STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Orange Youth Academy

True Core Behavioral, LLC.
(Contract Provider)
3150 39th Street
Orlando, Florida 32839

Review Date(s): October 15 - 18, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Bonita Williams, Office of Program Accountability, Lead Reviewer (Standard 1)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 5)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 1)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 2)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 4)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 1/Interviews)
Amanda Nelson, Office of Program Accountability, Regional Monitor (Standard 5)
Jonathan Stahl, Charles Britt Academy, Clinical Director (Standard 3)

Program Name: Orange Youth Academy
Provider Name: TrucCore Behavioral, LLC
Location: Orange County / Circuit 9
Review Date(s): October 15 - 18, 2019

MQI Program Code: 1127
Contract Number: 10145
Number of Beds: 41
Lead Reviewer Code: 148

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Orange Youth Academy is a forty-one bed program, for twelve to eighteen-year-old males, located in Orlando, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program is housed at the same location as Orlando Intensive Youth Academy. The layout of the program includes: one large H-shaped building housing all offices, modules, and kitchen, as well as master control; a pavilion attached to the maintenance building serves as a sheltered recreational area, and there are portables and permanent education buildings which are utilized by the school personnel.

The program provides the following services: Mental Health Overlay Services (MHOS) and Substance Abuse treatment Overlay Services (SAOS). In addition, the program fosters youth by providing Thinking for a Change (T4C), and Impact of Crime (IOC), gender-specific delinquency and treatment programming for boys Young Men's Work (YMW), and 24:7 Fathering Handbook, as well as additional treatment services including Life Skills Training, Teen Relationships, Living in Balance (LIB), Anger Management for Substance Abuse/Mental Health Clients, 100 Interactive Activities for Mental Health and Substance Abuse Recovery, Strategies for Anger Management, Life Skills 225, Skillstreaming the Adolescent, Creative Therapy, Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents (TFB), the Passport Program: A Journey Through Emotional Social, Cognitive and Self-Development and Don't Let Your Emotions Run Your Life for Teens, and individual and family counseling sessions.

Program administration is comprised of a facility administrator, assistant facility administrator, program director, case management supervisor, human resources manager, director of clinical services, health services administrator (HSA), and an administrative assistant. Case management services are provided by the case manager supervisor, four case managers and two transition services managers. Mental health staff at the program includes a director of clinical services, two licensed clinicians, four therapists, and one recreational therapist. The psychiatrist, psychologist, and two certified behavior analysts are contracted service providers, the staff are shared with Orlando Intensive Youth Academy. The psychiatrist is on-site once a week. Medical services are offered from 7:00 a.m. to 7:30 p.m. seven days a week and are provided by six registered nurses, one of which is considered the HSA. The doctor is a contracted position and is on-site at a minimum of four hours a week. Educational services are provided on-site by the Orange County School Board. At the time of the annual compliance review, the program had twenty-one vacancies: five youth specialist II, eleven youth specialist I, one physical plant manager, one non-licensed therapist (part-time), two licensed therapist, and one transition service manager.

Strengths and Innovative Approaches

- The youth were provided the opportunity to attend a local high school football game as a community outing. The program's recreation therapist and a supervisor accompanied the youth. By experiencing this, it inspired the youth to stay committed to their treatment and successfully complete the program.

- The youth went on a community outing to Full Sail University experiencing a tour coordinated by Kula for Karma. Kula for Karma is a 501(c)(3) nonprofit organization with over twelve years of experience bringing therapeutic yoga programs to youth and other populations in need. Kula for Karma partners with Orange Youth Academy to offer activities to youth in the program.

- The program recognizes the challenges of being a parent/guardian or sibling of a youth committed to a program; therefore, they host a family day event to show support to the whole family. The family day is conducted on a quarterly basis. Family members are invited on campus to attend a full day of fun activities which includes a meal.

- The program has a cottage advisor program where leadership skills are taught by selecting a youth leader in each module who receives a shirt to wear signifying their status and allowing extra responsibilities.

Standard 1: Management Accountability

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

The program has a policy and procedures for background screening process for new hires. The program conducts background screening for all Department employees, contracted providers, volunteers, and interns who have access to the youth in the program. Since the Orlando Intensive Youth Academy (OIYA) annual compliance review in August 2019 OIYA and Orange Youth Academy only had two new hires; therefore, each staff was reviewed for initial background screening. All new hires had their background screening completed before their hire date. The program added the new hires in the Clearinghouse employment roster. Each of the new hires completed the pre-employment assessment tool and passed with a high score. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to Department's Background Screening Unit (BSU) on December 7, 2018, along with the school board's annual screening which was submitted to BSU on January 10, 2019, meeting the annual requirement.

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

The program has a policy and procedures for five-year background screening. The program had five applicable five-year rescreenings. Four of the five background re-screenings were submitted within the required timeframe. One of the five background re-screenings was submitted to Clearinghouse more than twelve months prior to the staff's five-year anniversary. The program submitted the rescreens to Department's Background Screening Unit more than ten days prior to the five-year anniversary date for each of the remaining four staff.

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

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

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

The program has a policy and procedures to ensure an abuse free environment for youth, staff, and others while in the program. During the program tour, the Florida Abuse Hotline and Central Communications Center (CCC) contact numbers were posted throughout the program. Each of the new hires had a signed code of conduct, which was located in the staff personnel records. Upon request, the program was able to produce the Trauma Responsive and Caring Environment (TRACE) self-assessment for the program. Since the last annual compliance review, Orange Youth Academy had two abuse allegations toward staff which were reported to the Florida Abuse Hotline and CCC. Each of the seven staff interviewed, reported when a youth wants to call the Florida Abuse Hotline or CCC, they are to notify the supervisor and allow the youth to call. In addition, staff are allowed to call the Florida Abuse Hotline. The seven staff reported never observing staff informing a youth they could not place a call to the Florida Abuse Hotline. Three of the seven staff interviewed reported hearing staff use profanity as a result of being frustrated and working long hours, as a result the supervisor will allow the staff to take a break to calm down. Interviews with seven youth revealed each reporting feeling safe in the program. They reported never having to call the Florida Abuse Hotline. When staff speak to youth, each of the seven youth reported staff are calm and show they care about them. Six of the seven youth reported never hearing staff use profanity towards youth, one reported hearing staff use profanity once. The facility administrator reported abuse of youth will not be tolerated and if this is violated staff could receive disciplinary action up to termination.

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

The program has a policy and procedures to ensure management responds to all allegations appropriately. Since the last annual compliance review, Orange Youth Academy had two abuse allegations toward staff. The program documented internal investigations into each incident such as incident reports, interviews, reporting to the Florida Abuse Hotline and Central Communications Center (CCC), and reprimand and/or terminating the staff. The program suspended each staff immediately pending investigation. One of the two incidents was substantiated and the other was unsubstantiated. After the investigation, each incident was closed resulting in one staff receiving a reprimand and the other being terminated. Each of the staff received a disciplinary action as a result of the investigations.

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

The program has a policy and procedures to ensure the program notifies the Central Communications Center (CCC) within two hours of the incident. Since the last annual compliance review, the program had a total of sixteen CCC's, five CCC reports were reviewed for compliance. The CCC was notified for lost keys, youth injury, and background screening. All five incidents were called within two hours of the incident; however, one of the five, was not located in the facility logbook. During the annual compliance review, the team did not uncover any incidents requiring notification to the CCC. The program had a total of seventeen CCC incidents since the last annual compliance review, previously the program had a total of seven. The program reported while some of the reports are unavoidable, such as youth injury, the program continues to work to reduce the number of incidents by conducting fidelity checks and re-training staff for identified problem areas. The facility administrator reported all staff are to immediately report any knowledge or suspicion of abuse. Staff are trained during pre-service training on the process of reporting to the CCC. The facility administrator reported CCC's are reviewed during daily management meetings. The facility administrator reported there was one staff who received disciplinary actions due to allegations; however, after further review, there was two staff.

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

The program has a policy and procedures to ensure Protective Action Response (PAR) is used in accordance with Florida Administrative Code. The program has a PAR Training Plan signed and approved on March 13, 2019. Since the last annual compliance review, the program had

twenty-eight PAR reports; therefore, a review of five reports was conducted. Each of the five PAR reports were completed by each staff member involved in the incident and by the end of their shift. None of the PAR's documented mechanical restraints or any injury as a result of the use of a PAR technique. None of the PAR's had documentation the youth wanted to call the Florida Abuse Hotline. Each of the five PAR's were reviewed by the PAR certified instructor/supervisory staff, and administrator within two hours of the incident. Each month for the last six months, the program submitted monthly PAR reports to the Department. The program's PAR rate during the annual compliance review period was 2.84, which is above the statewide Residential PAR rate of 1.54. The program reported in order to decrease the PAR's, the expectation is for staff to constantly utilize appropriate sight and sound supervision. The facility administrator reported, each PAR incident is reviewed during daily management meetings. In addition, a review of the video footage is conducted of the incident to ensure compliance with PAR policy and procedures.

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

The program has a policy and procedures to ensure new hires complete required training prior to having contact with youth. Orlando Intensive Youth Academy (OIYA) and Orange Youth Academy (OYA) share staff since both programs are located in the same building. OIYA had their annual compliance review in August 2019, and as a result OYA had three applicable staff to review for pre-service/certification requirements during the annual compliance review. The program submitted the pre-service training plan to the Department's Office of Staff Development and Training on January 10, 2019 and was approved on January 16, 2019. All instructors were qualified to deliver training provided to the new hires. Each of the three staff reviewed are still within their 180 days of hire to complete required training. Each of the three staff have completed the required training needed prior to having contact with youth. In addition, the staff completed on the job training which includes trainings on grievance procedures, tool management, infection/exposure control, and the program's behavior management system. Each staff's pre-service training was entered into the Department's Learning Management System (SkillPro).

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

The program has a policy and procedures to ensure staff completed twenty-four hours of training for the calendar year. The program submitted the pre-service training plan to the Department's Office of Staff Development and Training on January 10, 2019 and approved on January 16, 2019. Seven staff were reviewed for completion of in-service training. It should be noted none of the supervisors could be used for in-service training due to the program having five supervisors, of which, three were hired in 2019 and the remaining two were reviewed during the Orlando Intensive Youth Academy annual compliance in August 2019. The program has an annual training calendar, which is updated as needed. All instructors were qualified to deliver

training provided to the new hires. All seven staff completed the required twenty-four hours of annual training and were recorded in the Department's Learning Management System (SkillPro). The training included specialized training to address enhanced treatments for mental health and substance abuse services. Each of the seven staff training records reviewed included Protective Action Response (PAR), suicide prevention, professionalism and ethics (including standards of conduct), and cardiopulmonary resuscitation (CPR), first aid (FA), and automated external defibrillator (AED) certifications. Each of the current healthcare staff has a current certification in CPR/FA and AED.

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

The program has a policy and procedures on the grievance process and training for staff. A review of three pre-service and seven in-service training records, revealed each of the staff were trained on the grievance process. According to the policy and procedures, the grievance process includes three phases: informal, formal, and the appeal phase. The grievance process is to be completed within seventy-two hours, excluding weekends and holidays. In the last year, the program had a total of ten grievances. Five were reviewed and all were processed within the seventy-two hour timeframe. None of the grievances reached the appeal phase. Each of the seven staff interviewed reported the grievance forms are located throughout the program and youth are allowed to request a grievance form. In addition, the supervisor or the program director review the grievances with the youth. The seven interviewed youth confirmed the grievance forms are located throughout the facility and was able to explain the process. All the youth reported being able to request assistance when filling out the grievance forms. The facility administrator reported the grievance forms are posted in locations accessible to youth. The forms are maintained in a file for one year. The program director has been assigned as the grievance officer.

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

The program's contract requires Thinking for a Change (T4C), Impact of Crime (IOC), and Life Skills Training (LST) as evidenced-based services, promising practices, or practices with demonstrated effectiveness, which are provided according to the program's written description addressing delinquency interventions. The program has seven facilitators for delinquency intervention models who all had the level of education, years of experience working with offenders to qualify for the assignment and training in the interventions they facilitate. The program's activity schedule indicates the provision of at least sixty percent of the youth's awake hours are spent in structured, planned programming or activities. A review of group sign-in sheets and the program schedule indicated every day of the week the program provides

delinquency interventions to the youth they serve. Staff indicated the groups provided sometimes differ from the time table due to staff varying schedules and other unforeseen circumstances. Six months of documentation reviewed confirmed the program provided life and social skills training to the youth according to the program's daily activity schedule. Seven youth records were reviewed, including each youth's performance plan which addressed criminogenic needs, identified by the Residential Assessment of Youth (RAY), and all of the youth were involved in a delinquency intervention, which is addressing an identified priority need. The facility administrator (FA) interview indicated staff must be trained according to the Department standards and be educational background screened to determine which staff should deliver life skills training or groups. Groups provided are T4C by two individuals, IOC by four individuals, and LST by one individual. Youth are matched to staff/counselors/case managers and intervention groups through a review of each youth's comprehensive evaluation and previous history prior to admission. The FA indicated the evidenced-based delinquency intervention model or strategy, promising practice, or a practice with demonstrated effectiveness which has been implemented to address the priority needs of youth are T4C, IOC, and LST. The clinical director interview indicated the program utilizes cognitive behavioral therapy (CBT) and motivational interviewing (MI) techniques/interventions to address youth needs. During the intake process evidenced based assessments are administered for each youth to develop a comprehensive evaluation and individualized treatment plan to meet their needs.

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

The program provides Life Skills 225 as a life and social skills intervention service specifically addressing interpersonal relationships and interactions, communication, non-violent conflict resolution, anger management, and critical thinking. The curriculum is provided once a week for one hour, according to the activity schedule and the group sign-in sheets. A review of the last six months of the curriculum sign-in sheets determined the program did not provide Life Skills 225 in five random weeks. The clinical director interview indicated the program is providing Life Skills 225 as life and social training to the youth. The program conducts Skillstreaming the Adolescent, Teen Relationships and Life Skills Training (LST) during the week for a period of one hour for each group. The youth were receiving groups as outlined in their individual treatment plans. The program provided an activity schedule along with sign-in logs indicating the youth are receiving services for the review period. Five youth were able to specify the groups by name and the remaining two were able to describe the groups by topics. Five of seven youth stated they learned various skills/behaviors in the groups, which they did not know prior to coming to the program; two indicated they learned nothing new. Three of the youth stated they learned how to deal with anger better and various anger management techniques, one stated he had to prove himself to others but now he knows does not need to let others bother him, and one more youth indicated it has helped him figure out to live in peace and to stay away from fights, and enlightened him on different things. The youth were questioned if they practiced the skills learned in, as well as outside of the group environment. One of the seven indicated he did not practice the skills, four said they do role playing in the groups, act out visually what they try to understand. One youth stated he stays away from negative people and he considers this inside and out of the group as a practiced skill, another said he will mentally practice things in and outside of the group setting. One youth stated he practices things in the group but not outside.

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

The provider's contract identifies Impact of Crime (IOC) to be delivered to address restorative justice practices. The IOC group assists youth to accept responsibility for harm they have caused by their past criminal actions, challenging them to recognize and modify their irresponsible thinking, such as denying, minimizing, rationalizing, and blaming victims, as well as teach youth about the impact of crime on victims, their families, and their communities. The program had various speakers who came out and interacted with the youth including a prior juvenile offender, domestic violence victim, and a prior prison inmate who turned his life around and now owns his own company training dogs. The youth also participate in community service events such as gift and food drives. The program's schedule identified the IOC curriculum is to be delivered twice a week for one hour. The staff facilitating IOC have been trained to conduct the groups. A review of the last six months of IOC sign-in logs indicated the program only conducted one hour instead of two hours during four random weeks. A review of seven youth records showed each youth received services increasing their accountability for criminal actions and harm caused to others. The facility administrator (FA) interview indicated IOC is offered as restorative justice awareness for the youth along with community service, IOC is typically rendered on Mondays and Fridays at the program. The program provides speakers and presentations to expose youths to victim's perspective.

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

The provider's contract identifies Young Men's Work (YMW) and 24:7 Fathering Handbook to be provided to address gender-specific programming. The curriculum utilized addresses the needs of the gender group and the program's primary target population. The program's activity schedule included YMW to be delivered once a week. A review of the last six months of sign-in logs indicated the YMW curriculum was not provided for two random weeks. The staff indicated they had not conducted the 24:7 Fathering Handbook curriculum since the last annual compliance review due to not having enough youth to run a group; the curriculum is targeted toward male youth who are fathers. The facility administrator (FA) interview indicated the program addresses the needs of a targeted gender group by providing YMW and the 24:7 Fathering Handbook curriculum.

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 policy and procedures to ensure alerts are maintained internally to ensure staff are made aware of alerts. The policy and procedures include how alerts are identified, documented, updated, and communicated to staff. Alerts are passed down through shift briefings held in the conference room and in the logbooks. Additionally, alerts are reviewed in morning management meetings. All alerts in the internal alerts system matched up to the Department's Juvenile Justice Information System (JJIS). Of the seven youth reviewed, six had identified alerts. Seven closed youth alerts were reviewed and each was documented in both the internal alerts system and in JJIS. Each alert was discontinued by the appropriate staff. Alerts are entered into JJIS by healthcare staff, director of case management, or clinical director. Six of the seven youth with alerts were located in the logbook and the internal alert system. During the annual compliance review, the team reviewed alerts and confirmed all alerts were identified, documented, and updated.

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

The program has a written policy and procedures in place for youth records. The program separates the youth records into three separate individual healthcare, case management, and mental health and substance abuse records. Each record included the youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The program labels each youth record as "Confidential". The youth records are located in a secured room with limited staff access.

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

The program has policy and procedures for youth input. Interviews with administration revealed the sources for youth input include the youth advisory board meeting and weekly community meetings. The program documented youth advisory board meetings monthly for the past six months. Four youth attended each of the meetings except for June in which three youth attended. Each meeting was documented with a sign-in sheet and an outline of the meeting. April to June and August meetings included introductions, concerns of the cottage, and new

ideas. July and September meetings included introductions, old business, and new business. The meeting documentation which included old business documented progress on previously proposed ideas/changes, while the months documented cottage concerns did not track progress of previous youth suggestions. However, there is documentation the program has approved some of the activities youth requested or new incentives as documented in the Department of Juvenile Justice weekly newsletter. In addition, the youth are provided an opportunity to have input during documented weekly community meetings which is held by the recreation therapist. The facility administrator reported youth are able to provide input into the program's operations through youth advisory board meetings and weekly community meetings. The seven youth reported they are able to provide input to the assistant facility administrator, facility administrator, or the program director. In addition, they can utilize the "Let's Talk" process.

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

A review of the last six months of advisory board meeting minutes, agendas, and sign-in sheets indicated the board met on a quarterly basis. The advisory board members consist of law enforcement representatives, the judiciary, business community, school board, faith community, lesbian, gay, bisexual, transgender, questioning, intersex (LGBTQ) community, as well as victim advocate partners. The program provided recruitment efforts for parents/guardians of prior youth involved with the system. The program maintained documentation of email invitations sent to prospective board members for the each planned meeting dates. An interview with administration revealed the program has a community advisory board which provides information about services the youth can benefit from once released. The advisory board includes representatives from a local Narcotics Anonymous chapter, Project Bridge, a member from Kula for Karma, transition specialists and program youth. Kula for Karma is a nonprofit organization with over twelve years of experience bringing therapeutic yoga programs to youth and other populations in need who partners with the Orange Youth Academy and Orange Intensive Youth Academy to offer activities to the youth in the program. Informal staff interviews indicated invitations to juvenile judges and the state's attorney were sent by mail. Staff also indicated they made a phone call to the court liaison to inquire about judicial attendance. However, there was no documentation to support these invitations and phone calls. An interview with one community advisory board member revealed she was the parent/guardian of a youth formerly involved in the juvenile justice system. The parent/guardian had attended one meeting and intended to continue involvement. She described the meetings involved individuals from the community who might help youth following release with jobs and educational opportunities. The meetings last about an hour and a half and also involve youth at the program. Another community advisory board member returned the review team's telephone call and was interviewed by phone. She represents a non-profit involved with programming for discharged youth. She described the meetings as supportive of programming for youth returning to the community and opening opportunities. She personally arranged for eligible youth a tour of the Full Sail University to acquaint them of opportunities after discharge. One of the agencies invited was the victim service center program director. The center responded identifying a staff member who would participate and there was email correspondence to verify these efforts. Staff interviews indicated contact was made with a parent/guardian of a youth in trouble with the law to participate. The youth was not a former Department of Juvenile Justice youth. There were phone text messages to support this recruitment effort.

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

The program policy and procedures address program planning. The program conducted internal surveys with youth and staff in order to receive input regarding the operations of the program. The program conducts all campus wide meetings to inform staff of pertinent information. A review of the monthly all campus wide meeting minutes was conducted, which included information/reports received by the Department. The program also conducted daily management meetings to discuss program systems and data, as well as collected parent/guardian and youth surveys quarterly on Survey Monkey to obtain feedback to make necessary changes to the program; one result of such survey was the change in their food vendor. At the time of the annual compliance review, the program had twenty-one vacancies. The company hosts job fairs and recruits for new staffs. An interview with administration revealed the program regularly conducts monthly mandatory all campus meetings, staff mentor meeting, and daily shift briefings for every shift. The program conducts parent/guardian and youth surveys and data is reviewed by corporate prior to distributing to the program where results are then considered and discussed amongst the management team. The review team reviewed the surveys and results. The surveys were conducted within the last three months prior to the annual compliance review. It included input from both the youth, parent/guardian, and staff. The surveys identified areas of improvement. Seven staff interviewed reported staff meetings are held monthly and topics are youth behavior, ratio, mental health issues, drills, staff issues, and safety and security concerns. Each of the seven staff reported being briefed on annual reports and youth and parent/guardian surveys during meetings. Communication amongst the staff is very good according to three staff, good for three staff, and fair for one staff. Staff reported being able to provide input/feedback to the assistant facility administrator and facility administrator during staff and individual meetings.

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

The program's facility operating procedure indicates each employee of the program shall be evaluated once annually by an authorized person specifically designated to conduct the evaluations. The evaluations shall be placed in the employee record and be given to the employee. There shall be a discussion with the employee, in a conference, with the manager/supervisor conducting the evaluation. A review of the program's job descriptions indicated each staff member's performance standards are clearly identified. The five staff reviewed evaluations reflected those standards in the evaluation, which were completed annually. The program's key personnel, as outlined in the contract, are being maintained. The program did have a vacancy for the recreational therapist from June to August 2019, but it was filled two weeks prior to the annual compliance review.
A review of seven staff records revealed each staff had a position description consonant with their assigned duties. Each position description was signed by the incumbent. Each staff record contained an annual performance evaluation. The facility administrator reported performance evaluations are conducted after the first ninety days and annually thereafter. The interviewed staff were indecisive about when evaluations are conducted, answers ranged from sixty days, ninety days, and annually.

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

The program employed a recreation therapist, as required by their contract, during the annual compliance review until June 2019. A new recreation therapist was hired in August 2019. Each of the staff have a bachelor's-level degree in either sports management or recreation. The program's activity schedule outlined a block of time for daily large muscle activity. A review of the last six months of logbooks to determine if the youth are receiving one hour of large muscle activity daily. It was clear in the logbooks on the weekend, the youth are receiving more than the one hour of large muscle activity. However, during the week, it was difficult to confirm if the youth are receiving one hour of large muscle due to documented entries in the logbook were not always legible. In addition, the daily schedule has large muscle and other activities occurring at the same time, which made it difficult to confirm the one hour of large muscle activity. However, observations during the annual compliance review week and interviews with youth and staff confirmed youth were having one hour of large muscle exercise. The recreation therapist, along with the youth, developed a calendar with recreation activities for each day. Activities include, soccer, dodgeball, football, basketball, and kickball. Youth are able to express ideas for recreation and leisure activities during weekly town hall meetings and youth advisory board meetings. Seven youth individual treatment plans were reviewed for a wellness goal. Of the seven individual treatment plans reviewed, four included wellness goals and the remaining three did not. However, the wellness goal was added to the next plan at time of the thirty-day review. It should be noted, each of the wellness goals were the same for each youth. The seven interviewed youth reported participating in basketball, football, weight lifting, play cards and watch movies. They reported having one hour of recreation activities. Each of the seven youth reported they receive mental and physical exertion throughout the day. Each of the seven staff interviewed reported youth received one hour or more of large muscle exercise daily. The youth participate in kickball, basketball, and football.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures in place regarding initial contacts and notifications to the youth's parent/guardian and the court, to ensure they are notified of the youth's arrival. Seven youth records were reviewed and each had documentation the program notified the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, and by written notification within forty-eight hours of admission. The youth's committing court, assigned juvenile probation officer (JPO), and post-residential services case manager were notified in writing within five working days of any admission.

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

The program has a policy and procedures in place regarding the orientation process for youth admitted to the program. A review of seven youth management records contained documentation indicating each youth completed the orientation process on the day of their admission. The orientation process included all the required elements. Each reviewed record has a signed checklist acknowledging the youth received orientation which included information on the program services, daily schedule, expectations and responsibilities of youth, and availability of and access to medical and mental health services. Orientation also included how to access the Florida Abuse Hotline or the Department's Central Communications Center (CCC), items considered contraband, performance planning process, dress code and hygiene, procedures on visitation, mail and use of the telephone, community access, grievance procedures, and emergency procedures. One admission was observed during the annual compliance review, and the case manager conducted the orientation utilizing the orientation checklist which was verified to include all required elements. Seven youth were interviewed and each reported the orientation process started the day of their admission.

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

The program has a policy and procedures to obtain written consent of youth who are eighteen years of age or older. One of the seven reviewed case management records were applicable ; therefore, two additional youth records were provided for review. All three-applicable reviewed youth records contained the required signed consent for the program to discuss with the

parent/guardian any information relating to the youth's physical or mental health screening, assessment, or treatment.

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

The program has a policy and procedures regarding classifications factors, procedures, and reassessment for activities process. The program policy utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services in the program. The initial classifications completed upon admission into the program had all the required elements. Seven youth case management records were reviewed and verified there was documentation the classification assessments included all the required information. The admission classification form is used to determine the youth's living unit and room assignment based on the following: physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, suicide risk, medical risk, escape risk, and security risk. The program reassessed youth prior to considering an increase in privileges or freedom of movement, participation in work projects or other activities involving tools or instruments which could be used as potential weapons or means of escape, or participation in any off-campus activity. Each of the seven reviewed case management records documented the completion of a reassessment. Reviewed documentation in each youth record found the program completed a monthly re-assessment of activities on each youth during treatment team. The classification process was confirmed through an interview with the facility administrator. The program has an internal alert process in place to alert staff of any potential safety and security risks posed by a youth.

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

The program has a policy and procedures regarding gang prevention and intervention, identification, and notification to law enforcement. The program policy indicated the Facility Administrator (FA) is responsible for ensuring gang prevention and intervention strategies when youth are identified as being a criminal street gang member, affiliated with any criminal street gang, or are at risk of gang involvement. Three of the seven youth case management records reviewed were applicable for gang involvement for this indicator. The program also shared the youth's gang status with the education department, juvenile probation officer (JPO), and applicable post-residential counselor. The review of the applicable youth records confirmed youth participated in gang intervention groups. All three applicable youth records had documentation the program notified local law enforcement and the JPO of the youth's placement in the program.

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 policy and procedures regarding prevention and intervention services to address gang activities for youth affiliated with gang involvement. GANGS: 50+ Stories of Fractured Lives entitled Enough is Enough Gang Violence and Gang Resistance and Drug Education (GRADE) are curriculums provided to the gang affiliated youth. Seven youth case management records were reviewed and three were applicable. Each of the youth's performance plans included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities, which was conducted at least once a month. Youth in the program also participate regularly in Impact of Crime (IOC) curriculum groups as a component of the program's gang awareness and prevention strategy.

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

The program has a policy and procedures regarding Residential Assessment Youth (RAY) assessment and re-assessment for youth in the program. The RAY was completed within thirty days in each of the seven youth case management records reviewed. The RAY re-assessments were completed within ninety days of the initial RAY in each of the seven youth records. The RAY assessments were in each youth's case management record and located in the Department's Juvenile Justice Information System.

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

The program has a policy and procedures regarding the completion of the Youth Needs Assessment Summary (YNAS) for each youth admitted into the program. A review of seven youth case management records found each contained a YNAS. Six of the seven youth's YNAS were completed within thirty-days of the youth admission to the program. One youth's YNAS

was completed two days late. The YNAS was in each youth's record and in the Department's Juvenile Justice Information System.

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

The program has a policy and procedures regarding performance planning which contained specific guidelines for the development, completion, goals, and transmittal of the youth's performance plans. Seven youth case management records were reviewed. Six of the seven youth's performance plans were completed within the first thirty days of the youth admission to the program. In one reviewed record, the performance plan was completed two days late. All seven reviewed youth case management records documented each goal on the performance plan has specific target dates for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal. All seven youth performance plans included the signature page and each plan was signed by the youth, intervention and treatment team leader, and all parties who had significant responsibility in the goal completion. All the reviewed performance plans included transition activities targeted for completion during the last sixty days of the youth's anticipated stay. Within ten working days of the completion of the performance plan, the program sent a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation office (JPO), the parent/guardian, and the applicable Department of Children and Families (DCF) counselor. Each record documented a copy of the plan was provided to the youth. Seven interviewed youth indicated they participated in the development of their performance plan and know their current performance plan goals. Each of the reviewed records contained an electronic transmittal indicating a copy of the performance plan was sent to the youth's parent/guardians, JPO, and committing court.

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

The program has a policy and procedures addressing performance plan revisions. Seven youth case management records were reviewed, and each was applicable for revisions to the performance plan. Documentation confirmed each performance plan was revised based on the Residential Assessment of Youth (RAY) re-assessment results, newly obtained information, demonstrated progress toward completing a goal, lack of progress towards completing a goal and/or to facilitate transition activities within sixty days of the youth completing the program. Documentation found the performance plans were updated with recommendations from

treatment team members and other pertinent parties. Two of the seven reviewed case management records were applicable; therefore, a review of the Juvenile Justice Information System (JJIS) found one additional youth records for review. All three applicable reviewed case management records indicated each youth was in transition and revisions to the performance plans were made to facilitate necessary transition activities.

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

The program has a policy and procedures regarding performance summaries and transmittals. Seven youth case management records were reviewed and each included summaries which were completed every ninety-days. Two of the seven records included summaries prior to the youth's release from the program; therefore, a review of the Juvenile Justice Information System (JJIS) found one additional youth record for review. All three applicable reviewed case were completed prior to the youth's release from the program, which was pending at the time of the annual compliance review. All the records indicated each has a performance summary to include the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peers and staff, and significant positive or negative events. Three of the seven youth were in transition and each performance summary included a justification for release. Reviewed documentation verified all seven records had performance summaries completed indicating youth were given the opportunity to review and provide comments before signing and were provided a copy of the report. All seven reviewed performance summaries were signed by the youth, treatment team leader, staff member preparing the summary, and facility administrator (FA) or designee, and were sent to the committing court, juvenile probation officer, parent/guardian, and youth within ten working days. Seven youth interviews were conducted. Four youth reported receiving a copy of the summary while the other three youth reported not knowing what a summary was. Reviewed documentation confirmed all three applicable youth records had the victim notification letter waived. None of the youth were applicable for the Sexually Violent Predator Program (SVPP).

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 has a policy and procedures to encourage and facilitate involvement of youth's parent/guardian in case management services. Seven youth case management records were reviewed for compliance. All seven indicated the parents/guardians were informed of the youth's treatment team schedule for the duration of their stay in the program. If the parent/guardian is unable to physically attend the meeting, they are afforded the opportunity to attend by telephone or written input prior to the meeting. All seven youth signed consent forms allowed the program to share treatment information with the parent/guardian. Three of the seven youth were admitted

to the program in the custody of the Department of Children and Families (DCF) as documented in the Juvenile Justice Information System (JJIS). In the three youth case management records there was documentation of the program encouraging DCF involvement in services. An interview with the facility administrator (FA) reported case managers attempt to contact the parent/guardian during the intake process along with mailing various correspondence as it relates to the program and the youth's progress. Observation of two treatment team meetings during the annual compliance review included participation of the youth's guardian by telephone and contact with the juvenile probation officer (JPO) was attempted. The second treatment team meeting included participation of the youth's parent/guardian, the DCF and the JPO by telephone.

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

The program has a policy and procedures addressing members of the treatment team. The director of case management oversees the coordination of the treatment team and the youth's case manager is responsible for leading the treatment team meetings. The treatment team members included the case manager, who serves as the treatment team leader, youth, education department, administration representative, living unit representative, mental health treatment staff, education representative, juvenile probation officer (JPO), parent/guardian, medical staff, and transitional service staff. Seven youth case management records found each youth participated in an initial treatment team meeting. Observations of two treatment team meetings during the annual compliance review week confirmed each member actively participated by providing input either verbally, or a written report. The JPO and parents/guardians participated by telephone for one of the treatment teams. During the observation of formal treatment team, all members provided feedback to the youth, both positive and negative. The youth were actively engaged in the treatment team. The youth were aware of their performance goals and able to discuss their progress on goals. During another formal treatment team, the Department of Children and Families (DCF) case work was a part of the treatment team meeting. Three of the seven reviewed youth case management records were applicable for involvement with the DCF.

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

The program has a policy and procedures regarding the incorporation of other plans into the performance plan. Reviewed seven youth case management records. Each incorporated academic and mental health/substance abuse goals. The goals included the person responsible for assisting the youth to successfully complete each goal. Three of the seven youth records were applicable for the Department of Children and Families (DCF) and behavior support plans. Each reviewed youth records include youth involved with DCF care plan during treatment team meeting.

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

The program has a policy and procedures regarding treatment team meetings. Formal and informal treatment teams are each held monthly allowing for a bi-weekly review of each youth's progress, including Residential Assessment for Youth (RAY) results. The review of seven youth case management records revealed the juvenile probation officers (JPO), parent/guardian, and other pertinent parties were invited in advance, and encouraged to participate in treatment team meetings. Seven reviewed youth records confirmed formal reviews are held at least every thirty days, and informal reviews are held bi-weekly, and both included the youth's name, date of the review, all applicable meeting attendees, comments from treatment team members, and a brief synopsis of youth's progress in the program, positive and negative behaviors, and RAY results. Observations of two formal treatment team meetings and one informal confirmed the treatment team members included the youth, assigned case manager, mental health staff, transitional staff, medical staff and program administration. Observations of the meetings also confirmed each member of the team participated by providing input either verbally or a written report. The assigned JPO and the parents/guardians participated by telephone. Youth were actively engaged in the treatment team process and aware of their performance goals and were able to communicate their progress.

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

The program offers Type 2, career education programming services appropriate to the age group served in the program. The lead teacher interview indicated the following services/assessments are offered to youth in the program: résumé building, Florida Food Handler's Certification programs, Florida Ready to Work, ICT – Internet Communication Technology, IBA - Internet Business Associates, and Typing Web (proficiency in typing), as well as employability skills provided by Orange County Public Schools. In addition, the Test of Adult Basic Education (TABE) testing (requirement for certain jobs and training programs), ASVAB Testing – Armed Services Vocational Aptitude Battery, and GED (General Education Diploma) Ready/GED are offered to the youth in the program, as appropriate. A review of three closed youth case management records found documentation to verify each youth had sample employment applications, a résumé, and a valid Florida identification card. A calendar showing scheduled appointments was included, noting the responsibilities of each participant. The youth, parent/guardian, education, and program staff were aware of the plan and requirements for each individual.

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.	

Orange County Public Schools provides the education programs and approves the instructional schedule to be followed daily. The lead educator oversees the educational instruction, career training, and technical education, as well the academic instruction year-round, a minimum of twenty-five hours of instruction weekly. The educational instruction schedule showed classes start at 7:30 a.m. and end at 1:48 p.m., six periods estimate fifty-three minutes a class, which total 26.5 hours of instruction weekly. The lead educator confirmed classes are taking place, as scheduled with minimal inferences. The first and second shift logbooks show evidence documented when students transition to class and when classes end. All classes and the cafeteria area are interconnected, and youth do not leave the courtyard until the end of the school day. The youth would arrive on time to class and leave as scheduled. Seven interviewed youth confirm six out of seven indicate there are not a lot of interruptions during educational instruction. The remaining youth indicated there were a lot of interruptions but did not offer explanation of the types of interruptions during educational instruction.

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

A review of three closed youth case management records supported each youth had an individual education transition plan developed based on youth's post-release goals while in the program. Key personnel such as the youth, parent/guardian, instructional personnel, the Department personnel, post-release representative from the school district, certified school counselor, and registrar from school district were involved in each of the youth's transitions activities. The transition plans contained provisions for the continuation of education or employment, sample employment applications, a résumé, a valid Florida identification card, a calendar showing scheduled appointments with the Career Source Center. In addition, services/intervention based on educational needs and post-release education plans, recommendations for educational placement, monitoring responsibilities by individuals who are responsible for the reintegration and coordination of support services are included in each of the youth's transition plans. Evidence the youth's case manager and parent/guardian are aware of the plan, documents, and post-release discharge plan. All three closed records had appropriate documents essential to obtaining employment upon leaving the program.

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

A review of three closed records indicated three open and all closed were applicable regarding the transition process. In the three applicable records, the transition conference was conducted at least sixty days prior to the targeted release date and the youth, treatment team leader, program director or designee, as well as other treatment team members participated in the meeting. The juvenile probation officer (JPO), parent/guardian, education staff and other pertinent parties were invited and encouraged to participate through advanced notice. In all three closed records, the transition conference included a review of transition activities on the youth's performance plan, identified target completion dates, as well as the person responsible for completion of the task. In one of the meetings, additional transition activities were identified and discussed. In all three, the copy of the plan was sent with a request for return with signature to anyone not in attendance who has responsibility for completion of transition goals. In all three records, the treatment team leader obtained attendees signatures, representing their acknowledgement of the transition goals and accountability for completion. All three records were applicable for conducting a Community Reentry Team (CRT) meeting. In all three records, the CRT was conducted prior to the youth's release from the program, the program was invited to, and the youth and case manager participated in the meeting.

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

A review of three closed records were applicable regarding the exit portfolio. In all three records, the exit portfolio was discussed and initiated during the transition conference and included a copy of the youth's transition plan, calendar with all dates/times/locations of upcoming community appointments, educational and vocational certificates earned while in the program, educational records, school transcripts, résumé, and completed sample employment application. In each of the three records, the exit portfolio included the state-issued identification card and birth certificate. In one of the three, the documents were not included due to the parent/guardian not providing the documents. All three contained a social security card. All three exit portfolios were verified at the exit conference, completed and provided to the youth upon his release and forwarded to the juvenile probation officer (JPO), which was documented in the youth record.

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.	

A review of three closed records regarding an exit conference being conducted after the program notified the juvenile probation officer (JPO) of the youth's release. In the three records, the exit conference was conducted at least fourteen days prior to release and was documented in the case record, including the date, signatures, and a summary pending transition goals. During the exit conference, the status of transition activities established at the transition conference and to finalize plans for the youth's release were reviewed, and the intervention and treatment team leader, the youth, the education representative, and other pertinent parties participated in the meeting. The parent/guardian and JPO either participated telephonically, attempts to reach them were made or they provided written input. The exit, transition and Community Reentry Team meeting (CRT) were conducted separate from each other in all four records and the date of admission and termination documented in the case record matched the Department's Juvenile Justice Information System (JJIS) data.

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 policy and procedures addressing the designated mental health clinician authority (DMHCA). The position description includes the incumbent will act as the facility's mental health and substance abuse authority, provide at least one hour of clinical supervision a week for each unlicensed mental health therapist, ensure compliance with overlay requirements, proper completion of documentation and integration of a mental health delivery system which meets all state and federal guidelines, maintain technical and administrative duties, provide testing, individual, group, and family therapeutic activities, research, and participation in overall institutional programming and administration. The DMHCA is available on-call twenty-four hours a day, seven days a week for emergencies. The DMHCA reported meeting with clinical staff on a daily basis to discuss and supervise services provided. The clinical director provides a minimum of one-hour direct supervision weekly to clinical staff. Interviews with other staff indicate the DMHCA is a licensed clinical social worker (LCSW) who is on-site forty hours a week, conducts clinical supervision for the non-licensed clinicians, sits on the facility management team, meets with the facility administrator daily in management meetings and meets with the psychiatrist, psychologist, and certified behavior analyst during their weekly visits to the program. The DMHCA provides direct care services such as initial behavioral interview, administration of the initial risk assessment tools, completion of Assessment of Suicide Risk (ASR), mental health and substance abuse evaluation and treatment plan, and guides execution of the mock suicide drills. The DMHCA also carries a small case load and provides individual, group, and family therapy when required. The DMHCA's license expires on March 31, 2021. During a portion of the annual compliance review period, the DMHCA was on extended maternity leave; however, the DMHCA duties were completed by the corporate regional clinical director (a licensed clinical social worker), other regional licensed clinicians, and licensed clinicians already on-staff at the program. The review team found no gap in administrative oversight of clinical services during the DMHCA's leave period.

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

The program has policy and procedures addressing licensed mental health and substance abuse clinical staff. The program utilized the services of three licensed mental health counselors to provide mental health or substance abuse services. The program provided a copy of each clinician's license including for each contracted provider. The program contracts with a licensed psychologist to provide services. Each of the three clinicians hold a clear and active license in her/his field with the Department of Health, Bureau of Medical Quality Assurance, expiring on March 31, 2021. In addition, the program contracts for the services of a certified behavior analyst. The company provided services through two of the contractor's staff. Each of the two behavior analysts held current credentials with the Certification Board for Behavior Analyst.

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 currently has three full-time, non-licensed master's-level therapists, two who are registered mental health counseling interns. These full-time staff members provide both mental health services and substance services to youth, under the program's Chapter 397 license. A review of the training records indicated each of the three non-licensed therapists completed all pre-service training and have also completed the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each non-licensed clinician completed five Assessments of Suicide Risk as part of the training. A review of the clinical supervision documentation from the last six months, indicated with the exception of three individuals, each on a different day, for each of the three non-licensed clinical staff who provided clinical services in a given week, received one hour of face-to-face, direct supervision which was provided by the designated mental health clinician authority (DMHCA), or licensed designee. All supervision was documented to have taken place on-site, with most supervision sessions being in a group setting. Supervision sessions consisted of case consultation, instructions and recommendations to staff, and a sample of staff work which was reviewed. The documentation form for supervision contained all the elements included in the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form for documentation of weekly supervision. All staff members who provided clinical services regardless of job title at the facility were documented to have the requisite training and hold a master's degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field.

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 policy and procedures addressing mental health and substance abuse admission screening. The policy requires the administration of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen every youth upon admission and readmission if they are taken out of the facilities custody for any reason. Seven youth records were reviewed, and all indicated the screenings were completed entirely in the Department's Juvenile Justice Information System (JJIS), on the day of admission. Documentation was provided indicating all MAYSI-2 assessments reviewed were completed by trained staff. Two of the seven records indicated the MAYSI-2 assessments were completed by a licensed professional and the remaining five were completed by non-licensed mental health staff members. Four of the seven reviewed MAYSI-2 Assessments indicated further assessment was required, and the remaining three youth were referred for further assessment based on a review of provided documentation. Each of the seven records indicated the reason for the referral and the youth were referred for an Assessment of Suicide Risk (ASR), Comprehensive Assessment as well as referral to see the psychiatrist. During an interview with the program director and the DMHCA, it was confirmed the MAYSI-2 is completed in a confidential manner and all youth admitted to the program are referred to mental health for an ASR, a comprehensive assessment, and an initial evaluation by the psychiatrist.

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 policy and procedures addressing mental health and substance abuse comprehensive evaluations. The procedures include each youth receives a new comprehensive mental health and substance abuse biopsychosocial evaluation within thirty days of admission. The program, which is licensed under Chapter 397 Florida Statutes for Substance Abuse provided their facility operating procedure, which included a written plan for delivery of mental health and substance abuse services. According to the provided plans for each youth, a new full comprehensive evaluation is completed, within thirty days of arrival, for each youth entering the program. The comprehensive assessment includes elements for both mental health and substance abuse. Furthermore, the mental health and substance abuse comprehensive evaluation includes demographic information, justification for the evaluation, reason for the assessment, behavioral observations, mental status examinations, methods of assessment, interviews or other procedures used to acquire the needed information, patterns of alcohol and drug usage, impact on major life areas, risk of continued usage, discussion of findings, diagnostic impressions including the DSM diagnosis, recommendations and relevant background information. Relevant background information includes home environment, family functioning, history of abuse to include physical and sexual, history of neglect, witnessing of violence and other forms of trauma, behavioral functioning, physical health, and educational functioning. All seven reviewed records included consent signed by the youth for substance abuse services. Five of the seven reviewed records had new comprehensives completed by a non-licensed clinical staff person and in all five the comprehensive evaluations were reviewed

and signed by a licensed qualified professional. The remaining two comprehensive evaluations were completed by a licensed qualified professional. All seven comprehensive evaluations included all required elements for both mental health and substance abuse evaluations and addressed the original reason for the referral. Of the seven records reviewed, six contained Comprehensive Mental Health and Substance Abuse Evaluations which were completed within thirty days of the youth's arrival in the program. In one record the Comprehensive Mental Health and Substance Abuse Evaluation was completed on the thirty-third day after the youth arrived.

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 policy and procedures addressing mental health and substance abuse treatment. The program assigns each youth admitted to the program with a multidisciplinary treatment team. The treatment team consists of the youth and representatives from program administration, the residential living unit, medical staff, vocational training staff, education and mental health staff, substance abuse staff, other staff responsible for delinquency intervention and treatment services and when possible the youth's parent/guardian. Seven of the seven youth records reviewed validate the treatment teams for the youth were made up of the above-mentioned disciplines. All seven of the reviewed records contained properly executed Authority for Evaluation and Treatment (AET) forms, signed Substance Abuse Consent Forms and Release forms. In all seven reviewed records, treatment was documented on forms which contain all the required elements. The program is licensed by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services under Chapter 397 of the Florida Statutes. The program's contract specifies substance abuse (SA) clinical staff shall provide the Living in Balance (LIB), Anger Management for Substance Abuse (SA) and Mental Health (MH) Clients, and 100 Interactive Activities for MH/SA Recovery. The MH clinical staff are to provide Strategies for Anger Management, Life Skills 225, Skillstreaming the Adolescent, The Teen Relationship Workbook, Creative Therapy, Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents, The Passport Program: A Journey Through Emotional, Social, Cognitive and Self-Development and Don't Let Your Emotions Run Your Life for Teens. Services are provided by qualified licensed and non-licensed clinical staff and include daily group therapy, bi-weekly individual therapy, monthly family therapy, and psychosocial skills training. A review of the seven records document mental health groups contained ten or fewer youth and substance abuse groups contained fifteen or fewer youth. Each of the seven staff interviewed, reported direct care staff do not facilitate mental health or substance abuse groups. All seven youth interviewed, reported participating in groups and receiving specialized therapies.

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 policy and procedures addressing treatment and discharge planning. The process includes each youth receiving an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. Seven youth mental health and substance abuse (MHSA) records were reviewed. All seven contained an initial MHSA treatment plan completed on the date of admission and included all the required elements. These documentation requirements include the youth's demographic information, reason for MHSA treatment, initial diagnostic impression or presenting symptoms, current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses and symptoms, initial treatment methods, and initial treatment goals. All seven MHSA initial treatment plans were signed by the clinician completing them and treatment team members who participated in creating the plan and on five of the seven plans were prepared by a non-licensed clinical staff person they were countersigned by the licensed clinical supervisor within ten days of completion. The initial MHSA treatment plans indicated the youth would have an initial psychiatric evaluation which would be conducted within fourteen days. Six of the seven records contained an individualized MHSA treatment plan (ITP) completed within thirty days of the youth arriving at the program. The one exception contained an ITP which was completed thirty-five days after the youth was admitted to the program. In all seven of the reviewed files the ITP included all Department required information. This information included documentation of youth demographics, current Diagnostic and Statistical Manual of Mental Disorders diagnoses and symptoms, mental health and /or substance abuse treatment goals mental health and /or substance abuse treatment methods or interventions, psychiatric services, and strength and needs of both the youth and family. Three of the seven records included youth receiving psychiatric services. In all three of the applicable treatment plans, the treatment plan included the need for psychiatric services, which included the medication the youth was taking as well as the frequency of monitoring by the psychiatrist. In all seven records, the ITP was signed by the Mental health/Substance Abuse clinical staff person completing the plan and all other treatment team members who participated in the development of the plan. In five of the seven records, the ITP was completed by an unlicensed staff person and in all five records the ITP was countersigned by the licensed supervisor within ten days. In all seven reviewed records, there was documentation indicating the youth were receiving the services prescribed in their ITP. Reviews are completed every thirty days in order to document the youth's progress towards the goals and objectives on their ITP. These treatment plan reviews contained documentation of a current DSM diagnosis and symptoms, mental health and /or substance abuse treatment goals with documentation of progress made by the youth in meeting each treatment goal, and any changes in mental health and/or substance abuse treatment methods or interventions and psychiatric evaluations and recommendations which are the required elements. In the seven records reviewed there were a total of twenty-seven treatment plan reviews. Twenty-six of the twenty-seven treatment plan reviews were completed within the thirty-day standard, one was completed thirty-two days after

the ITP was created. A total of three closed youth records were reviewed. All reviewed records contained documentation of the discharge instructions from the discharge summary being discussed at the exit staffing and signed by the youth and therapist. The records also provided documentation a copy of the Discharge Summary was provided to the youth's parent/guardian and the youth's 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 policy and procedures addressing specialized services, specifically intensive mental health. The program is licensed under Chapter 397 and offers specialized treatment services in the form of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). As a part of these services, the program provides group therapy seven days a week, each youth receives individual therapy at a minimum of once every two weeks and family sessions at a minimum of one time a month. Therapeutic activities are provided seven days a week. The program contracts with a licensed psychiatrist who provides on-site psychiatric services every week. There are two full time and one part time licensed therapists employed at this program. One of the full-time licensed therapists is the Designated Mental Health Clinician Authority, who works Monday to Friday weekly for a minimum of forty hours a week. The therapist caseload is limited to ten youth and the facility has a psychologist available to provide additional services as needed. The program provides urinalysis drug testing which is completed by the medical staff. Youth with co-occurring substance abuse and mental health disorders receive both substance abuse and mental health treatment by qualified personnel. Based on the reviewed records, mental health groups were limited to no more than ten youth and substance abuse was limited to no more than fifteen youth.

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

The program contracts with a licensed psychiatrist for the provision of psychiatric services to youth in the program. These services include an initial psychiatric evaluation, within fourteen days, for all youth entering the program, participation in treatment planning, and supervision of the treatment for youth who are prescribed medications in collaboration with the designated mental health clinician authority (DMHCA) and members of the treatment team. The initial psychiatric interview is documented on the Clinical Psychotropic Progress Note (CPPN) and includes a mental status exam, Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, treatment recommendations and the youth's history related to medical, mental health and substance abuse. When the youth is admitted to the facility on psychotropic medications or is prescribed them following the initial psychiatric evaluation, the CPPN will also include the prescribed medication, the frequency of medication monitoring and management, an explanation and justification for the medication as it relates to the youth's diagnosis, target symptoms and initial treatment goals and any applicable side effects and risks and benefits of

taking the medication. Three of the seven reviewed records indicated the youth arrived at the program on psychotropic medication and contained an Initial Diagnostic Psychiatric Interview which included all necessary elements. The remaining four records also included an Initial Diagnostic Psychiatric Interview, which contained all necessary elements for youth not prescribed psychotropic medication. At the time of the review, four youth were taking psychotropic medication, three arrived on medication and one did not arrive on medication and was not prescribed medication during the initial diagnostic psychiatric interview but was prescribed medication at a later date. All four of these youths' records contained a CPPN with all necessary elements. The four records also indicated the youth were receiving follow-up and medication management services from the psychiatrist at least once every thirty days. The contracted psychiatrist is on-site every week on Friday to provide services and the psychiatrist is available twenty-four hours a day, and seven days a week for emergency consultation. Weekly, the psychiatrist meets with representatives from the clinical staff to discuss the progress of youth prescribed psychotropic medication as well as new youth in the program. The DMHCA reported meeting with psychiatrist on a weekly basis to discuss youth receiving psychiatric services.

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 suicide prevention plan in place which received an annual review on July 19, 2019. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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.*	

Of the seven youth records reviewed, all were referred for an Assessment of Suicide Risk (ASR) as part of the program's standard intake process and the assessments included all required elements. Two of the seven assessments were completed by licensed mental health professionals and five of the seven were completed by clinical staff under the supervision of a licensed mental health professional. The five assessments completed by non-licensed staff all included a review and signature of a licensed mental health professional. Documentation was provided which indicated all staff who conducted ASRs received the required twenty hours of training provided by a licensed mental health professional which included the completion of five co-assessments. Following the completion of the ASRs, six of the seven youth were placed on standard program supervision and one was authorized to be placed on precautionary

observation at a level of constant supervision. An alert was placed in the Department's Juvenile Justice Information System and there was documentation to indicate the youth's parent/guardian and juvenile probation officer were notified of the change in the youth's supervision level. The ASR findings were documented in the facility logbook. There was documentation of a supportive session provided by the mental health staff to the youth was placed on precautionary observation. The youth was stepped down to close supervision following a Follow-Up ASR and a conference between the program director and licensed mental health professional. Following the completion of a mental status exam and consultation between mental health staff and the program director, the youth was placed on standard program supervision. During the time the youth was maintained on constant supervision, he was able to participate in select activities and the safe housing areas were clearly identified. There were no other youth placed on Precautionary Observation during the review period. During interviews with seven staff, it was reported when a youth expresses suicidal thoughts they are responsible to notify mental health and administration, place youth on constant sight and sound, document supervision, and search youth. The staff reported the knife-for-life is located in master control, medical, and the break room.

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

The program has policy and procedures addressing suicide prevention services. One of the seven reviewed youth records contained Suicide Precaution Observation Logs for a youth who was on some level of Precautionary Observation during the review period. All logs were maintained for the entire time the youth was on Precautionary Observation. The logs indicated the youth was maintained at the appropriate level of supervision and identified the safe housing areas were identified. There were no warning signs documented as observed on the log. The logs all indicated they were reviewed by each shift supervisor and mental health clinical staff and were signed by the respective disciplines in the appropriate location. There was only one youth placed on precautionary observation during the review period and they were not available to be interviewed due to no longer being at the program.

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

The program has policy and procedures addressing suicide prevention training. A review of three pre-service and seven in-service staff records indicated all completed the requisite six hours of annual suicide prevention training which included two hours of training documented in the Department's Learning Management System (SkillPro) and four or more hours of instructor led or webinar training. A review of mock suicide drills revealed drills were conducted on each quarter including a cut-down exercise for all shifts. A review of sign-in sheets revealed all staff reviewed participated in at least one mock suicide drill semi-annually involving a cut-down exercise. All staff members who were not involved in the drills each quarter were provided the opportunity to review the drills. An interview with the facility administrator indicated the program provides training or mock drills for staff, which includes emergency response to suicide attempts or self-inflicted injury.

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

The program has a crisis intervention plan separate from the emergency mental health and substance abuse services plan in place which received an annual review on July 19, 2019. The plan included notification, an alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The plan included the use of the Department's Crisis Assessment form.

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 policy and procedures addressing crisis intervention services. Procedures include staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. None of the seven youth were applicable for crisis assessment; therefore, an additional three youth records were provided. In all three instances, the youth were seen within two hours of the youth being determined to be in crisis. The provided assessments included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations for supervision, treatment and follow-up or further evaluation. In all three instances, the parents/guardians were notified of the assessments as well as the results. All the crisis assessments provided were completed by a licensed mental health counselor. After completion of the assessments, none of the youth were found to pose a threat to themselves or others so they were not placed on precautionary observation and there was no need to input the information into the Department's Juvenile Justice Information System.

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 emergency mental health and substance abuse services plan separate from the crisis intervention plan in place which received an annual review on July 19, 2019. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills), 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 review; 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 has a contract with a licensed physician, who acts as the program's designated health authority (DHA), and they are responsible for providing oversight and supervision of all health and medical services, including general supervision of all medical personnel. The DHA is responsible for the overall clinical direction, policies, and protocols for medical services at the program. A review of the Department of Health Medical Quality Assurance License search website revealed the DHA's license is clear and active in the state of Florida and expires on March 31, 2021. The DHA is scheduled to be on-site weekly, and is on call twenty-four hours a day, seven days a week. A review of the provider's contract indicates the DHA shall be on-site an average of four hours a week or sixteen hours a month as clinical needs of the population may dictate. A review of the supporting documentation validates the DHA was on-site weekly for four hours with the exception of one week. The DHA uses the services of two other licensed physicians, as a back-up when they are unable to provide services to the youth at the program. A review of the medical sign-in/out-logs indicated one of the back-up physicians was on-site during the one week the DHA was not. A review of the Department of Health Medical Quality Assurance License search website revealed one of the back-up physician's license is clear and active in the state of Florida and expires on January 31, 2021. The second back-up physician's license was reviewed, which is clear and active in the state of Florida and expires on January 31, 2020. A review of seven youth Individual Healthcare Records (IHCR) indicated the DHA conducts sick calls when they are on-site, as well as, provides routine medical care, and periodic evaluations for youth with chronic conditions. The DHA provides all follow-up medical care when a youth is referred by nursing staff. An interview with the DHA indicated they are on-site weekly to evaluate new youth, chronic conditions, episodic care, and assist with sick calls. The DHA further indicated they review lab and radiology information and participated in the development of the program's medical policy and procedures. The DHA also indicated they participate in meetings with medical staff and other program departments. The DHA further indicated they ensure the health of the youth at the facility and everything related to their care. The DHA confirmed they have two doctors available for coverage and they notify the health services administrator and the regional nurse to help organizing coverage when necessary. During the interview the DHA indicated they have no concerns about the health care being provided at the program since they communicate with the medical and program staff as necessary to address any concerns.

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 facility operating procedures (FOP) for all health-related procedures and protocols used at the facility. A review of documentation indicated both the facility administrator (FA) and the designated health authority (DHA) conducted an annual review and signed off on the FOPs and protocols on June 25, 2019. A review of the psychiatric FOPs indicated the program's psychiatrist conducted an annual review of their respective protocols on June 21, 2019. As part of the program's nursing pre-service training plan, all new medical staff are required to review the medical FOPs and protocols and sign the cover sheet indicating they

have reviewed them. Five full time nurses and two pro re nata (PRN) nurses who work at the facility signed a FOP cover letter acknowledging they have read and understood all nursing FOPs and healthcare protocols.

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 policy and procedures in place to ensure parents/guardians are afforded the right to give or withhold consent with regards to the healthcare provided to their children while they are in the program. Seven youth Individual Healthcare Records (IHCR) confirmed none of the youth had an original Authorization for Evaluation and Treatment (AET). Four of the seven reviewed records contained a signed AET, with the word 'copy' stamped or printed on the AET. The fifth record was a youth who arrived at the program at the age of eighteen and upon their arrival the youth signed the program form entitled, Authority for Evaluation and Treatment for Youth Over Eighteen Years of Age, which granted permission for the program to release only emergency medical information to a parent/guardian. The remaining two youth were being served by the Department of Children and Families, and both records contained a court order authorizing medical treatment and prescription medication. An interview with the program's health services administrator (HSA) indicated the Department's Juvenile Probation Officer (JPO) is responsible for ensuring the AET is signed and dated by the parent/guardian at the first available opportunity. The HSA also indicated when a youth is eighteen years of age the youth completes a release of information authorization form for youth eighteen years and older.

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

The program has a policy and procedures in place to address parental notification and consent for treatment. Seven youth Individual Healthcare Records (IHCR) were reviewed for parental notifications and consent for treatment. Six of the seven records required parental notification and the seventh record did not require parental notifications since the youth was eighteen years old at the time of admission, and only consented to their parent/guardian receiving emergency medical information. A review of the six applicable records revealed three records required the youth's parent/guardian to receive parental notification for over-the-counter (OTC) medications beyond those covered by the Authorization for Evaluation and Treatment (AET). None of the records were applicable for notification of a vaccination not consented for on the AET. Four of the six records were applicable for notification when significant changes to existing medications occurred. Two of the records were applicable for discontinuation of medication prescribed prior to the youth entering the Department's custody. One of the records were applicable for changes in condition/medication for youth with chronic conditions. Three records were applicable for parental notification for invasive dental procedures. Three youth were taken off-site for medical treatment, and their records contained notification to the parent/guardian when these events occurred. None of the records were applicable for off-site emergency notifications. Four of the six applicable records contained documentation in the nursing progress notes verbal attempts, and parental consent was received for all new medications. All applicable records contained written notifications regardless if verbal consent was received. All applicable records contained documentation a second staff member witnessed all telephone call attempts and conversations regarding parental consent. Four youth were applicable for written consent for the administration

of psychiatric medications and all four records contained written notification with an attached Clinical Psychotropic Progress Note (CPPN), which was sent to the youth's parent/guardian. Two youth were in the care of the Department of Children and Families (DCF) where there had been a termination of parental rights, and each record contained a court order authorizing all treatment, medications and procedures. The health services administrator (HSA) was interviewed and indicated parental notifications are made verbally and then a written document is sent out as soon as an order is given, or an event has occurred. The HSA indicated parental notifications are required for all emergencies, off-site appointments, hospitalizations, and for new, revised, or discontinued medications. The HSA also indicated each parent/guardian is verbally contacted for consent prior to starting psychotropic medications, and if the parent/guardian cannot be reached verbally they are sent a consent form along with page three of the CPPN. The program has a policy and procedures in place to ensure a youths' immunization history is obtained and all youth have received proper immunizations. The program obtains the youth's immunization records from the youth's electronic commitment packet and from the electronic Florida Shots database. A review of seven youth IHCR contained immunization and vaccination records and they were reviewed by a facility nurse within thirty days of each youths' admission. One of the applicable records revealed the youth required a vaccination and the youth was eighteen years of age and consented to the vaccination. None of the reviewed records contained a refusal for consent of immunizations for religious reasons. An interview with the program's HSA indicated the youth's parent/guardian should provide the program with a copy of the except form from the county health department and the form will be filed in the youth's IHCR.

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

The program has a policy and procedures in place for the completion of the Facility Entry Physical Health Screening (FEPHS) form for all youth on the date of their admission. A review of seven youth Individual Healthcare Records (IHCR) contained a FEPHS completed on the date of the youth's admission. All reviewed FEPHS were completed by a registered nurse. None of the reviewed records indicated the youth had a change in their physical custody since their admission. The program was able to provide one additional youth record which indicated the youth had a change of custody within the review period. Upon review of the record it confirmed the youth received a healthcare admission re-screening using the FEPHS form, and the form was completed by a registered nurse. An interview with the health services administrator (HSA) indicated newly admitted youth's first stop after they are released from handcuffs and shackles is the medical department for a medical evaluation. The HSA confirmed the FEPHS form is completed by a registered nurse. The HSA also indicated upon re-admission to the facility the youth is brought to medical first and screened for lice and a new FEPHS and body chart is completed.

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

The program has a policy and procedures in place indicating all youth will receive orientation to the program's healthcare services on the day of their admission. A review of seven youth Individual Healthcare Records (IHCR) contained documentation the youth received healthcare orientation the same day they were admitted to the program. The program documents each youth's orientation to healthcare services on a program form entitled, Healthcare Services Orientation. There was documentation in all reviewed records the youth were oriented to the sick call process, access to medical care, what constitutes an emergency, the medication process and side effect monitoring, the right to refuse care and how to document it, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care staff. Each youth's orientation form indicated they were advised of who the designated health authority (DHA) was, as well as the name of the program's psychiatrist. The program had a list of healthcare staff contacts located on a bulletin board in the medical clinic and the list was in an area where the youth could not view it. A review of the list had the correct DHA, nursing staff, and psychiatrist listed. All seven reviewed IHCRs contained a completed health education record form indicating all the topic's each youth had or will receive education on while at the program. Topic's the youth will be education on are prevention of accidents, alcohol/substance abuse, sexually transmitted diseases, smoking cessation, prevention of communicable diseases, cardiovascular health physical fitness, human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) general information, nutrition basics, dental hygiene, personal hygiene, breast self-exam, testicular self-exam, family planning, parenting skills, anxiety reduction, coping with depression, domestic violence, and coping with anger.

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

The program has a policy and procedures in place indicating after the healthcare staff reviews the youth's record and completes the screening and/or reviews the completed screenings, they are to notify the designated health authority (DHA) telephonically or verbally for all newly admitted youth regardless of any identified medical conditions. The purpose of the notification is to provide a comprehensive overview of the youth's medical conditions to the DHA and to obtain initial admission orders, initial medication orders, preliminary laboratory studies, diet orders, activity release or restrictions, and any other specific treatment orders or instructions for the youth with a health-related condition. A review of seven youth Individual Healthcare Records (IHCR) revealed the DHA was notified of each youth's admission to the program and their medical history was shared with the doctor. There was documentation in all records of the date and time the DHA was notified. All records contained a nursing progress note indicating the DHA was notified by telephone of the youth's admission. In two of the seven records, the DHA was notified of the youth's chronic condition. None of the reviewed records reflected the youth needed emergency services upon their admission. There was also documented in all IHCRs each youth was referred to the doctor for their comprehensive physical assessment. An interview with the health services administrator (HSA) indicated the nursing staff notify the DHA

of each youth's admission with a chronic condition and the youth are referred to the DHA, which is captured on the admission nursing progress note.

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

The program has a policy and procedures in place indicating a Health-Related History (HRH) form will be completed within seven days of a youth's admission. A review of seven youth Individual Healthcare Records (IHCR) revealed the program completed a new HRH form on all youth the day they were admitted to the program. All HRH forms were completed by a registered nurse. All HRH forms were reviewed by the designated health authority (DHA) and were all completed prior to the Comprehensive Physical Assessment (CPA). An interview with the health services administrator (HSA) confirmed all HRH forms are completed by a registered nurse upon the youth's admission.

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

The program has a policy and procedures in place to ensure each youth receives a physical health evaluation after their admission. A review of seven youth Individual Healthcare Records (IHCR) revealed each youth had a Comprehensive Physical Assessment (CPA) completed by the designated health authority (DHA) within seven days of their admission. Each CPA contained the youth's medical grade issued at admission and were completed in accordance with the Department's Rule. All seven records contained documentation the clinician deferred the examination of anus and rectum due to each youth having no significant past medical history and the female portion of each examination was not applicable to the reviewed records. Each youth's problem list accurately reflected each youth's medical conditions. An interview with the health services administrator (HSA) indicated the DHA completes an initial CPA at admission and annually thereafter. The program has a policy and procedures in place to ensure youth receive routine healthcare screenings and evaluations upon admission to the facility for latent or active tuberculosis, as well as environmental controls for the program. The program's policy follows the Centers for Disease Control and Prevention, as well as the Occupational Safety and Health Standards. A review of seven IHCR revealed each record contained a current verified tuberculin skin test (TST) test. The tier 1 tuberculin (TB) screening portion of the Facility Entry Physical Health Screening (FEPHS) form was completed and found in all records. All records also had the TST results documented on the Infection and Communicable Disease (ICD) form, as well as the Comprehensive Physical Assessment (CPA) form. Four of the seven reviewed records required the youth to have an updated TST test while the youth was in the program, and the youth's IHCR reflect the youth received a new TST test. An interview with the health services administrator (HSA) confirmed all youth are screened for TB upon admission and re-entry using the FEPHS form. The HSA also indicated all youth are given a TST test annually.

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

The program has a policy and procedures in place to ensure youth receive sexually transmitted disease/infection screening, evaluations, and testing. A review of seven youth Individual Healthcare Records (IHCR) revealed all youth were screened by nursing staff upon their admission for sexually transmitted infections (STI); however, the designated health authority (DHA) did not ordered STI testing for any of the youth based to their answers to the STI screening. None of the reviewed records were youth who were out of the Department's custody for more than thirty days and did not require a re-screening for STIs. An interview with the health services administrator (HSA) indicated all youth are screened for STIs upon admission and if the screening indicates a need for further evaluation the youth is referred to the DHA. The HSA indicated all STI screenings, evaluations, referrals and testing documents are maintained on the STI screening log. The program has a policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, and referred for medical treatment. The facility uses the Orange County Department of Health Miracle of Love center to conduct their pre- and post-HIV testing. The program's practice is to have an individual certified by the Florida Department of Health-Division of Disease Control and Health Protection from Miracle of Love comes to the program to conduct HIV prevention counseling, testing and linkage to services. The program was able to supply the review team with the Miracle of Love individuals 500/501 HIV/AIDS certification by the Florida Department of Health, which was updated in June 2019. A review of seven youth IHCR revealed all youth were offered HIV testing, counseling, and received general education about the disease. Two of the seven youth records revealed each youth consented to HIV testing. The program provided the review team with an additional youth record for review of HIV testing and consent to ensure the Department's minimum sample size was met. All three applicable records revealed each youth consented to HIV testing. Each youths' health education records revealed they received pre- and post-testing counseling from the Miracle of Love certified HIV counselor. Two of the three reviewed records contained a sealed envelope, which contained the youth's HIV testing results, and the envelope was marked confidential. The third youth's record did not contain a sealed confidential envelope since they were released from the program the day prior to the annual compliance review and the youth was given the envelope upon their release. A review of the program's internal medical alerts and the Department of Juvenile Justice Information System (JJIS) alerts revealed there were no alerts related to a youth's HIV status. An interview with the health services administrator (HSA) confirmed all youth are offered an HIV test upon admission and the HIV consent form is completed indicating their consent or refusal. The HSA also indicated the HIV consent form is maintained in each youth's IHCR. The HSA confirmed the program uses the Orange County Department of Health Miracle of Love program to perform all HIV pre-counseling, testing and post-counseling. The HSA indicated HIV testing is documented on the youth's Health Education Record form. Seven interviewed youth indicated they could request an HIV test if they wanted one.

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

The program has a policy and procedures in place to ensure there is a system in place to response to the complaints of youth illness or injury of a non-emergent nature. The policy indicates sick call care, including dental complaints shall be available to all youth. Sick call care shall be provided by licensed health care professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program has postings of the sick call hours in each of the facilities cottages, and on the medical examination clinic door. The program also has Sick Call forms available on each of the youth cottages along with a locked sick call box, which is checked several times a day by nursing staff. The program completes sick call two times a day, seven days a week and nursing staff is on-site daily for twelve hours. Sick call is always conducted by a registered nurse (RN) since the program only hires RNs. Sick call is conducted Monday through Friday from 12:00 p.m. to 12:30 p.m. and then again from 4:00 p.m. to 4:30 p.m. On Saturday and Sunday sick call is conducted from 7:30 a.m. to 10:20 a.m. and then again from 4:00 p.m. to 4:30 p.m. A review of seven youth Individual Healthcare Records (IHCR) revealed two youth submitted one Sick Call Request each; therefore, the program provided one additional youth record who had a sick call for review to ensure the Department's minimum sample size of three was met. There was a total of three sick calls reviewed. None of the three reviewed records presented with similar sick call complaints three or more times within a two-week period. All Sick Call Request forms were filed in the progress note section of each youth's IHCR in reverse chronological order. There were no sick call complaints of any severe pain with which nursing staff were unfamiliar. All Sick Call forms were documented in accordance with the Department's Rule and contained the youth's vital signs, treatment, education, and any follow-up plans. All sick calls were documented on the youths' Sick Call Index in their IHCR and on the program's Sick Call Referral Log. During the review, a sick call was observed after the youth and registered nurse granted permission for the reviewer to be present. The youth was escorted to the medical clinic by a direct care staff, who stood in the hallway with the clinic door cracked for security reasons; however, the youth's confidentiality was maintained during the entire sick call. The nursing staff identified themselves to the youth, the youth sat next to the examination table and reviewed the Sick Call Request form with the nurse. The nursing staff discussed the youth's symptoms with the youth and took the youth's vital signs. The nurse examined the youth and then the youth received the treatment as indicated by the nursing protocols. The youth reviewed and signed the Sick Call form prior to exiting the medical clinic. Seven youth were interviewed, and five youth indicated they could see the nurse within one day of putting in a sick call and two indicated they could see the nurse immediately. Seven staff were interviewed and they all indicated nursing staff responds to sick calls; however, one staff also indicated the doctor also responds to sick calls. Another staff stated Sick Call forms are located on each cottage and the youth fill out the form and place it in the sick call box. Five of the same seven staff indicated nursing staff conducts sick call and two indicated the doctor conducts sick call. The staff indicated if a youth requests to see the doctor the youth can be placed on the doctors list and they will be seen by the doctor. An interview with the health services administrator (HSA) confirmed sick call is conducted two times a day, seven days a week at the times listed above. The HSA further indicated if the youth is to be referred to the doctor for further assessment they are placed on the doctors medical list and are seen when

the doctor is next on-site. The HSA confirmed the DHA has approved all treatment protocols and the signed protocols were provided to the review team.

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

The program has a comprehensive process for the provision of episodic, and first aid care. The program has a registered nurse (RN) on-site twelve hours a day, seven days a week; during the review period, there was no evidence of non-healthcare staff providing first aid/or episodic care to the youth. A review of seven youth Individual Healthcare Records (IHCR) confirmed five records were applicable for episodic care, first aid and emergency care. There were twelve instances of episodic care reviewed in the five applicable records. Nursing staff documented each event in the nursing chronological progress notes and labeled it, as an episodic event. Each episodic incident was documented in problem-oriented narrative charting indicating the subjective, objective, assessment, and plan (SOAP format). All twelve instances of episodic care were listed on the program's episodic care log. One of the episodic incidents resulted in the youth being transported to the local hospital for emergency care upon orders from the designated health authority (DHA). The DHA also conducted an evaluation of the youth the next time they were on-site after the youth returned from the hospital to follow-up on the youth's care. The program has written policy and procedures for the provision of emergency medical care, including emergency dental treatment. The DHA is available by telephone twenty-four hours a day, seven days a week for consultation. Postings were found throughout the facility informing staff of their right and responsibility to call 9-1-1. A review of ten non-healthcare staff training records contained documentation of current first aid, epinephrine auto injector, basic cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certifications. The five full-time nurses and two part-time nurses all had current first aid, CPR, and AED certifications. The program had listings of emergency telephone numbers to include the Poison Control Center number in the medical clinic; and they were inaccessible to the youth. Interviews with seven staff indicated they all knew they could call 9-1-1 regarding a medical emergency. Four of the staff further indicated they would have to radio master control and have them call 9-1-1 because there are no telephones on the youth cottages. One of the interviewed staff indicated they would have to radio a supervisor if no one else was present and have them call 9-1-1; however, if there were numerous people around can then go and make the call. Another staff indicated unless they were in an office they would have to radio master control to call 9-1-1 because there are no telephones on the youth cottages. Another staff indicated they would take the youth to medical and medical would call 9-1-1 or they would have to contact master control and have them call 9-1-1. Seven interviewed youth indicated they could see a dentist if they had tooth pain and could see the doctor instead of the nurse, if needed. The program has a total of seven first aid kits and they are in master control, copy room, cafeteria, school building, and three are in master control to be used for transportation. The program has two suicide response kits and they are in master control, and the copy room. Documentation reviewed supported the nursing staff conduct weekly reviews of the first aid kits and monthly checks of the suicide response kits. During the review four first aid kits were opened and inventoried. Three of the first aid kits inventoried were used for transports and one was maintained in the school buildings. All the first aid kits contained all items approved by the DHA to be in the first aid kits and were within expiration dates except for one. One of the transportation first aid kits had an empty bottle of saline and another bottle of saline, which was expired. During the review, the program replaced the saline and re-sealed all the first aid kits. The program has one AED and it is maintained in master control. The AED battery expires July 20, 2021 and were last changed on

March 15, 2018. The pads expire in May 2020 and were last changed on February 20, 2018. The AED instructions were found in a little red pouch attached to the AED and the health services administrator (HSA) stated the instructions are also located within the medical clinic. Reviewed documentation confirmed the nursing staff conducted monthly testing of the AED for the entire review period. The program is required to conduct monthly medical drills on all three shifts with CPR/AED being practiced at least quarterly. A review of the medical drill documentation for the last year indicated drills were conducted monthly. The medical drills further indicated the program staff demonstrated CPR and the use of the AED at least quarterly on each shift while conducting the medical drills. An interview with the HSA indicated the program documents all episodic care conducted by the doctor or the nurse in the nursing progress notes. The HSA indicated if a non-healthcare staff provided first aid/emergency care they would document the incident on the Report of On-Site Health Care by Non-Health Care staff form. The form would then be reviewed by a registered nurse the following morning and the incident would be placed on the program's episodic log. The form would then be filed in the youth's IHCR. The HSA also indicated they track all off-site appointments on the program's monthly tracking log and off-site appointment calendar.

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

The program has a policy and procedures in place outlining the programs procedures for off-site care and referrals. Seven youth Individual Healthcare Records (IHCR) were reviewed and four were applicable for off-site care visits. Three of the applicable records were applicable for parental notification and the parental notifications were maintained in each youth's IHCR. The fourth record did not require parental notification for the off-site care due to the youth being eighteen years of age. There was a total of five off-site care instances in the four applicable records. All records had the Department's Off-Site Care form used and the forms were filed in each youth's IHCR. Three of the four Off-Site Care forms were reviewed and signed by the designated health authority (DHA). During the debriefing process, the program advised the fourth Off-Site Care form was not reviewed and signed by the DHA since the youth had just gone to the appointment the week prior and the program filed the form in the youth's IHCR for the review team to examine. All four reviewed records required follow-up testing, referrals, or appointments and there was documentation in each record the youth received the necessary follow-up care or appointments have been scheduled. An interview with the health services administrator (HSA) indicated the program tracks all off-site youth appointments by placing the appointments on the program's off-site appointment calendar, medical tracking log and by placing the youth's name on the daily shift report. The HSA indicated they ensure all Off-Site Care forms are reviewed by the DHA by placing them in a folder labeled, MD to sign. The DHA will then review and sign all forms in the folder during their next visit to the program. An interview with the DHA confirmed the process described by the HSA as the program's process to ensure Off-Site Care forms are reviewed by them.

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

The program has a policy and procedures in place for youth with chronic medical condition(s), which indicates youth shall have treatment plans/physical progress notes which specify a youth's course of therapy, identifies the role of qualified health professionals in carrying it out, and is updated as needed. The policy further indicates youth with a chronic condition, communicable disease, receiving prescription medications including psychotropic medications, or are being treated for tuberculosis shall receive a periodic evaluation from the physician every sixty days. A review of seven youth Individual Healthcare Records (IHCR) revealed two of the youth had a chronic medical condition identified at admission and required placement on the program's chronic condition list. Two more of the seven reviewed records revealed the youth were on the chronic conditions list due to being on psychotropic medications; therefore, there was a total of four youth reviewed for chronic conditions and periodic evaluations. A review of the program's chronic condition list revealed all youth were appropriately placed on the list and their corresponding medical conditions and/or medication regiment was properly listed. The two youth identified with a chronic medical condition were also identified as being on psychotropic medications. These two youth were seen by the designated health authority (DHA) every sixty days for a medical periodic evaluation and by the psychiatrist monthly for medication monitoring. The other two records were youth who were placed on the chronic conditions list due to being on psychotropic medications and they received monthly medication monitoring by the psychiatrist. All documentation for the periodic evaluations and medication monitoring evaluations were found in each youth's IHCR. All applicable youth records contained specialized treatment plans for the youth based on their chronic conditions. None of the youth were applicable for anti-tuberculosis medications. All treatment orders were written clearly and were distinguishable for clinical staff to interpret. None of the periodic evaluations were conducted off-site. A review of all applicable records revealed there were no lapses in care or missing periodic evaluations. A review of seven youth IHCRs revealed all youth's problem list accurately reflected each youth's physical health, dental health, and mental health. An interview with the DHA confirmed youth with chronic conditions are evaluated every sixty days unless otherwise specified. The DHA indicated the nursing staff keep track of chronic conditions with a tracker and the nurse put the youth on their clinic list when they are due for their periodic evaluations. An interview with the health services administrator (HSA) indicated youth admitted with a chronic condition are evaluated by the DHA during the initial physical and are placed on the program's chronic condition list and seen every sixty days after the initial physical. Furthermore, the HSA indicated a youth who develops a chronic condition after admission will be seen sixty days after the diagnosis by the DHA.

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

The program has a policy and procedures in place to ensure youth receive all prescription medication(s) as prescribed by a physician. The policy indicates medical staff shall verify any medications arriving with a newly admitted youth. The program's policy also indicates only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into the facility. The policy further indicated verification of

the actual medication contents is not required if the youth has been transferred directly from the Department and the medications have been under the Departments controls the entire time. A review of seven youth Individual Healthcare Records (IHCR) revealed three youth entered the program with currently prescribed medication. The three applicable youth who entered the program with medications entered the program from a Department detention center and verification was noted on the Department form entitled, Medication Receipt, Transfer, and Disposition. Also, each youth's nursing progress note indicated staff verified the youth's medication with the parent/guardian upon the youth's admission. All applicable records reflected the designated health authority (DHA) was notified when the youth entered the facility with prescribed medications. All youth records reflected the DHA advised the program to continue all medications until the youth were seen in person for their initial medical evaluation. All three youth entered the facility with psychotropic medications, and the program's assigned psychiatrist was also notified of the youth's admission and the psychotropic medications they were taking. Each youth's nursing progress note indicated the psychiatrist continued all medications until the youth were seen in person for their initial psychiatric evaluation. An interview with the health services administrator (HSA) indicated the program nursing staff verifies medication upon the youth's admission from the Medication Administration Record (MAR) and medication transfer sheet, which is transferred with the youth from a Department facility. The HSA further indicated if the youth is admitted from home with medication, the pharmacy would be called to verify the medication. The HSA also indicated non-healthcare staff do not verify medications at the program. The program did not have any instances of restricted housing; however, the program's policy indicates youth in restricted housing will be given their medications as ordered by the physician. Two of the seven reviewed records reflected the youth received over-the-counter (OTC) medications not listed on the AET form and they were administered in accordance with the approved nursing protocols. None of the youth's parents/guardians prohibited the administration of OTC medications. All seven reviewed youth IHCRs contained one or more MAR form. Three of the seven records were youth who arrived at the program on medication and all applicable records contained an initial MAR which matched the medication the youth was receiving upon their arrival. All MAR forms contained the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, side effects, and medical alerts. A photograph of each youth is maintained in the current medication administration book, along with the current months MAR. Each MAR indicated the youth received medication as ordered and the MARs clearly indicated when medication started and stopped. Each time a medication was administered the staff initialed the medication entry. A review of the MARs indicated nursing staff documented weekly side effect monitoring for all medications administered. There were no lapses or errors in medication administration in the any of the reviewed youth records. All refusals were marked with the letter 'R' on the MARs and had a corresponding signed refusal form in the nursing progress notes. There was only one youth who refused their medication on two occasions and the refusals were documented correctly. An interview with the HSA indicated the program uses pre-printed pharmacy MARs provided by their contracted pharmacy, First Choice Pharmacy. Observations of the medication administration office indicated the office was neat, clean and organized and locked upon entry. The medical cart where all medications were stored was neat, clean, organized, and locked. The program stores oral medication separately than injectable and topical medications. The program stores narcotics and other controlled medications is a lockable drawer within the locked medical cart. All other medications are stored in the medication cart, which is secured, locked and inaccessible to the youth. The program maintains all stock medications in a locked cabinet in the medical clinic. The program has a process in place for the destruction of expired and/or discontinued medications. Unused non-controlled medications which are within the expiration date are returned to First Choice Pharmacy by giving the medications to the pharmacy consultant who comes to the program monthly and the program is given credit for the unused

medications. A review of documentation confirmed the program returned medications to the pharmacy. If the unused non-controlled medications are expired the program destroys the medications by using a medication jar called RXDestroyer. Two nurses verify the medication and then places the unused medication in the RXDestroyer jar and when the jar is filled it is disposed of in the trash. All unused controlled medications are destroyed with the pharmacist and two nurses using the RXDestroyer. The destruction of all medications is documented on the program's Disposal of Medication Logs. A review of the logs indicated all medications were destroyed in compliance with the program's policy and procedures. The annual compliance review team member was able to observe a 4:00 p.m. medication pass. Each youth was brought to the medical clinic door by direct care staff. The medication cart was pressed up against the medical clinic door frame and locked in place. When each youth came up to the medication cart the nurse verified the youth's name, medication, route, dosage, and time. The nurse also asked each youth about their allergies and side effects of the medications they were receiving. An interview with seven staff indicated the youth receive their medications from the nursing staff; however, one of the interviewed staff members indicated youth can receive medications from a trained supervisory staff. Seven youth were interviewed and four of the youth indicated they do not take medications and do not know the process for receiving medication. Three of the interviewed youth indicated they receive their medications from nursing staff and all three youth were able to articulate the program's process for medication administration. An interview with the HSA indicated the program does have non-healthcare staff trained to assist youth with self-administration of OTC medications. A review of documentation supports the program has six supervisory staff trained by a registered nurse to aid youth in self-administration of medication; however, only two of those staff have access to controlled medications and have been trained to aid youth with self-administration of controlled medications.

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

The program has a policy and procedures in place for the storage of medications, and sharps. The program's policy indicates the program shall ensure all chemical products, drug and medicines, and medical, dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Observations of medications indicated they were stored within the program's medical clinic. The youth's medications and over-the-counter (OTC) medications are in a locked medical cart maintained in the clinic. When observed the cart was locked and has separate storage areas for different forms of medications. The cart has an area where youth's medications are stored and has an additional lockable drawer, with a different key, which is used for controlled substances. The program maintains stock medication in locked cabinets in the medical clinic. The program contracts with First Choice Pharmacy, who is responsible for filling medication requests. The program also has a contract with a pharmacist who comes on-site monthly to retrieve medications for return, consultation and to aid in the destruction of medications. An interview with the health services administrator (HSA) indicated all medications are inventoried daily with a perpetual count. The program also conducts weekly counts of medications and the HSA confirmed medications are stored within the medical clinic in locked cabinets and/or in the locked medical cart. The HSA also confirmed class two medications are destroyed on-site with the pharmacist, and two nurses and all other medications are returned to the pharmacy. During the interview the HSA also confirmed all controlled medications are stored

in a secure storage box within the secure medication cart. Observations confirmed all medications and sharps were securely stored in locked cabinets in the medical clinic. Syringes and sharps were counted using a perpetual inventory. The inventories are verified on a weekly basis, and the reviewer was able to observe the weekly counts were conducted for the entire review period. Opened OTC medications were inventoried using a perpetual inventory and verified weekly, and the reviewer was provided with documentation to support the nursing staff conducted the weekly counts for the entire review period. The program also conducts shift-to-shift counts of controlled medications. The program maintains all controlled medication counts within the youth's individualized healthcare record or in the current monthly medication administration record binder. The program has a policy and procedures for detecting and responding to inventory discrepancies and the HSA indicated in their interview if a discrepancy was found they would start with a recount of the medication. They further indicated if the medication was still off they would check with staff to see if they had taken any medication without logging it, and follow-up with the nurse who did the last medication pass to ensure there were no refusals of medication which were marked wrong. If the medication was still off the nursing staff would report it to the facility administrator and the Central Communications Center. A review of the Department's Medication Administration Records (MAR) and documentation confirm the program maintained perpetual daily inventories for all prescription medications. During the review, an inventory of three sharps, three controlled medications, three youth medications and three OTC medications were conducted, and all were found to be accurate.

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

The program has an exposure control plan, as well as a policy and procedures in place for the control of infectious and communicable diseases. A review of documentation indicated both the facility administrator (FA) and the designated health authority (DHA) conducted an annual review of the plan and policy on June 25, 2019. An interview with the FA indicated the exposure control and infection control plan is located within the medical clinic and the health services administrator conducts training with staff upon hire and yearly thereafter.
The programs' infection control procedures included prevention, containment, treatment, and reporting requirements, as required by the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The infection control procedures addressed all required types and categories of diseases outlined in the Department's Rule. There were no instances in which the local county health department, CDC, or the Central Communications Center required notification of an infectious disease. The programs' exposure control plan includes risk assessment and methods of compliance and contains all requirements of the Occupational Safety and Health Administration (OSHA) federal regulations. The policy also included a comprehensive process for needle stick post-exposure evaluations. The program has not had any youth or employees who have experienced a facility/occupational exposure during the review period. There were no instances involving quarantining or hospitalization of at least ten percent of the program's total population or staff during the review period. A review of ten staff training records indicated all staff received annual training in infection control and site-specific exposure control plan. All staff

are offered Hepatitis B immunizations at the cost of the program. Seven reviewed youth Individual Healthcare Records contained evidence of training in infection control, hand washing techniques, universal precautions, prevention of communicable diseases, and vaccinations within seven days of their admission. An interview with the health services administrator (HSA) confirmed the program has an exposure control plan and infection control policy and they are responsible for training staff on both the plan/policy every six months. The HSA also indicated the nursing staff provide infection control training to the youth at admission and during the monthly education classes provided to the youth.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures addressing youth supervision. The policy for supervision is one staff to eight youth during the daytime and at nighttime. There are three living units, and all had the daily schedule and activity schedule posted. An interview was conducted with seven staff regarding procedures when the youth count cannot be reconciled. Staff provided specific instructions on how to handle discrepancies and recounts appropriately. Observations conducted throughout the annual compliance review period confirmed staff consistently maintained active supervision of youth during daily activities such as school, large muscle activity/recreation activities, groups, line movements, and meals. Staff searched youth before all movements of youth. Master control was also observed calling formal head counts throughout the duration of the annual compliance review. Program staff were observed adhering to the daily activity schedule and providing active supervision. Youth were also observed engaging in recreational and leisure activities on the recreation yard and in the living units. Staff were observed within the required ratio of one-to-eight during daytime activities and in the evenings while youth were sleeping. Staff positioned themselves at all times to be able to closely observe the youth. During the annual compliance review, the review team observed program staff quickly responding to an altercation between youth. Program staff responded quickly and deescalated the situation while maintaining control of the other youth.

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

The program has a policy and procedures regarding the behavior management system (BMS) called the Positive Performance System (PPS). There is a PPS tracker posted on all three living units. A review of the staff training records reflected all staff were trained on the BMS. There have been no changes in the BMS since the last annual compliance review. The program recognizes positive behavior and the consequences of negative behavior with a ratio of four positives to one negative, which was validated by staff interviews along with an interview of the facility administrator (FA). Seven case management records were reviewed. All seven had documentation to support youth received an orientation to the BMS, received a copy of the youth handbook, and discussed the positive and negative consequences for behaviors. All records reflected consistent implementation and oversight of the BMS. The BMS included all required information including how to maintain order and security, promotion and protection of youth rights, positive and negative consequences, constructive disciplinary actions, positive reinforcement, recognition of accomplishments, socially acceptable means, a process for

explaining sanctions, an opportunity for the youth to explain themselves, an opportunity for discussion, reasonable reparations, alternative behaviors, and promotion of positive resolution. The program accomplishes these tasks by having special treatment teams with documentation to reflect the required information above and providing expectations on the PPS. An individual behavior plan is developed, as needed, and the plans are developed around positive behavior in daily activities to minimize separation from the population. Through observations of the physical plant during the annual compliance review, it was evident staff are promoting a positive environment. Staff were observed having active conversations, greeting youth warmly, asking them questions, participating in recreation activities with youth, and verbally deescalating youth when needed. Seven youth were interviewed. All of the youth stated they are offered a variety of incentives and rewards used as positive reinforcement. All seven of the youth stated they received training of the BMS during orientation. Seven staff were interviewed about the BMS. All staff were able to discuss the point system, incentives to include outings, video games, and extra food, and consequences of the BMS. All staff confirmed they cannot take things away from youth as a consequence.

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 has a policy and procedures on the comprehensive and consistent implementation of the behavior management system (BMS) and training for staff on the understanding and implementation of the BMS. The policy covers protocol where staff provide feedback regarding implementation of the BMS. Position descriptions specified the required qualifications of staff whose job functions include implementation of the BMS. All required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS includes a process wherein staff explain to the youth the reason for any sanction imposed prior to the end of the staff member's workday. The program does not utilize room restriction as part of the BMS. The BMS does not include increased length of stay, denial of youth basic rights, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. An interview with facility administrator (FA) indicated the program utilizes a Positive Performance System (PPS) as the program's BMS. Rewards are monitored daily, weekly, and monthly and are developed by the youth advisory board and the recreation therapist. The FA states staff models a four-to-one model of rewards to consequences and peer support helps to ensure the practice is on-going. The BMS is reviewed daily during management meetings and is tracked on the Performance Outcomes Report. Youth are able to earn points daily and can move up to the next level by earning multiple positive days. Consequences can include a loss of points or a special treatment team. All seven interviewed youth reported they understand the BMS. All seven interviewed staff reported they are provided feedback on the implementation of the BMS during staff meetings, individually, and on formal evaluations. Three pre-service and seven in-service staff training records were reviewed, and all

documented training in the BMS. Records also showed the education staff were jointly trained on the utilization of the BMS during school by the FA.

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 a policy and procedures addressing the supervision of youth. The program currently has fifty-six cameras, of which forty-six are operational. The video footage is stored for thirteen days. There is a current work order to repair the non-operational cameras and the inability to store more than thirteen days of camera footage. All living units were reviewed by documentation and video footage for three randomly selected days for ten-minute checks. All dates and dorms had ten-minute checks within the required timeframe in real time and staff took the time to walk room-to-room and look into each room for safety and security. This was evident on the youth visual check sheet. Seven staff were interviewed, and six staff stated checks are conducted every six minutes when a youth is placed in their room while sleeping or for non-punishment reasons. One staff member stated they had never worked a night shift when youth were in their rooms and was unsure how frequent checks are when a youth is placed in their room while sleeping or for non-punishment reasons.

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

The program has a policy and procedures for census, counts, and tracking. The facility operating procedures specifies six specific times when formal head counts will be conducted during a twenty-four-hour timeframe. Counts are being conducted and documented in the logbook, in the scheduled count log, and on a white board in master control. All counts were documented in the master control logbook and scheduled count log to include the emergency counts during the program's two escapes earlier this year. The daily population count is passed on to each shift during the shift briefing as well as tracked on a white board located in master control. Multiple counts were observed during the annual compliance review and through the program's two-way radio in master control. Counts are conducted at the beginning of each shift,

after any outdoor activity, during movement, when youth are temporarily away from the program, and in emergency situations. Seven interviewed staff stated formal counts were completed multiple times a shift (at least three times) and informal counts are conducted randomly and in emergency situations. All of the staff stated any discrepancy will result in a recount until the discrepancy is cleared. Three of seven interviewed staff stated if count cannot be cleared, youth will be locked in their rooms and a search for the missing youth will commence.

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 has a policy and procedures addressing logbook entries and shift report reviews. A review of logbooks for the last six months validated all were bound with numbered pages, all entries were made in ink with no erasures or white-out areas, any errors were struck through with a single line, dated and initialed, all entries included the staff name, youth involved, and a brief description of the event which included the name and signature of the staff making the entry. No entries were obliterated or removed. The program's logbooks, which are kept in master control, document contraband searches, perimeter checks, security checks, head counts, information regarding class A tools, parking lot checks, youth restrictions, youth security alerts, Prison Rape Elimination Act (PREA) checks, fire safety walks, medical box checks, transition of youth from one location to another, heat index, medical pass, hygiene, education, emergencies, transports, admissions and releases, anytime law enforcement (LE) needs access to the youth, and escapes. The program had two escapes since the last annual compliance review and both incidents and any subsequent information regarding the escapes were noted in the logbook, to include contacting the Central Communications Center, emergency count, and LE contact. The program does not utilize living unit logbooks, but instead utilizes shift reports. A review of the last six months of shift reports validated each oncoming staff member signed the shift report indicating they reviewed the events, incidents, and activities from the last shift. In addition, the supervisor conducts a shift briefing on each shift to discuss the shift report. The shift reports are kept in the briefing/conference room for a minimum of forty-eight hours.

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

The program has a policy and procedures for their key control process which was validated during the annual compliance review. Their policy and procedures included the control, the use of keys, and contained the required elements. Distribution and collection of keys were observed during shift change, where all procedures were followed. A review of the inventory validated the inventory matched the actual key rings in use. Three staff were asked to review their keys for

comparison to the key inventory. Two of the staff had permanently assigned key rings. Of the two key rings, one key ring contained the correct number of keys and each key matched the inventory. The second set of keys had the correct number of keys; however, only two of the three keys were able to be identified and the third key's identification letter was worn off. The third set of keys contained the correct number of keys; however, of the thirteen keys on the keyring, only seven of the keys were able to be identified and the remaining key's identification letter were worn off. This information was brought to the attention of the facility administrator and was corrected the following morning; both sets then matched the inventory. The keys are maintained in a locked cabinet in master control, which both the cabinet and master control room remains locked at all times. The key slots in the cabinet are color coded to notate who is assigned permanent keys, and which are assigned temporary keys, each shift. The cabinet is secure, and staff are not able to obtain any keys while the cabinet is locked. Two keys were lost during the annual compliance review period. Each incident was documented in the logbook when the Central Communications Center was contacted. Of the two, one staff received disciplinary action and re-training. The other staff was not disciplined; however, a re-training of all staff was conducted as a result. The program has a policy and procedures regarding the reporting and replacement of damaged keys; however, there have not been any since the last annual compliance review. An interview with the master control operator validated she is familiar with the process of the usage of all restricted keys. The program's method of daily tracking of keys is each staff turns in their keys to receive program keys. In addition, the master control operator utilizes a key control log to log each program key assigned and notates in this log when it is returned. Seven staff were interviewed regarding their understanding of the program's key control process, how keys are assigned, the program's process for missing, lost or damaged keys, and restricted keys and each of the seven were able to explain the process.

5.08 Contraband Procedure	**Satisfactory Compliance**
The program's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

The program has a policy and procedures to address contraband, which includes the delineation of all contraband, how youth are provided with a list of contraband items, the consequences of having contraband, and all searches for contraband. The program's policy and procedures further detail the process to avoid introduction of contraband, indicates all incidents are documented, staff are trained, and action is taken when staff or youth are discovered with contraband, to include contacting law enforcement for any illegal contraband confiscated. It

further states any staff found in possession of contraband will be subject to disciplinary action up to and including termination and included all supervisors and administrators. There has been no illegal contraband confiscated since the last annual compliance review. A review of the logbook, as well as the room/box search log binder, for last six months, validated the rooms and youth boxes are searched on a weekly basis. Youth are provided, during their orientation process, with a list of items considered contraband, as well as the consequences for possession of any contraband. A review of seven youth records validated all seven signed for the youth handbook during their orientation. The facility administrator (FA) was interviewed regarding how the discovery of contraband and illegal contraband is handled and disposed of. He indicated all contraband items are to be turned over to the FA who will document the custody trail and preserve the items as evidence. Then the FA will contact local law enforcement and a criminal report will be filed.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance
The program shall perform searches to ensure no contraband is being introduced into the facility.	

The program has a policy and procedures regarding searches and full body visual searches. During the annual compliance review, annual compliance team was able to observe the return of a transport for youth returning from court as well as an admission. The new admission youth had a full body visual search conducted by two same gender staff members, while the youth returning from court was searched by a same gender staff member. Each of the youth were searched upon exiting the transport van. The annual compliance review team observed classroom transitions and transitions to and from recreation and group treatment meetings and all of the youth were searched as required by the Protective Action Response (PAR) training manual, and the required ratio of staff-to-youth was observed. The searches were observed to be a normal practice for the youth and were conducted by a staff member of the same gender. The youth were treated with dignity and respect while being searched. Seven staff and seven youth were interviewed, and all confirmed youth are searched every time there is a movement of youth.

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

The program has a policy and procedures on vehicles and maintenance. The program has two vans utilized for youth transports. The vans had their last annual inspection on August 14, 2019 and August 16, 2019, respectively. The 2010 van was off-site for the duration of the annual compliance review for staff training. The 2017 van was able to be observed returning from a transport on two separate days during the annual compliance review. A review of the van used to transport all youth found the van had operational seat belts, a fire extinguisher, a removable first aid kit, and a seatbelt cutter/window punch. Youth were not observed to be attached to any part of the vehicle by any means other than the seatbelt. The van was observed to be locked when not in use. The inside door is unable to be opened from the inside. A random check of

personal vehicles found all vehicles were kept locked when not in use and are located outside of the locked gate.

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

The program has a policy and procedures addressing the transportation of youth. The policy requires a cell phone or radio to be issued to the transporter, the staff ratio of one staff to five youth must be in place for all transports (two staff are required for five or less youth), and at least one of the staff on the transport must be the same gender as the youth. During the annual compliance review, the review team was able to observe two transports which validated this policy. The policy also includes secure transportation provided for non-secure youth determined to be at greater risk. The policy also states drivers must have a valid driver's license, staff shall not leave youth unsupervised in the vehicle, and all of the procedures together reflect youth are not permitted to drive vehicles. A background check is completed on all new staff to include driver's license checks. Driver's licenses are checked monthly through the Florida Department of Motor Vehicles for all program staff operating a program vehicle. A random check of personal vehicles found all vehicles were kept locked when not in use and are located outside of the locked gate. Seven staff were interviewed and six out of seven interviewed stated a cell phone or radio are provided during transports. One staff did not know if a communication device was provided during transports.

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

The program has a policy and procedures which addresses who is responsible for conducting the weekly security audits and safety inspections, the corrective action process and the internal system for verifying deficiencies are corrected, which meets the Department's Rule. A review of the weekly security audits and safety inspections for the last six months validated one was completed each week, with only three being one day late and all three completed on the eighth day. The review team was able to verify the corrective actions through a review of email correspondence and work orders addressing any deficiencies. An interview with the facility administrator validated he is involved in the program's process to identify, track and address any deficiencies captured during the weekly security audits and safety inspections.

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's policy and procedures address the issuance, inventory, and control of equipment and tools. Through observation, it was validated all tools, both class A and B, are secured in the locked maintenance room and each class A tool is hanging and marked on a shadow board. All tools, both class A and B are inventoried daily, following all work activities, and prior to being issued for work. All previously mentioned inventories were reviewed for the last six months and documented all were in compliance with their procedures. The program has a policy and procedures to address missing or lost tools; however, no tools were missing or lost since the last annual compliance review. If a tool becomes damaged or dysfunctional, the program follows

their procedures to replace the tool. Ten staff records and seven youth records were reviewed and each documented both staff and youth were trained on the intended and safe use of tools. Seven staff were interviewed and all indicated youth are permitted to use mops, brooms and scrub brushes. Two of the staff indicated youth are also permitted to use a dust pan and rag.

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's policy and procedures indicate staff to youth supervision during the use of tools is one staff to five youth. It further states the program has a process for issuance of tools, assessment of youth, tool distribution and the search criteria during work projects. A review of seven youth records validated all youth received an assessment to determine the youth's risk to self and others prior to the use of tools. Through an interview with the assistant facility administrator, her knowledge of the program's process for youth handling tools was confirmed. Seven youth were interviewed and asked what tools they are permitted to use, six indicated mops and brooms and one indicated they are not permitted to handle any tools; four indicated they are permitted to handle a scrub brush and one indicated a dust pan.

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 policy and procedures addressing the process for outside contractors. The program's Written Notification and Guidelines for Outside Contractors is utilized to document when contractors arrive on-site with tools, when they leave with the same tools, and any follow up if tools are missing. The policy further documents tool restrictions and indicates youth are not permitted in the work area. A review of three invoices and the Written Notification and Guidelines for Outside Contractors form for each invoice validated the program followed their procedures during each time an outside contractor was on-site. Each Written Notification and Guidelines for Outside Contractors form was signed by the contractor upon entry into the facility and signed by the contractor again when they exited, as well as by the physical plant manager. Each form documented a review by a program administrator within twenty-four hours. The program's procedures indicate prior written approval from the facility administrator is required for the approval/permission for a contractor to enter the facility with a personal cell phone or electronic devise capable of capturing pictures and/or audio/video recordings.

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.	

A review of the program's Continuity of Operations Plan (COOP) indicated fire drills and evacuation drills are to be conducted each month. The program's drills were reviewed for the last six months. A fire drill was conducted for each shift for the last six months. In addition, a major disturbance drill, an escape drill, a hostage drill, a power outage drill, a weather drill and a hurricane drill were conducted on each shift during the six-month review period. Each drill documentation captured the type of drill, date and time of the drill, participants, scenario,

findings, and recommendations. During the program tour, observations of fire evacuation routes and egress plans were posted throughout the program. On May 24, 2019 an inspection was completed, by a fire and security company, of all eighteen fire extinguishers and each were tested and passed inspection. The facility administrator was interviewed and indicated fire drills are conducted three times a month, medical drills three times a month, mental health drills one time a month, and others are conducted annually. Seven staff were interviewed and indicated they participated in the following drills: weather, major disturbance, hostage situation, chemical spills, flooding, escape, fire, medical, and suicide. Seven youth were interviewed and six indicated they have been instructed on what to do in case of a fire; one indicated they do not recall being instructed. Each of the seven youth indicated they do participate in fire drills.

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

The program maintains Continuity of Operations Plan (COOP), which was reviewed and updated on March 25, 2019. The program's COOP is posted in master control. The plan addresses alternative housing which was sent to and approved by the Department's regional director on August 13, 2019. The COOP is combined with the program's disaster plan. During a tour of the facility, the required COOP equipment was observed in a locked cage area in the kitchen. The COOP contains all the required elements, in addition to updated and approved annexes. The program maintains a Youth Emergency Shadow File for each active youth in a binder which documents all the required elements for each youth; the binder is kept is master control. When the facility administrator was asked where the COOP is posted, he indicated it was kept in master control, readily available to staff.

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.	

A review of the program's policy and procedures validated the program is in compliance with their policy regarding storage and inventory of flammable, poisonous, and toxic items and materials. All flammable, poisonous, and toxic items are maintained in a locked storage shed, behind a locked fence, of which both are secure at all times and inaccessible to youth. A review of the inventory of such items and the actual items on-site validated the inventory matched. On the door of the shed the program maintains a list of authorized staff, along with their positions and titles, who have access and are able to handle such items. Each of the reviewed items had a Safety Data Sheet to match.

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

A review of the program's policy and procedures indicated the program maintains strict control of all flammable, poisonous, and toxic items and further indicates youth do not handle or dispose of any such items. These items are secured behind a locked fence and in a locked shed; therefore, are inaccessible to youth at all times. On three occasions during the annual compliance review, youth were observed cleaning, and were never observed handling any flammable, poisonous, and toxic items. The program conducts preventative maintenance and documents their findings on the Preventive Maintenance Checklist. The facility administrator ensures these items are scheduled and repaired, in order to meet the Department's Rule. Seven youth were interviewed and five indicated they do not handle any type cleaning products or chemicals; two indicated the staff spray the cleaning chemical on a surface and the youth are permitted to wipe it off.

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

The program has a policy and procedures in place for the control of hazardous materials. The policy states the physical plant manager is responsible for disposal of hazardous materials. The procedures also indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed of on-site, according to Safety Data Sheet (SDS) requirements, and the disposal is to be documented on the applicable disposal form. The program's physical plant manager position is currently vacant; therefore, a review of the maintenance personnel's training record was reviewed and shows they were trained in flammable, poisonous, and toxic control. Items are stored in a room inaccessible to youth. Disposal procedures are in accordance with Occupational Safety and Health Administration (OSHA) standards. The program contracts with two providers to dispose of grease or any other bio-hazardous waste. During the annual compliance review, there was no materials disposed and the program has not had any materials to dispose of during the annual compliance review period. The program does not keep any hazardous materials at the facility. An interview with facility administrator confirmed the program would follow OSHA guidelines for all disposal of wastes, log any waste disposal, and would bring waste to the proper waste disposal provider agency.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a policy and procedures addressing visitation and communication for youth and their families. This information is also provided to the youth and parent/guardian at orientation and is located in the youth handbook. The policy further states the program will make alternative arrangements for visitation if needed. The program's visitation schedule is posted throughout the facility, which is listed on the program's facility schedule.

The visitation log was reviewed and validates consistent visitation took place for the last six months. It also documented a family day took place during the annual compliance review period. A review of seven youth records validated an approved and unapproved phone, mail and visitation list are maintained in each record. All phone calls, incoming and outgoing mail is maintained on this list. A review of each of these forms for each youth validated all were able to

communicate with their families by phone, mail and visitation. During the annual compliance review of Orlando Intensive Youth Academy, it was determined the staff were not documenting their review of incoming and outgoing mail. As a result, Orange Youth Academy updated their approved and unapproved phone, mail and visitation list. As of September 2019, all reviews of incoming and outgoing mail, in addition to reviewing the incoming mail in the presence of youth, is documented on this list, by initialing of the staff and youth. Prior to September 2019, staff documented the incoming and outgoing of mail; however, did not have the youth acknowledge their presence during the review of the mail. A member of the review team observed the program's case manager review incoming mail with a youth. The review team member spoke with the youth, who confirmed this is the process of reviewing incoming mail. Seven youth were interviewed and all indicate they have been given the opportunity to communicate with family members by mail, telephone, and at visitation.

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

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

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

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

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

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

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

The program has created a safety plan to utilize for youth which includes warning signs, youth's baseline behavior, crisis recognition, jointly developed coping strategies, interventions strategies, and debriefing preferences. Seven youth records were reviewed to validate the program's safety planning process for youth. Of the seven safety plans reviewed none were applicable for review of the plan being completed within fourteen days of admission due to the youth's admission date, which were all prior to the program's initial process of safety plans. Implementation of safety plans was effective starting July 1, 2019. The program completed safety plans no later than August 1, 2019 for all youth who were admitted prior to July 1, as well

as all youth who were admitted the first week of July 2019. All seven initial safety plans documented the joint preparation with the youth, youth's therapist, case manager, a living unit representative, and program administrator; however, did not document participation from the parent/guardian. The case manager indicated the parent/guardian was contacted by phone due to the process recently starting and in attempt to complete the initial safety plan for each youth in the program; however, was not documented on the plan. A total of sixteen updated plans for the seven youth were completed, where each party, including the parent/guardian, was contacted to participate and/or participated. Each of the sixteen updated safety plans were completed within thirty days of the initial plan, and within thirty days thereafter. Each plan documented the review and incorporation of previous screenings and assessments and incorporated trauma responsive practices. Safety plans, after the initial plan was completed, were completed in conjunction with the treatment team meetings. In addition, each safety plan is sent to the parent/guardian upon completion and this was validated in each of the seven youth records. An additional three records were selected for review with admission dates after September 1, 2019 to validate the practice of the safety plan being completed within fourteen days of admission and coordination with the youth's parent/guardian in preparing the initial safety plan. Of the three additional records, two safety plans were created on the day of admission and one was completed within five days of admission. Of the three, the pertinent parties and the parent/guardian were involved in the preparation of the safety plan. The initial plans and each of the follow-up plans for the three youth incorporated previous screenings and assessments and incorporated trauma responsive practices. Each of the three updated plans were completed within thirty days of the initial plan. Safety plans are kept on each of the dorms and in the administration building for staff to review. Seven staff were interviewed and all indicated they can review the safety plans at any time, as they are located on the dorms. Seven youth were interviewed and each indicated they participated in the development of their safety plan.