches available to observe during the review. Youth were observed between education transitions and were searched before leaving the classroom and randomly searched before entering the next classroom. The youth were treated with dignity and respect during searches. The youth appeared relaxed. The searches were conducted by two staff and all searches were completed by staff the same gender as the youth. The searches were pat searches, completed with a four quadrant approach, youth were thanked, and encouraged by providing emotional support or encouragement before going into the next class. Searches are conducted according to Protective Action Response (PAR) training manual. Seven interviewed youth indicated the searches are conducted after returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail. Three staff were interviewed and each staff stated searches are conducted after every movement.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 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 addressing vehicle security and the transportation of youth. The program has two vehicles which are utilized to transport youth. The program provided documentation of the annual safety inspection and maintenance records

completed for both vehicles. The maintenance staff maintains a monthly inspection sheet on the vans. The vans were observed to be secured when not in use. The vans were equipped with a fire extinguisher, seatbelt cutter, window punch, and appropriate number of seatbelts. The first aid kit for both vehicles were maintained in the program's master control room. Staff indicated youth are not to be attached to any part of the vehicle by any means other than proper use of a seat' belt.

5.11 Transportation of Youth	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns 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 to ensure compliance of all requirements outlined by the Department relating to the transportation of youth and driver eligibility. A cellular phone and two-way radio is issued to a staff member before each off-campus trip. There is a one to five staff to youth ratio with all transports, having a minimum of two staff per transport. One transport was observed during the annual review. There is secure transportation provided for secure high-risk and maximum-risk youth and non-secure youth determined to be a greater security risk. One staff of the same gender as the youth is sent on each transport. A random check of both personal and program vehicles was conducted. All vehicles were locked. Each vehicle was inspected to ensure it was equipped with a safety screen separating the front seat or driver's compartment from the back or rear passengers' compartment with the youth. Both staff and youth were observed wearing seatbelts during the annual compliance review. Youth are not attached to any part of the vehicle by any means other than the proper use of a seatbelt. A vehicle inspection was conducted and the vehicle has a rear door which cannot be opened from the inside and doors to the youth passenger area cannot be opened form the inside. All staff operating program vehicles have a current driver's license. Staff are not allowed to leave youth unsupervised in a vehicle per written program policy and procedures. Youth are not permitted to drive program vehicles. Three staff were interviewed and each staff indicated they do not use personal vehicle to transport youth and tare provided with a company cellular phone for transports.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns 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 which outlines weekly safety and security audits. The shift supervisor is responsible for conducting the weekly audits and safety inspections. The program director is responsible for the development and implementation of corrective actions warranted as a result of safety and security deficiencies found during any internal or external review, audit, and or inspection. There are internal systems to verify the deficiencies are corrected and existing systems are improved. The program's written policy and procedures meet all the requirements outlined within Florida Administrative Code (FAC) 63E-7.013 (5). During the annual review period, there was a minimum of one security audit and safety inspection completed weekly during the last six months.

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 to provide instruction on the control of tools and sensitive items within the program. The policy addresses practices to ensure the safety, security, and accountability of all youth, staff, and tools in the program. Only the maintenance staff, program director, and assistant program director have keys to the tool room. Housekeeping staff have keys to the chemical closet. Each of the program's tools are marked for easy identification and are maintained securely within the maintenance office. In addition, tools are marked and inventoried in the outside secured shed. An inventory of all tools was inventoried prior to being issued for work and following work activities. A daily inventory is conducted on the maintenance staff tool bag which included sharp-edged and pointed tools. The program used a system of tool management where all tools were marked within toolboxes and hanging shadowboxes along with the corresponding number of tools in each drawer. Any tool which is checked out by maintenance would be signed out. A monthly inventory of all tools was also completed by the maintenance staff. Machetes, bowie knives, and other long blade knives are prohibited in this program. An inventory of kitchen tools was also conducted in which all items were accounted. Damaged tools are replaced and disposed of. The damaged tool will be disposed of by maintenance person and replaced if necessary. The program also maintains a limited number of cleaning tools such as a mop and broom within a secured closet located outside the dining room. Seven staff pre-service training records were reviewed and each staff received training in tool safety.

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 for youth tool handling and supervision requirements. The program's procedure for using tools for youth and staff, including youth's risks to self and others was reviewed. The program's procedure to determine the established ratios, tool distribution and collection, and search criteria was reviewed. Staff to youth ratio was maintained at one staff to five youth during activities using tools, one staff to three youth during discipline work projects, and vocational training one staff to three youth. Youth were observed completing work detail in the dorms and supervision was within ratio according to written policy. Youth are searched after each work project by staff.. Risk assessments were reviewed and seven youth had risk assessments completed. Risk assessments are completed on youth participating in tool projects or activities. Three staff were interviewed and indicated youth can use screwdrivers, hammers, saws, scrub brush, mops and brooms, and kitchen knife. The program has a vocational component on-site, Home Builders Institute (HBI) which youth are screened for prior to their participation.

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 for addressing outside contractors when entering the program to perform a work project which may require the use of tools. Approved

vendors who enter the program must have their tools inventoried by maintenance staff. An outside contractor on-site work project log is completed when entering the program which lists the tools. All tools will be checked upon arrival and departure. When a contractor is on-site, no youth are allowed in the work area. There are instructions of what to do if a tool is missing. A review of project invoices submitted to the program by the vendor was completed and the sign-in sheets matched the dates of the projects which were completed. The program's written policy and procedures also outlines who is responsible for providing approval for personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings which are prohibited in the secure area without approval.

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

The program's written disaster and continuity of operations plan (COOP) was reviewed and the program conducts practice drills and is prepared for immediate implementation or mobilization of plans whenever an emergency or disaster situation is necessary. Reviewed documentation revealed the program conducts fire drills monthly. The program conducts COOP drills annually. Fire evacuation routes and egress plans are posted throughout the program. The program director stated the program conducted fire drills, escape drills, evacuation drills, and hurricane drills. Seven youth were interviewed and responded fire drills are conducted monthly.

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.	

The program's written disaster and continuity of operations plan (COOP) was easily accessible and is readily available to staff in the program's master control room. The COOP was updated and submitted on March 19, 2019. The COOP was updated and submitted to the Department residential regional director on March 19, 2019. The program's written COOP addressed alternative housing plans approved by the Department. Documentation is present confirming the COOP was submitted to the Department for approval. Provision of equipment and supplies required for continuous operation and services were observed. The program director stated the COOP was in the master control room. The COOP contains fire and fire prevention and evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff rolls and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions of continuity of care and custody of youth, and provisions for public protection.

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

The program has a written policy and procedures which addressed flammable, poisonous, and toxic items and materials. The written policy requires flammable, poisonous, and toxic item to be stored in secured areas which are not accessible to any youth. These items were observed to be secured in the locked closet outside dining hall. The program stores the flammable materials such as diesel, gas, or pesticides outside in the maintenance shed. The program maintained an accurate inventory of all the chemicals, flammables, and toxic items, which are located in each area. The only staff authorized to handle these items in the program is housekeeping. Safety Data Sheets (SDS) are kept within a binder in each storage unit area. The binder also included a copy of the program's operating procedures for flammable, poisonous, and toxic control items, as well as a copy of the chemical disposal protocol. A review of each item observed found the corresponding SDS was conducted. Only housekeeping staff have a key to access to the chemical storage areas.

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 has a written policy and procedures regarding handling and supervision of flammable, poisonous, toxic items, and materials. The program has all poisonous, flammable and toxic materials locked behind a door. Youth do not use, handle, or clean-up dangerous or hazardous chemicals. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. There is restricted youth access to areas where items are being used or stored. Staff sprays area and youth wipe away cleaning solutions. Seven youth were interviewed and six reported they do not use any chemicals/cleaning products. One youth were interviewed and reported they use paint and floor wax. Seven youth were interviewed and each reported staff spray chemicals and youth wipe it up.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance mechanic, 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 addresses flammable, poisonous, and toxic control, and the disposal of these items. The maintenance staff is the only individual authorized to dispose of these items. There was documentation where the maintenance staff received training for disposing hazardous items and toxic materials. The maintenance staff stated the follow the Safety Data Sheets (SDS) sheets for disposal of these items. According to the maintenance staff, all corrosive and flammable items are disposed of through a hazardous waste container taken to a local dump in the Crestview area. Hazardous waste is disposed of in

accordance with the SDS and stored in a hazardous storage area. Liquid waste such as dirty mop water are disposed of in plumbing drains. Grease is placed in a separate container for disposal. An outside contractor picks up grease for disposal. The shift supervisor directs the shutdown of all air handlers and ventilation systems and closes all windows and doors at the direction of the on-scene supervisor. Assistance from outside the program is contacted as necessary and consistent with emergency procedures. The program director was interviewed and stated maintenance staff places items on the disposal list and transports material to the local dump for hazardous material disposal.

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

The program's activity schedule was reviewed. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. Activities are documented in the logbook according to the activity schedule. The program's written policy and procedures provided a list of activities based on the developmental levels and needs of the youth within the program. The activity schedule includes a choice of leisure and recreation options. Youth are encouraged to explore options and interests. Youth engage in constructive leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program was observed taking precautionary measures to prevent overexertion, heat stress, dehydration, and existing illness or physical injury. The program has a full-time recreational therapist position. Therapeutic activities are provided and are incorporated in all seven youth's treatment teams. The program has a youth assembly meeting which is conducted monthly. Seven youth were interviewed and each indicated they are involved in at least one hour of sports activity daily. Youth interviews stated they participate in basketball, flag football, and workout exercises. Three staff were interviewed and each indicated youth play at a minimum of fifty minutes of recreation activity per day.

5.22 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.

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

5.23 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

On-site observation of the program’s posted visitation schedule noted visitation occurs at 10:00 a.m. through 12:00 p.m. on Saturday’s and Sunday’s. Only individuals listed on a youth’s approved visitor log are allowed for visitation. The program’s written policy and procedures were reviewed as it relates to visitation, youth correspondence, and use of the telephone. The visitation log and schedule are consistent, telephone logs and schedules were reviewed and are consistent. Correspondence log and schedules were reviewed and are consistent. Alternative visitation is available with the parent/guardians. Youth are able to communicate with family by mail. Youth are given the opportunity to communicate with family members by telephone. The youth indicated they can mail two letters per week and unlimited legal correspondence. The youth stated they are allowed one call per week from the approved list. All seven youth interviewed had call logs. Seven youth reported the opportunity to communicate with family during via visitation, mail, or telephone.

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

The program had a total of four controlled observations during the annual compliance review period. The programs' controlled observation room is a minimum of thirty-five unencumbered square feet, has a metal door with a shatter-resistant window, vents are not easily accessible and covered with a metal plate, fire retardant plastic mattress suitable for use on the floor, recessed light fixtures covered with shatter-resistant material, shatter-resistant windows, and no electrical outlets inside the room. A review of documentation for staff conducting youth searches and room inspections prior to placing a youth on controlled observation was completed. Each of the four controlled observations had a staff conduct an inspection of the room prior to placing youth in the room or leaving youth alone in the room. Each of the four controlled observations had staff of the same sex search the youth before the youth is left alone in the room.

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

The program had a total of four controlled observations during the annual compliance review period. Each of the four controlled observations did not have any indications the youth exhibited behaviors indicative of a mental health crisis or suicide. The four controlled observations had supervisory or higher-level staff authorize placement. Each of the four controlled observations were authorized due to the youth's violent behavior which, if continued is likely to result in immediate injury or harm to self or others, and or substantial property damage. In each of the four controlled observations, staff advised youth for the reason of placement in controlled observation and expected behavior for removal. One of the four controlled observation reports was missing the name of the staff who advised youth the reason of placement in controlled observation and expected behavior. Three of the four reports had a healthcare professional or staff of the same gender as the youth complete the health status checklist. One of the four reports had an incomplete health status checklist. Number of hours in controlled observation were one hour and forty-five minutes, one hour and fifty-five minutes, two hours and thirty minutes, and three hours and thirty-two minutes. Two of the four reports documented the PD or designee granted extension for placement over two hours, not to exceed twenty-four hours. The other two controlled observations lasted less than two hours; therefore, they were not applicable for an extension. The two reports which extended beyond two hours were also approved by the PD or designee at least every two hours throughout the extension period. The PD designates supervisory or higher-level staff to approve placement of youth in controlled observation.

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

The program had a total of four controlled observations during the annual compliance review period. All four controlled observations documented staff making the placement completed the first page of the controlled observation report and submit to a supervisor. All four reports included documentation staff conducted and documented safety checks at least every fifteen

minutes to observe the youth's behavior. All four reports had document staff conducted all safety checks and observations on the controlled observation Safety Checks form. All four reports included written approval from the program director (PD) or supervisor who has delegated authority before youth were released from controlled observation with staff determining if an internal alert is warranted. All four reports had the controlled observation report, health status checklist, and controlled observation safety checks forms maintained in an administrative file and in the youth's individual management record. All four reports documented the PD or designee approved the release when it was determined, based on the youth behavior, the youth was no longer an imminent threat to self or others. All four reports included a review by the PD or assistant program directors to approve the controlled observation report within fourteen days of the youth's release from controlled observation to determine if the placement was appropriate.

Program Name: Okaloosa Youth Academy
Provider Name: Gulf Coast Youth Services
Location: Okaloosa County / Circuit 1
Review Date(s): April 30 - May 3, 2019

MQI Program Code: 830
Contract Number: 10288
Number of Beds: 60
Lead Reviewer Code: 144

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.20 Exit Portfolio	1.12 Restorative Justice Awareness for Youth
3.13 Suicide Prevention Training*	