STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Orlando Intensive Youth Academy
True Core Behavioral, LLC.
(Contract Provider)
3150 39th Street
Orlando, Florida 32839-9207

Review Date(s): January 8-11, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Paul Czigan, Office of Program Accountability, Lead Reviewer (Standard 1 and 3)
William Hopkins, Orange Regional Juvenile Detention Center, Supervisor (Standard 5)
Melissa Johnson, Office of Program Accountability, Regional Supervisor (Standard 2)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 4)
Kamille Payne, Office of Program Accountability, Regional Monitor (Standard 1 and Interviews)
Rowena Rowe, Office of Education Development, Regional Education Coordinator (Standard 2)
Sherri Wilson, Office of Program Accountability, Technical Assistance Specialist (SPEP)

Program Name: Orlando Intensive Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Orange County / Circuit 9
Review Date(s): January 8-11, 2019

MQI Program Code: 7281
Contract Number: 10145
Number of Beds: 16
Lead Reviewer Code: 77

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **2** # Case Managers
- **3** # Clinical Staff
- **1** # Food Service Personnel
- **3** # Healthcare Staff
- **1** # Maintenance Personnel
- **3** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **2** # Other (listed by title): **Lead Teacher, Corporate Compliance**

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- **5** # Health Records
- **5** # MH/SA Records
- **25** # Personnel Records
- **14** # Training Records/CORE
- **3** # Youth Records (Closed)
- **5** # Youth Records (Open)
- **10** # Other: **exit packets for education requirements**

Observations During Review

- ☒ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☐ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☒ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Limited
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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Orlando Intensive Youth Academy is a sixteen bed program, for non-secure risk boys ages twelve to eighteen years old in need of intensive mental health treatment services, located in Orlando, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program provides the following services: mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). In addition, the program includes the following seven interventions: Thinking for a Change (T4C), Living in Balance (LIB), Impact of Crime (IOC), Life Skills training (LST), Cannabis Youth Treatment (CYT), and Teen Relationships including Young Men's Work (YMW). Additional interventions supplement the evidence based services, include: 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.

Program administration is comprised of a facility administrator, assistant facility administrator, program director, director of case management, human resources manager, director of clinical services, health services administrator (registered nurse), human resources manager/administrative assistant, and the physical plant worker. Case management services are provided by director of case management, four case managers, and two transitional case managers. Mental health staff at the program includes director of clinical services, two licensed clinicians, four non-licensed clinicians and one recreational therapist. The psychiatrist, psychologist and behavior analyst are contracted services. The psychiatrist is on-site a minimum of one time weekly. Medical services are offered 7:00 a.m. to 7:30 p.m. seven days a week and are provided by three registered nurses (RN), one of which is considered the health services administrator and one part-time RN. The position of medical doctor is a contracted position requiring on-site weekly services a minimum of four hours. Educational services are provided by the Orange County School Board on-site. At the time of the annual compliance review, the program had nine vacant positions; part-time therapist, staff mentor (supervisor), physical plant worker, two master control staff, two youth care worker-II (YCW II), and two YCW-I.

The layout of the program includes: a main building which includes administrative offices with two identical housing wings attached at right angles on opposite sides of the administration portion. The dining hall with kitchen is on the opposite side of the main building with a large paved lot including a basketball court. Adjacent to the dining hall is a sheltered outdoor dining area attached to a maintenance building. There are two permanent education buildings and two portable education buildings. There is a portable shed in the middle of a large grassy area behind the main building currently storing unused equipment. The entire site is fenced except for the parking lot immediately in front of the main building. The program has forty-six operating security cameras providing coverage. The program did not have any approved waivers prior to the annual compliance review. The program has one open Outcome Based Corrective Action Plan (OBCAP) regarding a major deficiency due to a backlog of maintenance work orders.

Strengths and Innovative Approaches

- The recreation therapist for the program has developed a partnership with another provider program, Daytona Residential Facility (DRF), to engage in intermural activities to foster sportsmanship, cooperation and teamwork following a request from the Youth Advisory Board. During the annual compliance review period, the program participated in a football game and a spelling bee with DRF.

- The program holds a monthly awards ceremony where program staff, teachers, and youth gather to recognize youth accomplishments. Awards, such as the Ace Award for the highest GPA and Shining Star award for youth progress, are given out to help recognize youth accomplishments and bolster youth morale and efforts in the program.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place regarding initial background screenings for new employees. A review of eighteen records, including staff and interns, was conducted and seventeen staff were found with completed and eligible background screenings in the Agency for Healthcare Administration (AHCA) clearinghouse system prior to their hire date. One staff had a background screening submitted and completed six days after hire; however, the staff was hired from another provider, had an eligible background screening in the AHCA clearinghouse system from the previous employer, and did not have contact with youth prior to the background screening completion. The program did not have any new contractors or volunteers during the annual compliance review period.

A review of the eighteen staff records found documentation the provider reviewed the Central Communications Center (CCC) Person Involvement Report, the Staff Verification System module, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) prior to hire. One of the eighteen records reviewed included a staff who already had an eligible background screening on record and one staff was an intern; neither of these required completions of the pre-employment assessment tool. Sixteen staff were eligible for administration of a pre-employment assessment tool. Each of the sixteen eligible staff had a pre-employment assessment tool; however, eight failed the tool and were allowed to retake it prior to hire. The program reported their practice is to allow staff to retake the test two times, if needed, in order to pass the assessment prior to hire.

The program submitted the Affidavit of Compliance with Level 2 Screenings to the Department on January 3, 2018. The program utilizes Orange County School Board Teachers to staff their school. The Orange County School Board submitted their Affidavit of Compliance with Level 2 Screenings to the Department on January 25, 2018.

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

The program has a written policy and procedures in place regarding the rescreening of all staff every five years of employment. A review of employee, volunteer, and contractor records

indicated six staff were eligible for five-year rescreenings. Five staff had eligible rescreenings completed in the Clearinghouse prior to the employee's five-year anniversary; one staff submitted a resignation effective one day prior to the staff's five-year anniversary.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a written policy and procedures to establish an environment in which youth, staff, and others feel safe and are free from abuse. During the annual compliance review, a tour was conducted, during which postings were found with the Florida Abuse Hotline and Central Communications Center (CCC) numbers. Five staff were interviewed and each reported youth have immediate and unhindered access to call the Florida Abuse Hotline in the event they wish to report allegations of abuse. Each of the staff described the process as calling the supervisor on duty who would then call the Florida Abuse Hotline number and hand the youth the phone. None of the staff reported witnessing a co-worker deny a youth a call to the Florida Abuse Hotline. In addition, staff felt free to call 9-1-1 in the event an emergency was occurring. An interview with the facility administrator confirmed this process. Seven youth were interviewed and each reported not having to call the Florida Abuse Hotline but feeling as if they could if they needed to.

The program maintains a code of conduct, which outlines appropriate behavior of staff, and requires each staff to sign an Affidavit of Good Moral Character upon hire. Eighteen staff records were reviewed and each contained a signed Affidavit of Good Moral Character. An interview with the Facility Administrator confirmed the code of conduct requires staff to provide quality care for youth free from abuse and any violations can result in consequences for staff, up to and including termination. Seven youth were interviewed and each felt safe in the program and reported staff treat them with respect. Five of the youth reported never hearing a staff member use profanity, threats, or intimidation; two youth reported hearing staff use profanity once or twice but never towards a youth. Five staff were interviewed and each reported never hearing a co-worker use profanity, threats, or intimidation. A review of program CCCs found no instances of substantiated abuse during the annual compliance review period.

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.	

During the annual compliance review period, the program had two incidents of allegations of abuse against staff. Documentation was provided for both incidents in which the program initiated an investigation into the allegations. One incident was closed unfounded without a child protective investigator coming to the program to interview the youth. The other incident was reported to the Central Communications Center (CCC) and was initiated by the youth's mother who called the CCC to report the alleged abuse. Documentation reflected the staff was placed on no youth contact while the internal investigation was occurring. The second incident was eventually closed as unfounded. There were no instances in which corrective action was necessary. The Facility Administrator was interviewed and reported all staff have the ability to call the CCC, Florida Abuse Hotline, or 9-1-1 and this is communicated to staff during pre-service training, on-the-job training, and on an on-going basis through postings around the program and staff meetings.

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

The program has a written policy and procedures in place which outline their process for handling Central Communications Center (CCC) reporting. The program documented the five CCC reports in the review period. Four were reported within the timeframe. Each one was documented in the logbook. One incident called in late involved a visit on a Tuesday to the campus by child protective worker and the call was placed with the CCC on Thursday. The program explained the Child Protective Invetigator (CPI) came to the campus and the youth in question could not be located on the roster. The management designee for the day did not deem it necessary to call the CCC; however, two days later management reviewed the incident and called the CCC.

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

The program has a written policy and procedures in place which outlines their process for Protective Action Response (PAR). There were only four PAR reports in the review period. A review of four PAR reports revealed the required elements were consistently documented with one exception. One report did not have an administrator review.

Interviews with staff revealed administration inquires in daily management meeting if any physical restraints have occurred during the previous shifts. The findings are documented on

daily morning management meeting minutes. Administrators review any applicable PAR reports, including the post-PAR interview, the staff mentor's review and if applicable, the PAR medical review findings within seventy-two hours, excluding weekends and holidays, to determine if the use of interventions were in compliance with the PAR policy. If the PAR incident was captured on the facility camera system, administration ensures all engaged staff and designated supervisory staff review the video with the facility administrator as part of the review process. Staff upload the video related to any level 2 or 3 physical interventions to the program's computer system and notify the director of staff development and training through email once the video has been uploaded. For all applicable incidents staff forwards all related PAR paperwork through email to the following individuals: chief operating officer, regional director, general counsel, chief compliance officer, director of clinical services and the director of staff development and training. If applicable, staff initiates corrective action, including abuse reporting, reporting to the Central Communications Center (CCC) and law enforcement notification, before the report is finalized. Staff files the PAR report and any attachments in a centralized file within forty-eight hours of being signed.

The program's PAR rate for the most recent quarter was 2.12, which is above the statewide Residential PAR rate of 1.47. The program had no restraints in the months of July, August, and September 2018.

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

The program has a written pre-service training plan which outlines all required trainings for newly hired staff which was approved by the Department on December 28, 2017. Seven staff were reviewed for pre-service/certification requirements and each received required training in Protective Action Response (PAR), first aid/cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and prison rape elimination act (PREA) prior to contact with youth. Each of the seven staff completed all additional contract-required training with the exception of staff stress management, in which only two staff completed the training. The program did not give a reason for why only two staff completed the training. The pre-service training and all on-line courses were entered into the Department's Learning Management System (SkillPro); however, the trainings completed as part of the forty-hour on-the-job training were not entered into SkillPro for any of the staff. Each staff had completed more than the contract-required 127-hours of training in the first thirty days; however, SkillPro only reflected between ninety and ninety-five hours for each staff. Documentation of training sign-in sheets was found to confirm this additional training was completed. Active certifications were provided for the trainers who instructed PAR and First Aid/CPR/AED courses. A list of all staff counted as part of the direct care ratio was provided and a review of a sample of staff records indicated each staff who are responsible for supervising youth have appropriate training.

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

The program has a written in-service training plan which outlines all required trainings for staff to complete on an annual basis which was approved by the Department on December 28, 2017. Seven staff were reviewed for in-service training and each had more than the required twenty-four hours of annual training and had completed required training in Protective Action Response (PAR), first aid/cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), suicide prevention, and professionalism and ethics. The contract did not require staff to complete additional in-service training. The program utilizes a training calendar which may be updated as necessary to track and schedule all in-service training for the program. Three of the reviewed staff were applicable for supervisory training. Two of the staff had nineteen hours of supervisory training and one staff had twenty hours of supervisory training in management, leadership, personal accountability, employee relations, and communication skills. While each of the staff completed more than eight hours of supervisory training, the program contract requires forty hours of supervisory training a year; therefore, the program was assigned a minor deficiency for in-service training. All training was entered in the Department's Learning Management System (SkillPro) and certifications were provided for the trainers who instructed PAR and first aid/CPR/AED courses. A list of all staff counted as part of the direct care ratio was provided and a review of a sample of staff records indicated each staff who are responsible for supervising youth have appropriate training.

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

The program has a written policy and procedures in place which outline their grievance process, which includes an informal phase where youth can talk to staff or fill out a "Let's Talk" form, a formal phase where youth fill out a formal grievance, and an appeal phase for youth if they do not agree with the outcome of their grievance. Five pre-service staff records were reviewed and each documented staff received training in the program's grievance procedures. Five staff were interviewed and each confirmed they understood the different phases of the grievance process. The facility administrator was also interviewed and confirmed the phases of the grievance process and response requirements for management staff. The program maintains a binder of all grievances, including a tracking sheet which allows staff to monitor the timeframes and outcomes of each grievance, which included grievances for the last twelve months. The program had six grievances during the annual compliance review period, five of which were reviewed. Each reviewed grievance found the grievances were responded to by the appropriate management staff within forty-eight hours and youth signed the grievance forms acknowledging the outcome of the discussion. None of the grievances were applicable for an appeal. Five

youth were interviewed and none of them had filed a grievance but knew how to if they needed to and felt staff would help them if asked.

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

The program offers three delinquency interventions Thinking for a Change (T4C), Impact of Crime (IOC), Life Skills Training (LST), and Living in Balance (LIB). The program contract requires T4C, IOC, and LST. The facility administrator (FA) confirmed the interventions are assigned to each youth based on the youth's individualized needs. Each intervention was found to be a promising practice in the Department's Sourcebook of Delinquency Interventions. Each youth is assigned to complete LIB and either T4C or IOC while in the program based on identified needs. Only youth receiving Substance Abuse Overlay Services (SAOS) are assigned to complete LST. This process was confirmed through a review of seven youth performance plans, progress notes, and group sign-in sheets. A further review of the group sign-in sheets found each group was delivered as designed and offered in accordance with the program's contract, except for LST. The contract requires two to three cycles of LST to be delivered to youth annually; however, only one cycle occurred during 2018 and none of the applicable youth were currently engaged in LST. A review of staff records who had facilitated a group during the annual compliance review period found each staff which delivered one of the interventions during the annual compliance review period is trained in the curricula they facilitated. The program contract outlines the LIB curriculum is facilitated by mental health clinical staff, LST is delivered by the director of case management, and the T4C and IOC curricula is facilitated by a case manager or staff member. A review of the documentation reflected the appropriate staff are facilitating groups. An interview with the FA confirmed each staff had the appropriate work experience and education which were considered by the FA when assigning staff to facilitate the groups. In addition to the delinquency interventions, a review of the program's activity schedule found more than sixty percent of the youth's time was occupied by structured activities. Although the program was providing interventions, it was difficult to determine if the program was providing the correct interventions as identified on the programs group sessions table, as the table may need to be updated to reflect current practices.

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

The program offers three different life skills curricula designed to help youth develop life and social skills. The program group schedule documents both Skillstreaming, Life Skills Training (LST), and Life Skills 225 are offered once a week for each youth in the program. Only youth receiving Substance Abuse Overlay Services (SAOS) are assigned to complete LST. In addition, the contract specifies mental health clinicians will deliver the life skills curriculum. A review of group sign-in sheets, performance plans, and progress notes confirmed the practice of all youth being offered life skills training in group format through Skillstreaming and Life Skills 225, and mental health clinicians facilitated these groups. This practice was further confirmed

through an interview with the facility administrator (FA). Further review of the sign-in sheets found the program is delivering the curricula as designed and in accordance with the program's contract, except for LST. Documentation indicated there had not been an LST group offered since July 2018. The contract requires two to three cycles of LST to be delivered to youth annually; however, only one cycle occurred during 2018 and none of the applicable youth were currently engaged in LST. Each clinician who facilitated a group was trained in the curriculum. Seven youth were interviewed and each described the multiple groups they were a part of including life skills in which they are given the opportunity to develop and practice new skills. Although the program was providing interventions, it was difficult to determine if the program was providing the correct interventions as identified on the programs group sessions table, as the table may need to be updated to reflect current practices.

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

The program has a written policy and procedures in place to establish restorative justice opportunities for youth. The program contract requires the program to offer Impact of Crime (IOC), a promising practice curriculum designed to assist youth to accept responsibility for their past criminal behavior, teach youth about the impact of crime on victims, and expose youth to the victims' perspective. The program group schedule list IOC as a group, the last group ended November 2, 2018, there is no current group being facilitated at the program. Therefore, restorative justice programming was not able to be observed. There were no current regularly scheduled opportunities occurring at the program. The program's activity schedule reflected there were no additional restorative justice opportunities offered on a regularly basis. A review of previous group sign-in sheets revealed the curriculum was delivered as designed when offered during the annual compliance review period. Staff training records indicated the staff who facilitated the group were trained in the intervention. The facility administrator (FA) was interviewed and reported the program allows youth to earn off-campus community service trips and provides youth an opportunity to process their negative behaviors at the program through a Write Your Wrongs form. The community service opportunities and Write Your Wrongs forms are optional; therefore, there is no process in place to ensure youth are receiving restorative justice programming. A sample of seven youth records and an interview with the FA found youth are assigned to complete either IOC or Thinking for a Change, which is a delinquency intervention, but may not complete either if they have completed one of the curriculums at a different program. A review of two of the seven youth records and two of five additional closed records indicated the youth completed IOC.

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

The program is an all-male program which offers gender-specific programming. The program contract requires Young Men's Work to be provided once a week. In addition, the program also offers Male Healthy Relationships to each youth and 24:7 Fathering Handbook to youth in the program who are fathers. The program group schedule and an interview with the facility administrator confirmed the gender-specific programming is provided to youth. A review of seven youth records and group sign-in sheets reflected each youth is receiving the gender-specific services. The Young Men's Work and Male Healthy Relationships curricula was

reviewed and were found to include gender-specific material and issues to be covered in the groups.

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

The program has a written policy and procedures which outline the process for placing youth on the internal alert system and updating alerts in the Juvenile Justice Information System (JJIS). Alerts are discussed with staff during shift briefings and are also updated on the program's alert board in the conference room. Mental health alerts are only able to be downgraded by a mental health clinical staff person, medical alerts are only entered and downgraded by medical staff, and safety and security alerts are entered and downgraded by program administration. The process for updating and discussing alerts was verified through an interview with the facility administrator.

Five records were reviewed; two were applicable for placement on internal alerts and in the JJIS alert system for medical issues and/or suicide precautions; two additional records were reviewed for youth involved in a street gang. The youth involved in a gang had been placed on the JJIS alert prior to their admission to the program. There was one youth who had been placed on suicide precautions; the youth was placed on and removed from the alert system as required by a Licensed Mental Health Counselor (LMHC) who is also the Designated Mental Health Authority (DMHCA). The instance was placed in the logbook; however, there was not documentation of the youth being discussed during the staff briefing from 'C' shift to 'A' shift while the youth was on precautions.

Five youth were placed on medical alerts during the annual compliance review period. Three of the alerts were entered and downgraded if necessary in the appropriate timeframe by medical staff. One youth was admitted on August 10, 2018 and JJIS updated with alerts for obesity and asthma; however, the internal alerts were not added until August 31. Another youth received glasses on September 28, 2018 and the internal alert list was updated; however, the JJIS alert was not added until November 2.

A review of current internal and JJIS alerts found all alerts were consistent. A review of case management, mental health, and medical records found all alerts were entered and discontinued as appropriate. There were no current alerts which would have affected classification.

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

The program maintains separate case management, mental health, and medical records for each youth. Each record is labeled with the youth's name, Department identification number, county of residence, and committing offense and is clearly labeled as confidential. The case management record includes sections on legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous information as evidenced through a review of youth records. All records are kept in locked filing cabinets behind locked doors which are clearly marked as confidential.

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

The program has a written policy and procedures which allow opportunities for youth to provide input into their programming. Seven youth interviews were conducted and each youth felt as though they could provide input into the program. Youth cited opportunities such as a youth advisory board, town hall meetings on the dorm, Let's Talk forms, and talking to program administration as ways to provide input. Documentation was provided to support the program operated a combined youth advisory board for Orange Youth Academy and Orlando Intensive Youth Academy. The board is run by the recreation therapist and the meetings are held monthly. Meeting documentation reflects the board discusses current events at the program and youth are able to provide suggestions and receive feedback from program administration on such things as needed personal items, recreation offerings, and off-campus outings. The result of one suggestion by the youth was an inaugural Christmas Eve football game with the Daytona Youth Academy. The Let's Talk forms were also reviewed and found youth utilize these forms to informally request items and discuss issues in the program. An interview with the facility administrator confirmed these opportunities for youth input and added additional informal ways for youth to be involved include check-ins during groups on the dorm and asking to speak with program administration.

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

The program has a combined advisory board for the Orange Youth Academy and Orlando Intensive Youth Academy programs. The board meets on a quarterly basis and documentation is maintained on the agenda, meeting minutes, and notification letters. The meeting minutes found the programs are talked about as one and separate activities and/or needs for each program are not addressed. The program maintains a list of board membership which includes all required representatives, including a victim of crime and parent of a former client; however, during the annual compliance review period only three board members attended any of the meetings and one meeting had no representation from board members, only program staff and

youth. An interview with the facility administrator confirmed this and reported the board meetings are used to discuss what is going on at the facility and different opportunities for youth once they are out of the program. Copies of letters sent to board members were provided. The letters notifying members of meetings were sent only two weeks prior to the meeting dates and no additional efforts were made to solicit active participation from interested community partners, as required. A board member was not available during the annual compliance review to be interviewed.

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

The program has a written policy and procedures for risk management which addresses the different types of meetings to be held for staff at the program and the use of data for program planning. An interview with the facility administrator revealed morning management meetings are held with program administration and monthly meetings are held for all staff. In addition, shift briefings and debriefings are held for each shift each day. Five staff were interviewed and each confirmed meeting frequency and four reported communication at the program as very good, while one reported communication was good. Three of the staff reported they are briefed on different reports, one staff said supervisors are briefed on reports, and one staff said they have not been briefed on reports. The facility administrator stated the administration utilizes data compiled by the provider to analyze trends and address issues going on at the program. This data is discussed ongoing at the morning management meetings and the monthly staff meetings. Additional data collected from sources, such as the admission parent/guardian survey, are discussed as they are available. Discussion of data was reflected in the meeting minutes for all meeting types.

The program has a written policy and procedures to address staff turnover, which includes the promotion of the TrueCore way and ongoing incentives to motivate staff. In addition, the program operates a Staff Morale committee which meets on a monthly basis to promote and organize opportunities for staff retention and positive morale. The meeting minutes found the committee has organized events such as the Christmas party, and brainstorms additional activities for staff to be engaged in the workplace.

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

The program has a written policy and procedures in place outlining the employee evaluation process. Five staff were interviewed and three reported evaluations were annual but more often if you were new and two reported evaluations were bi-annual. The facility administrator verified evaluations occur after an employee's first ninety days and annually thereafter. A review of fourteen staff records found either a ninety-day or annual program evaluation completed during the annual compliance review period. The evaluations were structured around the position description for each staff position. Each employee record included a signed copy of their position description in addition to the evaluations. Each evaluation also discussed the employee's use of the behavior management system. The evaluations for the mental health clinicians and staff who provide delinquency interventions reflected they were also evaluated on the interventions they delivered. The program maintains all required positions as outlined in their contract.

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.	

All five youth records contained documentation to support the program made contact with or attempted to make contact with parent/guardian by telephone within twenty-four hours of admission. The program notified the parent/guardian in writing the day of the youth's admission. The program uses survey monkey for parents to submit input in order to assist with the development of the performance plan. The program notified the court in writing of the youth's admission the day of the youth's admission for all five youth reviewed. The letter to the court was carbon copied to the youth's Juvenile Probation Officer (JPO) and post residential counselor. Three of the five JPOs were copied on the letter to the court. One letter indicated the JPO was not applicable and one letter left the JPO section blank. Two of the notification letters documented the program did not know the post residential counselor. Three of the letters left the section of the post residential counselor blank.

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 completed all five youth orientations on the youth's admission date. The orientation checklist addressed all required information pertaining to the program and services offered at the program. The orientation checklist was completed in its entirety in all five youth records with one exception. The performance planning section of the orientation list was left blank for one youth. An admission was observed by members of the review team. The case manager completed the orientation checklist with the youth and took the time to explain the topics listed on the orientation checklist. All five interviewed youth said they received orientation within twenty-four hours of admission. All five youth indicated they learned about the rules of the program and services offered.

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.	

Three applicable youth turned eighteen years of age while in the program. All three youth records contained a signed written consent indicating information can be shared with other parties.

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

The program has a policy and procedures outlining the classification process and system promoting the safety and security of the program and youth. The program uses an admission classification form which addresses all required information. All five youth records contained the completed admission classification form. All sections of the admission classification form were completed with one exception. There was one youth who had the following sections left blank on their admission classification form; maturity level and security risk. Applicable Juvenile Justice Information System (JJIS) alerts were addressed on the admission classification form. There was no newly identified alerts needing to be added into the JJIS. The program had the process of completing reassessments on a monthly basis during the formal treatment team meetings. Risk reassessments were completed on all youth the majority of the months. There was one re-assessment not completed for one youth. This youth was not participating in any work projects or off-campus activities which would have required the completed risk re-assessment. One of the five youth did participate in a work project and the risk re-assessment was completed prior to the project and the risk reassessment identified the youth as eligible to participate. There were no newly identified JJIS alerts based on the risk reassessments completed.

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.	

There were two applicable youth who were identified with gang involvement. Local law enforcement was notified by the program of one of the two youth. The program was not able to provide documentation to support local law enforcement was notified of the second youth's gang involvement. The youth's Juvenile Probation Officer (JPO) and program education staff were notified of the youth's gang involvement during the youth's admission classification meeting. A third youth had an admission classification form indicating the youth was affiliated with a gang. The youth's gang criteria form completed by program staff did not mention the gang information. The program explained to the review team during the screening process completed by the program, it was determined the youth did not have any gang affiliation.

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. The program uses a gang intervention called Gang Resistance and Drug Education (GRADE). This intervention includes lessons addressing respect, choices, conflict resolution, internet safety, gang awareness and intervention, and drug awareness. A review of gang prevention/intervention documentation revealed a gap in services from March 2018 to October 2018. The program reported a staffing shortage led to groups not being held during this time period; however, the current youth started monthly groups in November 2018 and December 2018, which was verified through group sign-in sheets.

Of the five records reviewed, two were applicable and identified with gang involvement. Staff interviews revealed there were no other youth applicable for gang involvement. One of the two applicable youth's performance plans had relevant goals and objectives relating to gang intervention strategies. The other youth's performance plan did not have goals related to gang involvement.

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

All five youth had Residential Positive Achievement Change Tool (R-PACT) assessments completed within thirty days of the youth's admission. The assessment was maintained in the Juvenile Justice Information System (JJIS). Four of the five were applicable for R-PACT Re-assessments. The re-assessments were completed within ninety days after the completion of the initial R-PACT assessment. Two youth had multiple re-assessments complete when deemed necessary by the treatment team; the other three youth had re-assessments based on the ninety-day timeframe. All R-Pact assessments and re-assessments were located in the youth's records.

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

All five youth had a Youth Needs Assessment Summary **(**YNAS) completed within thirty days of admission. All five assessment summaries were documented in Juvenile Justice Information System (JJIS). There was documentation to support the members of treatment team met to

discuss the results of the YNAS and prioritize needs to address on the youth's performance plan.

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.*	

All five records contained an Individualized Performance Plan (IPP) completed within thirty days of the youth's admission. All IPPs were developed after the completion of the initial assessment. All IPPs were signed by all treatment team members. All IPPs contained specific target dates for completion. The one applicable youth had court requirements included in the IPP. All IPPs included transition goals and goals addressing education and mental health. There was one exception where employment was one of the top criminogenic needs; however, it was not included on the prioritization list. The space to write the justification for not addressing the top criminogenic needs. The other four IPPs addressed the youth's top criminogenic needs. All five plans contained specific delinquency interventions with measurable outcomes decreasing the youth's criminogenic factors.

All records contained transmittal letters sent to parent/guardian, Department of Children and Families (DCF), judge, and Juvenile Probation Officer (JPO) within ten days of the plan being completed. Only one parent/guardian signature sheet was returned to the program. The other four signature sheets were not signed and returned to the program. All youth indicated they received a copy of their IPP and were able to discuss the goals on the plan. All five interviewed youth explained the process of formal and informal treatment team. All youth were able to discuss the goals they were currently working on achieving. All five youth stated they had received copies of their performance plans.

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.	

All five youth had performance plan revisions completed on a monthly basis during the formal treatment team meetings. Four of the five youth had performance plan revisions when target dates expired. One youth had an expired target date for one of the performance plan goals. All five youth demonstrated progress toward completing their goals. Youth were meeting their goals by the targeted due date.

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.*	

Each of the five reviewed youth records contained a performance summary completed on a sixty-day cycle. Each of the summaries were well written and detailed. They addressed all required information and all required parties signed all the summaries. The performance summaries included; the youth's status on the performance plan goals, overall progress on the treatment plan, the youth's academic status, level of motivation/readiness to change, interaction with peers and staff, significant positive and negative events and justification for release when applicable. Performance summaries were completed prior to the youth's Pre-Release Notification (PRN) and discharge from the program. Youth were provided the opportunity to review and make comments about the summary prior to signing. One of seven performance summaries had the youth comment section left blank. All summaries were signed and dated by the treatment team leader, program director, and the youth. All five interviewed youth said they received copies of their performance summaries. Copies of the summaries were sent within the required ten-day timeframe to the committing court, youth's Juvenile Probation Officer (JPO), and the youth's parent/guardian. The original summaries were filed in the youth's case management record.

Three closed case management records were reviewed for release summaries. All original summary contained the justification for release and was sent with the PRN to the JPO. The release summary was submitted to the JPO at least forty-five days prior to the planned release. A signed copy of the release summary was retained in the youth's closed record. All three closed records contained written notification to the youth's parent/guardian of the planned release sent after the program received the approved release. All three closed records contained a completed Residential Positive Achievement Change Tool (R-PACT) Exit Assessment. None of the youth required victim notification be made prior to their release. None of the interviewed youth indicated they had received a performance summary.

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.	

Throughout the youth's stay in the program, staff encouraged and facilitated involvement of the youth's parent/guardian in the case management process. Parent/guardians were sent various letters pertaining to; the assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. There was documentation in all five youth records to support the youth's parent/guardian was allowed to participate in meetings through telephone conference calls. Review team members

confirmed this practice while observing formal treatment team meetings and an intake meeting. Chronological notes document weekly telephone calls to the parent/guardian where the case manager has the opportunity to speak with the youth's parent/guardian after the youth has completed his call. All five interviewed youth stated their parents/guardians were involved in the development of the performance plan and treatment plan along with participating in treatment team meetings and family sessions.

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.	

Documentation supported the multi-disciplinary treatment team included all required members. The following treatment team members signed needs assessments, individual performance plans, and formal treatment team meetings; the case manager who served as the treatment team leader, the youth, administrative staff, a living unit representative, recreational therapist and treatment staff. Education and medical staff participated in needs assessment meetings and provided written information to the treatment team leader for formal treatment team meetings when applicable. The youth's parent/guardian and Juvenile Probation Officer (JPO) participated in meetings either in person or over the telephone. The Director of Case Management, who served as the program's gang prevention specialist also participated in all meetings. The Transition Specialist participated in meetings when applicable.

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.	

All five individual performance plans addressed additional plans to include the wellness plan, the treatment plan, and the education plan. None of the youth had a current behavior support plan.

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

All five records contained documentation where the youth's parent/guardian and Juvenile Probation Officer (JPO) were invited to participate in formal treatment teams. Formal treatment team meetings were completed on a monthly basis in three of the five records. Two youth were missing a formal treatment team for December 2018. Participants in the formal treatment team meetings included all required attendees except the recreational therapist. Four of the five youth records had examples where the recreational therapist signatures were missing; one youth had

the recreational therapist signature missing on one formal treatment team meeting. One youth had the recreational therapist signature missing on one formal treatment team meeting and there was an additional treatment team where the notes indicated the recreational therapist attended the meeting but there was no signature and no feedback pertaining to the youth's wellness plan. Two youth had the recreational therapist signature missing on two formal treatment team meetings each. There were no formal treatment teams where progress on the wellness plan were documented; however, all five youth had the wellness plan incorporated into their individual performance plan. During the annual compliance review period, the program did not have a vacant position for the recreational therapist. Three of the four applicable youth who had completed Residential Positive Achievement Change Tool (R-PACT) reassessments but the next treatment team meeting did not address the R-PACT results. Informal treatment team meetings were completed on a monthly basis with the youth and case manager. Formal and informal treatment team notes addressed positive and negative behaviors. All five interviewed youth stated they were given an opportunity to demonstrate learned skills during treatment team meetings.

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

The program provides a competent career education and vocational development program. The career education programming is a Type 2, services are appropriate to the age group and ability level to help maintain employment and living standards. The program addresses youth with employability goals by helping youth to complete an employment application and a resume which summarizes education, work experience, and or career training. The career education services and assessments are offered to youth by the Orange County Public Schools; the assessments offered include: Résumé Building, Florida Food Handler's Certification, Florida Ready to Work, Internet Communication Technology (ICT), Internet Business Associates (IBA), Test of Adult Basic Education (TABE) test, Armed Services Vocational Aptitude Battery (ASVAB) test, General Education Diploma (GED) readiness tests, Job Application Training and Cold Calls Interviews with potential employers. Ten closed records were reviewed and each contained all required documents including a sample application, résumé summarizing education, calendar with an appointment for Career Source Center, and appropriate documents with essential information for the youth to obtain employment.

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

The educational instruction schedule and the bell schedule were reviewed and found students are in the class on time, Monday, Tuesday, Thursday and Friday from 7:30 a.m. to 1:23 p.m. Students attend class on Wednesday from 7:30 a.m. to 12:29 p.m. Class on Wednesday is considered a short day due to the county requirement. Students are attending school for 250 days of instruction, distributed over twelve months, and instruction occurs weekly for a minimum of twenty-five hours. Based on interviews with the Lead Educator and seven youth it was confirmed there is minimal interference of educational instruction. Youth are receiving course credits for completion of education and training (Digital Information Technology Course). During the school day employability skills and vocational skills are infused into the education program and the school district supports academic courses.

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

A review of ten education transition plans of closed records revealed most had documentation of continuation of education, a résumé, sample completed employment applications, and an appointment with the Career Source Center within the youth's vicinity if they are seeking employment. One youth did not have a valid Florida identification card. None of the ten reviewed youth were applicable for employability goals; therefore, a review of two current youth with employability goals was conducted and revealed each youth's performance plan included required provisions. Further, the two open youth records also included a transition plan and necessary documentation of continuation of education, a résumé, and sample completed employment application.

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.*	

Three closed youth case records were reviewed for transition planning and the completion of the Community Re-Entry team meeting (CRT). All three closed records contained a transition meeting completed at least sixty days prior to the targeted release date with one exception. One youth's transition meeting was conducted fifty-nine days prior to the youth's release date. All required treatment team members attended the transition meeting. The youth's parent/guardian and Juvenile Probation Officer (JPO) participated in the meetings as well. Topics during transition meetings included; a review of transition activities, revision of performance plan goals, target dates for completion, and action steps for the youth and staff. A copy of the transitional plan was sent to the JPO with the pre-release notification. All three youth participated in a CRT meeting prior to the youth's release. Documentation supported the youth and case manager participated in the CRT meeting. Evidence of the invitation to participate in the CRT meeting was available for all three youth.

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

The transition conference documentation in all three closed youth case records supported the exit portfolio was discussed and initiated during the meeting. Two of the three youth were fifteen years old and the exit portfolio consisted of the youth's social security card, birth certificate, vocational certificates, educational documents, school transcripts, and completed sample job applications. One of the two applicable youth had a résumé completed in the exit portfolio. All three closed records contained a calendar of events the youth needed to follow-up on. Two of the three youth had documentation to support the youth's exit portfolio was verified at the exit conference

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.	

All three exit conferences were conducted after the Juvenile Probation Officer (JPO) was notified of the youth's release. The exit meetings were conducted at least fourteen days prior to the youth's release. Information addressed during the exit conference included the status of transition activities. The dates of admission and termination documented in the case record correlated with the dates in the Juvenile Justice Information System (JJIS). Documentation supported the treatment team leader, the youth's parent/guardian, and education representative participated in the exit conference.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a policy and procedures to ensure mental health and substance abuse clinician authority services are provided. The program provides intensive mental health treatment which is considered specialized services requiring a single licensed mental health professional specifically serving as the Designated Mental Health Clinician Authority (DMHCA).

The program has a Licensed Clinical Social Worker (LCSW) filling the position of Director Of Clinical Services who serves as the DMHCA. A review of the position description revealed it includes she provides clinical supervision for each unlicensed mental health therapist, ensuring compliance with overlay requirements including mental health overlay services (MHOS) and residential substance abuse treatment (RSAT), and intensive mental health. She is responsible to be available to provide emergency consultation services twenty-four hours a day, seven days a week.

Staff interviews and reviewed documentation revealed the DMHCA provides coordination of mental health and substance services through group scheduling, fidelity checks, and overseeing clinical services are being completed. She is on-site at least forty hours weekly. She personally provides coverage for all clinical services including groups, individual and family therapy sessions in the event of vacancy and/or vacation or emergencies. She also carries a small case load of youth providing services for each youth. The DMHCA meets with the staff formally once a week for one hour of clinical supervision and is available electronically and through telephone twenty-four hours a day, seven days a week. She meets with the psychiatrist once a week in a formal setting as well as for any situations demonstrating the need.

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 a policy and procedures to ensure applicable mental health and substance abuse staff are licensed. During the week of the review, the program had two licensed clinicians on staff. The program maintained a copy of the license for the six mental health clinical staff who provided services at some time during the review cycle. In addition to the six mental health clinical staff, the program contracted with the following to provide services: psychiatrist, psychologist and behavior analyst. Eight were applicable for state licensure, and all

eight individuals hold a clear/active license with the Florida Department of Health, Bureau of Medical Quality Assurance (five licensed mental health clinicians with expiration date of March 31, 2019, one licensed clinical social worker with expiration date of March 31, 2019, one psychiatrist with expiration date of January 31, 2019, and one psychologist with expiration date of May 31, 2019). The behavior analyst holds certification with the Behavior Analyst Certification Board, Inc. which expires August 31, 2019.

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 employs three non-licensed clinical staff. Each staff holds, at minimum, a master's-level degree; two in the field of study in counseling and one in the field of study in social work. A review of clinical supervision documentation during the annual compliance review period for non-licensed clinical staff validated each of the three received supervision from the Designated Mental Health Clinician Authority (DMHCA) weekly for a minimum of one hour, with the exception of two dates for one staff member; December 17, 2018 and December 27, 2018, where the staff member was on personal leave both weeks.

Documentation of the direct supervision was completed on a form similar to the Direct Supervision Log (MHSA 019) form, detailing all required information. All three non-licensed clinical staff have conducted the required Assessment of Suicide Risks (ASR) training, in which they completed the required twenty hours of training and five ASR's under the supervision of a licensed professional. When non-licensed clinical staff complete an ASR, licensed clinical staff review it within the required twenty-four-hour timeframe.

The provider holds a license under Chapter 397, F.S., allowing the clinical staff to provide substance abuse services. All clinical staff have received training for the curriculum in which they provide substance abuse groups in addition to being trained in all curriculum in which they provide services. All comprehensive evaluations, and initial and individual mental health and substance abuse treatment plans, which are completed by non-licensed clinical staff, are reviewed and signed by licensed clinical staff within the required ten-day timeframe.

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

The program has a policy and procedures to ensure mental health and substance abuse screening is provided. The Massachusetts Youth Screening Instrument, Version 2, (MAYSI-2) was found in all five reviewed youth records completed on the day of admission by a mental health therapist. The screening included a documented review of all available information for each youth. All five of the MAYSI-2 instruments were completed by a therapist (which is not required), two of which were completed by a licensed clinician. Only one of the five youth required a referral for Assessment of Suicide Risk (ASR) and the youth received an ASR by the licensed therapist immediately. All five youth required a referral for comprehensive assessment.

The program provides a new comprehensive assessment for all youth regardless of the results of the screening instrument. The program provided documentation to support all three clinical staff conducting the MAYSI-2 screening received training in use of the instrument.

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

The program has a policy and procedures to ensure mental health and substance abuse evaluations services are provided. Each of the five reviewed youth records contained a new comprehensive mental health and substance abuse assessment completed within thirty days of the youth's admission. Three of the comprehensive assessments were completed by a Licensed Mental Health Clinician. Two of the comprehensive assessments were completed by a Registered Mental Health Intern (RMHCI) and reviewed by a licensed clinician within ten days. Each of the comprehensive assessments included reason for evaluation, relevant background information, behavioral observations, mental status exam, interview procedures administered, diagnostic impressions, recommendation, and for substance abuse assessments patterns of drug use/abuse, impact of alcohol and other drug abuse on major life areas, and risk factors for continued use. Each of the five youth received a psychiatric evaluation prior to completion of the comprehensive and the results were documented on each youth's respective evaluation.

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

The program has a policy and procedures to ensure mental health and substance abuse treatment services are provided. A review of five records revealed each youth had signed both a consent for substance abuse treatment and a release protocol. The program holds two separate licenses under Chapter 397 to provide prevention services and outpatient services. The provision of youth treatment was consistently documented on the weekly progress notes.

Mental health groups were consistently ten or less participants and substance abuse groups were consistently limited to fifteen or less participants. A review of individual treatment notes and weekly treatment notes revealed each of the youth were provided individual therapy sessions weekly according to his individualized treatment plan. Most of the youth were provided family therapy sessions monthly; although two youth records only documented one family therapy session in the review period, weekly and individual case notes documented one or more unsuccessful attempts each month to contact each youth's parent/guardian to arrange family therapy.

The youth handbook indicates each youth will be assigned to a treatment team which is led by a case manager. The youth handbook further indicates the treatment team members consist of a case manager, therapist, administrator, staff mentor and nurse.

Five youth were interviewed regarding the types of groups they were provided. The responses included: relationships, substance abuse, young men's work, anger, and feelings. Five direct care staff were interviewed regarding if they or other direct care staff facilitate any mental health or substance abuse groups. Each of the five direct care staff indicated they did not facilitate any mental health or substance abuse groups.

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

The program has a policy and procedures to ensure treatment planning is provided for each youth. Each reviewed youth record contained an initial treatment plan completed on the day of admission, signed by all required parties and reviewed by the licensed clinician the same day. Each of the five youth entered the program already prescribed psychotropic medications and the initial treatment plan of four youth included the medication and requirement for the psychiatrist to interview the youth within fourteen days. The fifth plan did not address either the medication or the psychiatric interview. Three of the four initial treatment plans for youth admitted on psychotropic medications included the frequency of medication monitoring. The initial treatment plan for one youth did not include frequency of medication monitoring. The initial treatment plan for one youth did not include the information the youth was admitted on medication did not include the medications, the amount of medication, or the treatment method to include a psychiatric evaluation or frequency of medication monitoring.

Each of the five reviewed youth records contained an individualized treatment plan completed after the comprehensive assessment had been completed and within thirty days of admission. Each individualized treatment plan was signed by the youth, therapist, case manager, and licensed therapist and/or reviewed by the Designated Mental Health Clinician Authority (DMHCA). None of the individualized plans were signed by the parent/guardian; however, each of the five records contained documentation both the initial treatment plan and the individualized treatment plan were sent to the parent/guardian following development. The program documented a total of nineteen treatment team reviews among the five records reviewed. The treatment team reviews contained all required elements.

None of the five reviewed open records contained documentation of an exit conference or mental health and substance abuse discharge summary. A review of five closed records revealed each youth had a mental health summary completed prior to the exit conference and available for review at the exit conference. The summary included all required elements. There was documentation in each of the five records the mental health summary was provided to the parent/guardian upon discharge.

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

The program has a policy and procedures to ensure specialized services for intensive mental health are provided. A review of the program components revealed each youth is provided with a mental health and substance abuse evaluation, mental health treatment planning, group therapy seven days a week, family therapy according to the treatment plan, daily therapeutic activities including psychosocial skills training provided by mental health staff, crisis intervention when necessary, and on-site weekly psychiatric services with twenty-four hour consultation capability.

Staffing includes a licensed mental health professional on-site five days a week with twenty-four hour consultation capability, on-site weekly psychiatric services, mental health professional providing services seven days a week, a registered nurse on-site daily, and a counselor to youth ratio of one-to-eight for all shifts.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program has a policy and procedures to ensure psychiatric services are provided. The program has a subcontract with a licensed physician who completed a training program in psychiatry approved by the American Board of Psychiatry and Neurology. The contract requires the psychiatrist to provide psychiatric evaluation, psychiatric consultation, medication management and medical supportive counseling to applicable youth. The contract requires the psychiatrist to provide services on-site weekly. A review of sign-in documentation revealed the psychiatrist was on-site each week of the review period. The program provided documentation of substitute licensed medical staff to provide psychiatric services in case of a planned or unplanned absence of the contracted physician. A review of the policy and procedures and staff interviews revealed each youth receives a referral to the psychiatrist upon admission and the psychiatrist is required to provide a psychiatric evaluation within fourteen days. An interview with the psychiatrist revealed he assists in protocol and policy development, evaluates all youth for initial visits, sees youth periodically, evaluate youth as needed based on mental health referrals, prescribes medication, and provides suggestions for therapy and written prescriptions for discharge. The psychiatrist indicated he is on-site once a week and meets face-to-face with the Designated Mental Health Clinician Authority (DMHCA) and the Program Director at each weekly site visit. He further indicated the healthcare staff are at the weekly meetings prior to seeing the youth. The healthcare staff prepare a list of youth to be seen and provide a brief statement why the youth is to be seen.

All five reviewed youth healthcare records contained documentation each youth were admitted already prescribed psychotropic medications and were referred to the psychiatrist. Each youth received a psychiatric evaluation by the psychiatrist within the timeframe and was continued on medication. Each psychiatric evaluation contained all required elements including completion of the Clinical Psychotropic Progress Note (CPPN) with page three. Staff interviews revealed there

were no occasions in the review period in which a youth not on medications upon admission was subsequently prescribed psychotropic medication. All five records documented the psychiatrist consistently provided medication monitoring every thirty days. The program does not utilize the use of an advanced registered nurse practitioner for 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.	

A review of the program's suicide prevention plan validated the plan contains all the required elements, with the exception of communication; however, there is documentation throughout the plan indicating multiple steps to follow regarding communication. The plan was reviewed by the Facility Administrator on October 26, 2018.

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

The program has a policy and procedures to ensure suicide prevention services are provided. Five youth received an Assessment of Suicide Risk (ASR) using the ASR form upon admission as part of the regular admission process regardless of the screening instrument results. One applicable youth received a hit on the screening instrument for suicide risk and the licensed mental health professional administered an ASR to the youth immediately resulting in a recommendation the youth be stepped down to standard supervision.

Two of the five youth records contained documentation the youth was placed on precautionary observation/constant supervision and referred for an ASR subsequent to admission. One of the youth was referred from staff observation, and the other concerned a youth self-referral. Each of the youth received an ASR within twenty-four hours of referral and were maintained on precautionary observation.

One of the two youth was stepped down to standard supervision following completion of an ASR by the licensed clinician. The other youth was continued on precautionary observation/constant supervision until receipt of a follow-up ASR. The follow-up ASR utilizing form MHSA 005 conducted by a non-licensed mental health professional was completed the following day and recommended the youth be stepped down to close supervision. The non-licensed mental health professional documented a consultation with the licensed professional and the facility administrator each of whom approved the recommendations. Each of the licensed professionals and the facility administrator documented their review on the follow-up ASR directly on the form. The one applicable youth was not stepped down to close supervision until after the consultation

with the licensed professional and the facility administrator. There was documentation safe areas were identified on the precautionary logs and youth were allowed to participate freely in daily activities. Discontinuation of the one applicable youth on close supervision was documented on a mental status examination in accordance with program policy and procedures.

There were no other applicable youth in the review period. A review of the suicide precautions log revealed no other youth were referred for an ASR or placed on suicide precautions since the last annual compliance review. The program does not utilize secure observation.

Five staff were interviewed regarding their responsibilities if a youth expressed suicidal thoughts. Responses were as follows: notify mental health staff, search the youth and room for sharp objects and contraband, provide constant sight and sound supervision, document supervision, alert supervisor, take youth out of room and place in dayroom, and get an assessment form. Each of the five staff identified the location of the suicide response kit. A review of the suicide response kit revealed it contained all three required devices.

A review of program logbooks revealed the times youth were placed on and taken off suicide precautions/constant supervision and removed from precautions were consistently documented. A comparison of the ASR and the logbooks revealed youth were not removed from precautions until after the assessing therapist consulted with the licensed clinician and the program director or designee. The program maintained training documentation each non-licensed clinician performing ASRs received twenty hours of training in conducting suicide risk assessments including five co-facilitated ASRs in the presence of a licensed mental health professional.

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 a policy and procedures to ensure suicide precaution observation logs are completed according to requirements. A review of two applicable youth records revealed each precautionary observation log was maintained on the required form (MHSA 006) and maintained on precautions with no lapses in observation the entire applicable time. Each observation log was reviewed and signed by the shift supervisor and a mental health professional. Each log designated safe housing requirements.

An interview of two applicable youth revealed each youth was continuously monitored by staff while he was being maintained on suicide precautions. Both youth indicated they were never left alone for any period of time while on suicide precautions.

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

A review of mock suicide drills validated a drill was conducted quarterly for both A and B shifts for the last three quarters, which were reviewed. Shift C conducted a drill for two of the three quarters reviewed; however, all staff participated in the drills for each shift. All staff participated in a minimum of two drills semi-annually, but most participated in more than two drills. Each

mock drill included the use of cardiopulmonary resuscitation (CPR) and/or automated external defibrillator (AED) demonstration. Seven pre-service and seven in-service staff training records were reviewed, and all completed the required six hours of web-based and instructor led suicide prevention training.

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.	

A review of the program's Emergency Mental Health and Substance Abuse Services Plan validated the plan contains all the required elements. The plan was reviewed by the corporate officer on July 10, 2017 and by the facility administrator on October 29, 2018.

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 a policy and procedures to ensure crisis assessments are completed within the timeframe. Staff interviews indicated there were no instances requiring a crisis assessment in the review period or up to the last annual compliance review. A review of five youth records, incident reports, the Juvenile Justice Information System (JJIS) and program operation logbooks did not reveal any instances in which a crisis assessment should have been completed.

The program has a packet compiled for staff to use for crisis assessments including a crisis assessment form (MHSA 023) filled out as an example for staff. The crisis assessment instrument contained the following elements: reason for assessment, mental status examination and interview, determination of danger to self/others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up and notification to parent/guardian of follow-up treatment. The packet also contained a mental health referral (MHSA 014), a mental health alert, and a mental health alert observation log (MHSA 007) which was printed on orange paper. Program procedures include they utilize orange observation forms only for youth on mental health alert, while other colors are designated for suicide precautions/constant supervision and close observation.

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.	

A review of the program's Emergency Mental Health and Substance Abuse Services validated the plan contains all the required elements, with the exception of communication; however, there is documentation throughout the plan indicating multiple steps to follow regarding communication. The plan was reviewed by the facility administrator on October 26, 2018.

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

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

Standard 4: Health Services

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

The program has a policy and procedures to address the provision and responsibilities of a Designated Health Authority (DHA). The program has entered into a contract with a licensed osteopathic physician to serve as the DHA; the DHA has certification as a family practitioner. The DHA has an active, unrestricted license to practice in the State of Florida; the license expires March 31, 2020. As part of the DHA's responsibility, he provides oversight of the medical care provided to the youth. He reviews and signs the facility operating procedures and nursing protocols. The contract requires the DHA to visit the program weekly, and to be available for consultation twenty-four hours a day, seven days a week. The sign-in logs for the past six months were reviewed. There was documentation to support the DHA was on-site weekly. The program has entered into an agreement with a second osteopathic physician to cover administrative and clinical duties in the event the DHA is not available; the doctor's license will expire March 31, 2020. The program also uses a third doctor to cover in the event of the other two doctors' absences, who is a licensed medical doctor; her license will expire January 31, 2019. A clear background screening was received for all three physicians through the Agency for Healthcare Administration clearinghouse. The program does not utilize the services of an Advanced Registered Nurse Practitioner. The DHA was interviewed; he reported his role is to perform comprehensive physical assessments, conduct periodic evaluations, follow-up on sick calls, initiate treatment plans, ensure patient education, assist in the development of policies and procedures, and provide telephonic assistance as needed. He reported being available to the program twenty-four hours a day, seven days a week; he further reported the program has called him in the middle of the night for consultation, which he encouraged. The DHA reported he is on-site once a week.

The program conducts quarterly meetings to collaborate on methods of reducing programmatic, operation, or practice risk factors. The meeting is to identify and solve potential and actual problems. A review of agendas documented the following topics were discussed: risk reduction measures, notable trends which are potentially harmful, developments within the facility which impact the operation, adverse events, medical treatment/medication errors, critique of emergency drills, a discussion of youth identified with a chronic condition, and youth taking a psychotropic medication. The meetings also include the pharmacy consultant, to review pharmacy policy and to discuss destruction of patient specific medications. The meetings were conducted in July and October 2018. The sign-in-sheets documented attendance by the DHA, facility administrator, psychiatrist, pharmacy consultant, health services administrator and the program nurses.

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 policies and procedures to address health-related services provided to the youth. An annual policy and procedure review of health-related policies and procedures was conducted by the program; this review was conducted by the Designated Health Authority (DHA) and the Facility Administrator on November 27, 2018. In addition, the DHA conducted an

annual review of written nursing protocols. The health-related policies and procedures were reviewed annually by the nursing staff. The signature page documented a review by all nurses in the program. The medical staff completed an annual review of the nursing protocols; this was documented by a signature page. There was no medical staff hired in the past six months. There were no blanket protocols. The policy related to psychiatric services was also signed by the psychiatrist.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

The program has a policy and facility operating procedure (FOP) regarding Authority of Evaluation and Treatment (AET). In three of five records reviewed a copy of the signed AETwas maintained in the youth's individual healthcare record (IHCR). The AET was valid for as long as the youth is under any type of supervision, up to his eighteenth birthday. The copy of the AET had "COPY" stamped on the form. In the two remaining records the IHCR contained a court order signed by a judge allowing the Department consent to treat and provide care and medication to the youth. In one of the two records, the Department was allowed to provide only regular treatment and any as previously ordered psychiatric medications. All parent/guardian notifications were maintained behind the AET in the IHCR.

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

The program has a policy and facility operating procedure (FOP) regarding parental notification. In all five records reviewed the forms HSA 020 for changes in the youth's health status, and HSA 021 for practitioner ordering medication treatment or medication changes were utilized. Parental notifications included those for discontinuation of medications prescribed prior to the youth entering the custody of the Department, changes in the condition/medication for youth with chronic conditions, for off-site emergency care, hospitalization, whenever a youth is taken off-site for medical treatment, and for new medications. In all records the written notification was sent regardless of telephone notification. In all records where consent was required, a staff member witnessed all telephone call attempts or conversations conducted and documented the call in the chronological progress notes in the individual healthcare record (IHCR).

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

The program has a policy and facility operating procedure (FOP) regarding notification utilizing clinical psychotropic progress note. Two of five records reviewed were not applicable. In the three other records the youth had psychotropic medications initially prescribed, discontinued, and/or significant dosage adjustment made, the parent/guardian notification was completed in each case. The required Clinical Psychotropic Progress Note (CPPN) Parental Notification form was mailed, along with the CPPN to the parent/guardian. Parental verbal consent was obtained, which was witnessed and documented in the chronological progress notes in the individual healthcare record (IHCR).

On some of the CPPNs it was noted the parent/guardian does not agree with the treatment plan. The nursing staff informed the review team, when the nursing staff is unable to reach the parent/guardian for verbal notification the psychiatrist will mark the box for the parent/guardian not agreeing with the treatment plan, since there is only a “yes” or “no” box to choose from.

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

The program has a policy and facility operating procedure (FOP) regarding immunizations. In all five records reviewed the vaccinations were verified within thirty days of admission. None of the parents/guardians claimed exemption due to religious or medical reasons. Nursing staff stated immunization records are received within the commitment packet and are reviewed upon notification of admission. On admission day an immunization tracking form was completed for each of the five youth. Additionally, it is noted on the admission nursing chronological note the immunization record was received and reviewed.

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

The program has a policy and facility operating procedure (FOP) regarding healthcare admission screening forms. In each of the five reviewed records, the Facility Entry Physical Health Screening (FEPHS) form was completed on the date of admission by a registered nurse (RN).

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

The program has a policy and facility operating procedure (FOP) regarding medical alerts. The facility has an internal alert system, which is shared with all staff in contact with the youth. In four of the five records reviewed, the youth scored a medical grade five; one had a medical grade of two. In all of the records the nursing staff verified all alerts were up-to-date and the internal alerts system matched the alerts identified in the individual healthcare record (IHCR). Four of five interviewed staff indicated they are informed of each youth’s medical alerts in the following manner: during shift briefing, the alert board, one indicated through medical staff, one through the logbook and two others said the alert forms.

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

The program has a facility operating procedure (FOP) regarding youth orientation to healthcare services. In the five records reviewed each youth received general health care orientation upon admission, which included access to medical care, sick call, what constitutes an emergency and

when to notify staff, medication process to include side effects monitoring, the right to refuse care and how it is documented, what to do in the case of sexual assault or attempts of sexual assault, and the non-disciplinary role of the healthcare providers.

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

The program has a policy and facility operating procedure (FOP) regarding admission notification to the Designated Health Authority (DHA). The practice of the program is to notify the DHAof every admission. In each of the five reviewed records the DHA was notified on the day of admission and it was documented. In none of the records the youth was in need of an emergency response.

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

The program has a policy and facility operating procedure (FOP) regarding healthcare admission rescreening. In the five records reviewed only one youth was applicable for healthcare admission rescreening. The program was only able to provide one more example occurring in the review period. In the two applicable records the youth had a change of custody since his arrival to the facility and upon readmission each youth received a screening using the Facility Entry Physical Health Screening (FEPHS) form completed by a registered nurse (RN).

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

The program has a policy and facility operating procedure (FOP) regarding health-related history (HRH). In all five records reviewed the HRH form was completed within seven days of admission by a registered nurse (RN). The Designated Health Authority (DHA) documented the review of the HRH on the comprehensive physical assessment (CPA) form, The HRH was conducted at the same time as the CPA and the most recent Department form was utilized.

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

The program has a policy and facility operating procedure (FOP) regarding comprehensive physical assessment (CPA). In the five records reviewed the CPA was conducted within seven days of admission by a medical doctor (MD). The Department CPA form was utilized, all fields were completed as required and the physical examination was conducted by the examining practitioner. The parts of the CPA examination the physician felt were not necessary to be performed, were documented as "deferred by clinician". This is the appropriate documentation according to the facility operating procedure (FOP). The Department's Problem List was updated when required.

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

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

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

The program has a policy and facility operating procedure (FOP) regarding tuberculosis screening. The FOP follows the Centers for Disease Control and Prevention's new 2006 recommendations and Occupational Safety and Health Administration (OSHA) Standards.

In all five individual healthcare records (IHCR) reviewed a Tier I tuberculosis (TB) screening within seventy-two hours of admission was conducted, as well as the IHCR containing at least one Purified Protein Derivative (PPD) test from within the last year. The results of the Tuberculosis Skin Test (TST) were documented on the Comprehensive Physical Assessment (CPA) and Infectious Communicable Disease (ICD) forms.

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

The program has a policy and facility operating procedure (FOP) regarding sexually transmitted infection screening. All five youth were screened and evaluated for Sexually Transmitted Infections (STI). None of the five youth needed further evaluation or testing to be completed. None of the five had been out of the Department's custody for more than thirty days or presented with symptoms.

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

The program has a policy and facility operating procedure (FOP) regarding Human Immunodeficiency Virus (HIV) testing. In all five reviewed records, the youth was offered counseling and testing for HIV. Two of the five youth consented to receive HIV testing and the results were filed in a confidential manner consistent with Florida Statute 381.004, in a sealed envelope marked "CONFIDENTIAL". There was documentation maintained in the individual healthcare record (IHCR) in the Health Education Record section regarding pre and post-test counseling. A certified HIV counselor conducted the testing and the certificate for completing a two-hour course in HIV 501 update was reviewed. The program does not document the HIV status in their internal alert system. All five interviewed youth indicated they could ask to be HIV tested.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The program has a policy and facility operating procedure (FOP) regarding sick call process-requests and complaints. The FOP states sick call is conducted Monday through Friday 12:00 p.m. to 12:30 p.m. and 4:00 p.m. to 4:30 p.m., as well as Saturday and Sunday 7:30 a.m. to 10:20 a.m. and 4:00 p.m. to 4:30 p.m. Only licensed health care staff are to conduct sick call. The program has regularly scheduled sick call hours posted within the facility and a licensed nurse conducts sick call. The program has licensed nurses working seven days a week and when the computerized system is unavailable paper copies of notifications are available. None of the five youth presented with three or more similar sick call complaints within a two week period or presented with severe pain the staff was unfamiliar with. In two records, the youth requested a sick call and the completed sick call request forms were filed in the progress notes in the individual healthcare record (IHCR) in reverse chronological order.

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

The program has a policy and facility operating procedure (FOP) regarding sick call process-visits and encounters. The program's process includes the youth can approach the doctor when he is on-site, and they are seen about any medical complaints. Out of the original five youth records reviewed there were seven instances of the doctor seeing the youth without any sick call request or episodic log entry; complaints included: rash, migraine, thumb pain, chest pain, and lip lesion.

Only two of five records reviewed were applicable for completion of a sick call request form. One extra record was reviewed. In three applicable records reviewed the sick call form was documented in accordance with health service rule. Sick calls were documented on the sick call request form HSA 032, and on the sick call index. The youth signed the form and the request was filed with the progress notes in the individual healthcare record (IHCR).

The sick call for one youth was observed; the youth provided verbal consent for this observation. The youth was escorted to the clinic by direct care staff and was examined in the clinic for privacy by a licensed nurse. His vital signs were taken, and he was asked about any medical issues. Treatment was consistently provided according to nursing protocol. The youth appeared comfortable with the process; he signed the form following his exam. All five interviewed staff indicated a nurse conducts sick call.

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

The program's policy, procedure, or contract states that they do not use restricted housing, to include confinement, seclusion, room restriction, or secure observation; therefore, this indicator rates as non-applicable.

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

The program has a policy and facility operating procedure (FOP) regarding episodic and first aid care. The program makes available access twenty-four hours a day, seven days a week for emergency medical, dental care and Emergency Medical Services (EMS).

The program has one automated external defibrillator (AED), which is located in master control. The program has seven first aid kits; four are located in master control, three of which are for the vehicles, and the other three are positioned one each in the school building, the break room, and the kitchen. Six first aid kits were observed to be fully stocked and had approved contents (kitchen first aid kit was not observed). The nursing staff stated they keep track of items which can expire and will change them when needed. The monitor observed a tracking sheet in each first aid box which included the expiration date of the items contained within. If a first aid kit is used it will be brought to medical for replenishment. The program has two suicide response kits; one in master control and another in the break room, both contain the wire cutters, knife for life rescue tool, and needle-nose pliers.

All five youth records reviewed had instances of first aid and episodic care provided. Only one of the five youth received care by a non-healthcare staff. The staff documentation included nature of the complaints, date/time of the episodic care, findings of the person rendering care, treatment rendered, follow-up care, parental notification, printed name, credential of staff providing care, and the youth receipt of follow-up evaluation by a licensed healthcare staff. In all five records the licensed healthcare staff documented in either subjective, observation, assessment, and plan (SOAP) elements or standard narrative charting.

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

The program has a facility operating procedure (FOP) regarding emergency care procedures. The program has one automated external defibrillator (AED) located in master control. The medical staff conducted a test of the AED, which was in working order providing prompts to the user. The procedures are located in the clinic and the nursing staff documented a check of the AED batteries and pads on a monthly basis. The AED batteries expire in July 2021 and the pads on May 31, 2020. The AED batteries were changed last on April 9, 2017, and the pads on February 22, 2018.

The program conducts mock emergency drills at least once a quarter on each shift. At least one mock emergency drill included cardiopulmonary resuscitation (CPR)/AED demonstration once a quarter on each shift. The emergency numbers were posted in the clinic. The program maintains a list of individuals who are trained in the use of the epinephrine auto injector, and the training was reviewed. Five pre-service and five in-service staff training records were reviewed, and each had documentation of training in CPR, first aid, and AED. The five interviewed staff indicated participating in mock drills and being allowed to call 9-1-1 when a medical emergency occurs.

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

The program has a policy and facility operating procedure (FOP) regarding off-site care and referrals. Three of five reviewed youth required off-site care/referrals and parental notification was completed. The summary of off-site care form was utilized and filed in the individual healthcare record (IHCR), including discharge and other documents. The Designated Health Authority (DHA) reviewed and signed/initialed all off-site care findings, instructions and information. None of the youth needed referrals or off-site follow up care.

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

The program has a policy and facility operating procedure (FOP) regarding chronic illness and periodic evaluations. Two of the five records reviewed were applicable for chronic medical illness/periodic evaluations. One extra record was reviewed. In the three applicable records reviewed the youth was identified on the Facility Entry Physical Health Screening (FEPHS) form as possessing a current chronic condition. All three youth were taking prescribed medication on an on-going basis, one was undergoing treatment for an elevated Body Mass Index (BMI) and the other two had asthma. All three were identified with medical grade two or above and were placed on the chronic illness list to receive periodic evaluations. All three received a specialized treatment plan and received periodic evaluations at no greater than three months intervals. All three youth were tracked regarding periodic evaluations and the evaluation documentation was maintained in the individual healthcare record (IHCR). The Designated Health Authority (DHA) wrote the treatment orders clearly and distinctively for the clinical staff to identify. There was no indication of lapses in care or missed periodic evaluations and the problem list was updated as needed.

The Program Director indicated as a formalized procedure to review important medical issues pertaining to youth in the program, the DHA and nurses meet to discuss each youth's needs prior to seeing them. The doctor's list also states why each youth is being seen. The nursing staff indicated chronic conditions are maintained on a tracker by the nurses, which includes the due date of the next periodic evaluation.

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

The program has a policy and facility operating procedure (FOP) regarding medication management verification. In all five records reviewed the youth was taking medication at the time of admission, and each medication was verified prior to the youth being accepted into the program, as well as being documented in the chronological progress notes in the individual healthcare record (IHCR). When the verification process was completed the licensed healthcare staff notified the Designated Health Authority (DHA) to resume the specific medications. Nursing staff are on-site seven days a week, therefore they consistently see the youth and review incoming medication during the admission process.

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

The program has a policy and facility operating procedure (FOP) regarding medication management orders and prescriptions. In all five records reviewed, all medications had a current, valid order and were given pursuant to a current prescription. In four of the records the current medication prescribed prior to admission was renewed or refilled for the life of the prescription. In all five records, a current medication was either continued, discontinued, changed or a new one ordered and the Designated Health Authority (DHA) placed an order on the Practitioner Order Form in the progress notes.

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

The program has a policy and procedures to address the storage of medication and items defined as sharps, which includes a process for the destruction and disposal of applicable medications. The program disposes of controlled medication when the pharmacy consultant is on-site; other discontinued medication is returned to the pharmacy. The program stores medication and sharps in the medical clinic. There is a locked medication cart containing prescription medication for the youth and a working supply of over-the-counter (OTC) medications; the cart has separate drawers in which various types of medications are stored. The narcotics and controlled medications are on the medication cart, behind two separate locks. All sharps are maintained in the clinic. All medications and sharps are secured and are inaccessible to youth. The program has a locked box, in which gauze, bandages, gloves and a limited supply of OTC medications are maintained to be used by direct care staff when nursing staff are not on-site. The box, which is kept in the clinic, also includes the patient specific inhalers to be used on an as needed basis. There are two locked refrigerators in the clinic to be used for medical purposes; one refrigerator is used for labs and one is used for medications requiring refrigeration. Both refrigerators contained appropriate items when observed during the annual compliance review. During the quarterly meetings there was documentation to support the pharmacist disposed of controlled medication.

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

The program has a policy and procedures to address the storage of medication and items defined as sharps. The policy includes a procedure to be used in the event any discrepancies in the counts of medications and sharps are noted. The program securely maintains all prescriptions medications, over-the-counter (OTC) medications, syringes and sharps in the clinic. The patient specific prescription medications and a working supply of OTC medications are in the locked medication cart, which is maintained in the locked clinic. All prescription medications received from the pharmacy are on cardboard cards, with each pill in a bubble pack. Each pill is numbered, allowing for a more accurate accounting of the medications. The nurses completed weekly and perpetual counts of the sharps and the OTC medications for the

past six months. The inventories for the past six months were reviewed; there were no discrepancies noted. During the annual compliance review, the counts of three sharps (pill cutter, scalpel and TB syringes) were matched against the current inventory; all counts matched the inventory. Three bulk OTC medications were counted; the counts of all three items matched the current inventory. Three opened OTC medications were counted; the counts of all three items matched the current inventory. Three prescription medications were counted; all matched the current count of the medication. The OTC medications in the box to be used when nursing staff are not on-site were counted; all matched the inventory. Seven healthcare records were reviewed; all of the youth received either a prescription medication or an OTC medication while in the program. The Medication Administration Record (MAR) for each youth documented the youth received each medication as ordered. There were no lapses or discrepancies noted.

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

The program has a policy and procedures to address the management of controlled medications which includes a procedure for conducting shift-to-shift counts. The policy also requires discontinued medications to be counted until disposed. The program maintains all controlled medications in a separate locked compartment of the locked medication cart. The controlled medications are delivered from the pharmacy on cardboard cards, with each pill in a bubble pack; each pill is numbered, which allows for a more accurate accounting of the medications. The nurses complete a count of the medication cards at the beginning of each shift, as well as a count of the medications. A shift-to-shift count of controlled medications was observed during the annual compliance review; the counts were conducted by nurses. There were no discrepancies noted. The nurses consistently conducted a shift-to-shift count of the medication when controlled medication is prescribed for the youth. The program documented perpetual counts of the medications on the applicable youth's Controlled Medication Inventory Record. The controlled medications for three youth were counted; the number consistently matched the youth's medication administration record.

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

The program has a policy and facility operating procedure (FOP) regarding medication administration records. In the five records reviewed the preprinted pharmacy Medication Administration Record (MAR) was utilized and the form contained the name of the youth, the Department of Juvenile Justice identification number (DJJID), the date of birth (DOB), youth allergies, precautions, and medical grade. There was no picture of the youth on the MAR, but the program utilized a form in conjunction with the current MAR which contained the youth's name, DJJID, date of admission (DOA), DOB, height, weight, allergies and the statement "right youth, right medication, right dose, right time and right route", as well as a picture of the youth. In all five records the medication taken by the youth at admission matched the initial MAR and the form indicated the youth received medications as ordered. Each reviewed MAR indicated medication start and stop dates, and staff initialed each administered medication entry, as well as documented side effects monitoring. In a few cases the youth refused the administration of medication and this was clearly documented on the MAR with a "R", as well as in the individual healthcare record (IHCR) with the refusal of medication/treatment form.

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

The program has a policy and facility operating procedure (FOP) regarding medication administration by licensed staff. In all five records the youth was not receiving parenteral medication.

One medication pass was observed. The working space was clean and organized and the nurse had control over the medical cart and the medication containers. The facility has a structured process for youth to approach the licensed staff person. The Medication Administration Record (MAR) was utilized, and the allergy and alert status were verified. The nurse questioned the youth regarding side effects. Nurse and another staff observed the youth swallow the medications. The nurse removed the medication out of the bubble pack and placed it in a small container at the time of the medication pass; no pre-pour was observed.

All five interviewed youth indicated the nurse provides medication. The youth explained they have to line up alphabetically, remain quiet, then will be called up one by one, take the medication, and then get their mouth swabbed. One youth explained medications are put in a cup, he takes the medications, and then drinks the water.

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

The program has a policy and facility operating procedure (FOP) regarding medications provided by non-licensed staff. Only one of the five youth records reviewed had one administration of medication by a non-licensed healthcare staff. The staff confirmed the youth's allergy status and both the youth and staff signed the back of the Medication Administration Record (MAR).

Five staff interviews indicated over-the-counter medications can be provided to youth by a trained supervisor or youth care worker-II, including they must notify medical staff and fill out a form, as well as place the occurrence in the logbook.

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

The program has a policy and facility operating procedure (FOP) regarding psychotropic medication monitoring. In the five records reviewed the youth was admitted to the facility with psychotropic medication, the psychiatrist, the Designated Mental Health Clinician Authority (DMCHA), and the Designated Health Authority (DHA) were notified on the day of admission. The psychotropic medications were continued to be administered until the youth was seen by the psychiatrist for the initial psychiatric interview within fourteen days. The youth received

medication monitoring/review by the psychiatrist. The psychiatric evaluation was documented on the Department's Clinical Psychiatric Progress Notes (CPPN) including page three which detailed the diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication on target symptoms, prescribed psychotropic medications, side effects, weight, blood pressure, youth's adherence to the medication regimen, telephone contact with parent/guardian to discuss medication, signature of the psychiatrist, and date of the signature.

The program did not have any youth who were admitted without but were later prescribed psychotropic medications after admission. The program has a comprehensive process in place for the monitoring of psychotropic medication, to ensure each youth's safety. The program does not have any standing orders or treatment orders regarding psychotropic medications.

4.34 Infection Control – Surveillance, Screening, and Management	**Satisfactory Compliance**
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program has a policy and procedures to address infection control. The plan included all required elements, including the following: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, hepatitis A, B and C, Human Immunodeficiency Virus (HIV), infectious diseases, other outbreaks or epidemics caused by any other infectious agent, outbreaks of pediculosis, and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food-borne illnesses, bio-terrorist agents and chemical exposure in the workplace. The plan was reviewed and signed on November 27, 2018 by the Designated Health Authority (DHA) and the Facility Administrator. The plan addresses requirements for staff training, hepatitis B vaccination and post-exposure follow-up. The program offers hepatitis B vaccinations to all staff. During their orientation to the program, staff are provided information regarding hepatitis B immunizations. The staff sign to acknowledge the potential to be exposed to blood-borne pathogens and are provided the list of chemicals used and the approved preventative first aid measures. There have been no reportable incidents to the local county health department and/or Centers for Disease Control since the last annual compliance review. There are spill kits and personal protective equipment such as bio-hazard bags, gloves, gowns and masks available to the staff.

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

The program has a policy and facility operating procedure (FOP) regarding infection control education. In the five records reviewed the youth received training in prevention of communicable diseases and prevention of blood-borne pathogens, which was documented in the individual healthcare record (IHCR) on the health education record tab. The program's comprehensive infection control plan includes pre-service and in-service training for all staff, as well as youth infection control education, as per the Center for Disease Control (CDC) guidelines. Five in-service and five pre-service staff training records were reviewed. The records indicated all staff training was within the CDC guidelines.

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

The program has a combined infection control and exposure control plan. The plan includes all required elements and is available for the staff in the clinic. The plan was reviewed on November 27, 2018 by the Designated Health Authority and the Facility Administrator. There is training on the program's exposure control plan provided twice each year by the program's health services administrator. There is also a copy of the infection control and exposure control plan in a separate binder in the conference room and the facility administrator's office for easy access when needed. The Facility Administrator was interviewed; he reported the exposure control plan is located in the medical office. He further reported the plan is reviewed with staff during pre-service training, and annually as an in-service training. The training is conducted by the program's Health Services Administrator.

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

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

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

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

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

This is an all-male program; therefore, 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 policy and procedures regarding youth supervision which states youth care workers should always maintain direct sight and sound supervision of all youth, except during sleeping hours in which staff will conduct ten-minute checks. The program's contract requires a staff to youth ratio of one staff to eight youth during awake and sleeping hours and a one staff to five youth ratio during off-site activities. During the annual compliance review, youth supervision was observed each of the four days the review team was on-site. During all observations, the staff to youth ratio was met and line movement was appropriate. Youth were observed in the classroom setting, during line movement, at recreation, during group, at medication pass, in treatment team, and during leisure time. On three separate occasions staff were asked what the staff to youth ratio was and each time the staff advised the correct count ratio. Three staff were informally interviewed and each reported if a count is not able to be reconciled all movement is stopped and an emergency count is conducted. During the annual compliance review staff were asked the number of youth under their supervision and were able to provide an accurate count. The program has a schedule and the youth follow the schedule as posted on each dorm. Through informal interviews with the youth, it was reported youth feel program staff care about them and the interaction between youth and staff was observed to be positive.

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

The program has policy and procedures regarding their comprehensive behavioral management system (BMS). All parties required by the contract to be involved in the implementation of the program's BMS were documented as doing so. Seven pre-service and seven in-service staff training records were reviewed and each documented the staff were trained in the program's BMS. The BMS was observed to be posted throughout the program, including on the dorms. Each youth is provided the details of the BMS upon admission in the youth handbook. The youth handbook includes the rules, incentives, and consequences of their behaviors while at the program. Seven case management records were reviewed and each indicated the youth received and signed the youth's handbook upon admission to the program. Twelve staff were interviewed and each were able to explain the program's BMS and reported they receive feedback from the supervisors in regarding their use of the BMS. Seven youth were interviewed and each was able to explain the different levels of the BMS and indicate their current level. 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

the program administrator. The youth interviews revealed youth receive incentives such as canteen, awards, and extra snacks for positive behavior. The program administrator was interviewed and indicated the BMS had not been changed since the last annual compliance review.

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 policy and procedures regarding tracking infractions of the behavior management system (BMS). The program uses a Positive Performance System which tracks youth behavior on a daily point sheet. This data is then reviewed on a weekly basis as part of the Program Operational Report in morning management meetings and in each youth's treatment team meetings. An interview with the program administrator confirmed this practice. The youth are given chances to correct their behavior prior to receiving any infractions. If an infraction is received the infraction and consequences are explained to the youth and the youth is given the opportunity to explain their behaviors. Five staff were interviewed and each confirmed youth are advised of any consequences and are given the opportunity to explain their behaviors. The staff further confirmed nothing can be taken away from the youth as a form of punishment. Seven youth were interviewed and each described level suspension and adding time as consequences for negative behaviors, one youth reported Protective Action Response (PAR) as a punishment for a fight. None of the youth reported youth are ever allowed to punish other youth. Four youth rated the BMS as very good, one as good, and two as fair. The program does not use a room restriction as a form of punishment for the youth.

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 policy and procedures regarding ten-minute checks which requires all checks to be completed every six minutes. Five staff were interviewed and each confirmed checks are conducted every six minutes when youth are in their rooms. The program has forty-six cameras each of which were operational during the annual compliance review; however, it was discovered the program's digital video recorder is only retaining thirteen days of video instead of thirty. The program provided documentation a work order for a video upgrade has been submitted to the Department. Video footage was observed with the master control operator and assistant program administrator during the annual compliance review for December 29, 2018 (B shift), December 30, 2019 (C shift), January 1, 2019 (A shift), January 3, 2019 (A shift), January 6, 2019 (C shift), and January 9, 2019 (C shift) for all four dorms. All checks were observed to

be done in real time, matched the paper check sheets, and were completed appropriately. Additional ten-minute check logs were reviewed for June 30, 2018, December 29, 2018, and December 30, 2018. All checks were completed every six to eight minutes and were documented in real time. Ten-minute checks were not able to be observed during the annual compliance review.

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

The program has policy and procedures regarding the census, counts and tracking of youth. The master control logbook was reviewed to validate counts were being conducted as required. The policy states counts are conducted at the beginning of each shift, after any outdoor activity, during movement, and emergency situations. The policy requires an additional six formal counts to be conducted within a twenty-four-hour period. All counts are documented in the master control log book. The daily population count is passed on each shift during the shift briefing as well as tracked on a grease board located in master control. Multiple counts were observed during the annual compliance review as well as heard through the program's two-way radio. Five staff were interviewed and each indicated counts are conducted at the beginning of each shift, at random, during an emergency, and any time there is a discrepancy in the count, to include drills. Each staff was also about the describe the protocol for when a count cannot be reconciled.

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 policy and procedures regarding logbook entries and shift reports. The program utilizes one logbook each shift, kept in master control. A review of multiple logbooks validated each logbook is bound, numbered, and entries are written in ink. No entries were observed to have been removed or obliterated. Logbooks were reviewed for October 21, 2018 (A shift), June 16, 2018 (B shift), and August 26, 2018 (C shift). Each reviewed logbook summarized all individual incidents, activities, counts, and movement. During the annual compliance review, a shift briefing was observed in which all pertinent information such as youth

counts, incidents, staff on shift, alerts, any Protective Action Response (PAR) on previous shifts, any transport information, the status of class A tools, and any items needed for a shift supervisor to follow-up on were discussed. Each incoming staff member signs the shift report. The shift report is maintained in the shift briefing room and is posted for up to forty-eight hours for review. The program utilizes a security check list which verifies inner and outer perimeter checks are completed at the beginning of each shift.

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 policy and procedures regarding key control, including protocol for lost or missing keys. The key control logs for the months of August 2018 to December 2018 were reviewed and were completed with all required information. During the annual compliance review, distribution of program keys to staff was observed during a shift change. The practice was observed to be a key for a key system in which staff are required to sign in their personal keys and sign out program keys on the key control log. Five staff were interviewed and each were able to verify the key for a key process. Keys for a staff mentor, youth care worker, and the assistant program administrator were randomly checked and confirmed to match the key inventory for the corresponding set of keys. Additionally, three staff were checked for personal keys and each only had program keys in their possession. All program and personal keys are secured in master control and the master control operator has the key to access the lockbox. During the annual compliance review, no keys were documented as lost since the last annual compliance review; however, each of the five staff and master control operator interviewed were able to describe the response to a lost key as a complete program shutdown, with no one coming in or out of the program, until the key is found. The master control operator further explained the process to follow when a key is damaged which includes a work order being completed and provided to the maintenance staff which also notifies anyone else the key is broken and not able to be used, until a replacement is made. The master control operator was also able to explain certain keys are restricted to specific staff such as keys to the medical office and records, mental health records, and case management records and youth property lockers. The key lockbox was observed several times during the annual compliance review and it was secured at all times.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has policy and procedures in place regarding contraband, which coincides with the Departments recommended guidelines for contraband as distributed in 2015. The policy outlines the disciplinary action for staff found in possession of contraband, it also indicates law enforcement will be notified if necessary. Youth are provided with a program handbook upon admission and the youth also sign for the handbook during the orientation process. The handbook lists in detail what is considered contraband, which includes but is not limited to personal cellular telephones or equipment which can take pictures/videos, and what the consequences would be if the staff/youth are found to be in possession of such items. Random searches are conducted of the youth's rooms and are documented in the shift searches binder. The random searches conducted during the annual compliance review period yielded items such as books, pencils, extra clothing articles, and toothpaste. No items found required law enforcement involvement. All incoming and outgoing mail is searched by the case manager in front of the youth and is also documented in a binder. The Facility Administrator (FA) was interviewed regarding how searches of the physical plant, security checks and perimeter checks are conducted and how the program disposes of any illegal contraband located. The FA indicated there has not been any illegal contraband discovered in the last six months. The FA advised any items which are not illegal are thrown away or placed in the youth's property. The policy states any contraband which is illegal and confiscated is to be placed in a bag with a statement detailing the time, date and the location of the item(s). The items then will be turned over to local law enforcement and a criminal report will be made. When a youth is found to be in possession of illegal contraband, the youth can be charged with a rule violation which in turn would be documented on a special treatment team referral form and then placed in the youth's individual management record. The policy also states the youth can be charged with a criminal violation if the contraband is deemed to be illegal.

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 policy and procedures regarding searches and full body visual searches, which indicates youth are to be given a full body search upon admission and returning to the

program from any home visit, and when returning from any program-supervised activity away from the program, such as mental health/medical appointment, court or any other activity. During the annual compliance review a full body visual search was observed of a youth returning from an outside medical appointment conducted by two staff of the same sex as the youth. Male staff were also observed conducting thorough searches of the youth after dining hall movement. The staff treated each youth with dignity and respect, all searches were done in accordance with the Protective Action Response (PAR) training manual. Seven youth were interviewed, and each indicated searches occur when they return from court, outside appointments, after outside recreation, when transitioning to and from the dining hall, visitation, work details, and when items are missing. The team performed informal interviews with twelve staff and confirmed searches are conducted after all movement and when a youth returns from outside of the program.

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

The program has policy and procedures regarding vehicles and maintenance. The program currently has two vehicles in operation. A review of the van used to transport all youth found the van had operational seat belts, a fire extinguisher, a seatbelt cutter/window punch and a separator in between the driver's seat and rear passengers seat. The van was found to be locked when not in use. The vehicle had an annual inspection on January 4, 2019 which documented the vehicle failed the annual Department of Transportation (DOT) inspection. It was noted on the annual inspection the front windshield was cracked, the vehicle's engine light was on, and the front brakes were at thirty percent. The vehicle was used on the same day, after the failed inspection, to transport a youth from the Orange Regional Juvenile Detention Center to the program. The vehicle was used again on January 9, 2019 to transport a youth from the detention center to the program. On January 10, 2019 the vehicle was once again used to transport a youth to an outside medical appointment. Once the failed inspection was discovered by the review team, the Facility Administrator (FA) was notified. The van was currently in use at the medical appointment. The FA contacted the transport officer and advised them not to leave the medical appointment until a replacement vehicle had arrived. The Central Communications Center (CCC) was contacted and confirmed the incident is not reportable. The vehicle was removed from service by the FA until repairs could be done. The other program van was reported to be used only for staff transport as indicated by transport logs; however, the van had to be used for youth transport due to the youth van failing the safety inspection. The van was reviewed and found to have all required items except a divider; however, the youth transport was found to include one staff seated in the back with the youth.

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

The program has policy and procedures regarding transportation of youth which indicates the ratio of staff to youth during a transport as one staff to five youth. During the annual compliance review, a transport of one youth and two staff (one male staff and one female staff) was observed. The staff had the first aid kit for the transport, searched the van prior to allowing the youth in the van, and ensured the youth was handcuffed and shackled at his feet. The staff and youth were utilizing their seatbelts. Staff indicated youth are not allowed to drive the vehicle, nor are they ever left alone in the vehicle. Upon return of the transport the youth was searched along with the van. The transport staff utilize a two-page youth transportation checklist which was observed during the transport. The staff had a two-way radio and a cell phone, staff indicated they utilize the two-way radio and cell phone on every transport which was further confirmed through interviews with five staff members. Documentation was found to support the provider's human resources department checks each staff's driver's license upon hire and annually thereafter. A random search was conducted of vehicles during the annual compliance review and all vehicles were secure.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has policy and procedures regarding weekly safety and security audits which states a weekly safety check of the designated zones and areas will be conducted. The zones and areas include but are not limited to the closed caption televisions (CCTV)/surveillance equipment, radio/communication equipment, key/locks/doors, and metal detectors. A review of the program's weekly safety checks noted digital video recording (DVR) system was recording but only could store up to thirteen days of recordings. The Facility Administrator (FA) provided documentation an email was sent to the provider advising of the problem in which it was discovered the DVR system would need an upgrade in order to accommodate the system being able to record and store video for up to a thirty-day period. A work order was placed with the Department in order to get the DVR to meet requirements. All safety and security audits were conducted as required and documentation maintained.

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

The program has policy and procedures regarding tool inventory and management which indicates all tools shall be secured and properly controlled. The physical plant manager is responsible for the proper classification, secure storage, custody, inventory, and the issuance of tools which are stored in the maintenance shed and the secure kitchen area of the kitchen. An interview of the Facility Administrator (FA) revealed tools are inventoried twice a day, which was confirmed through review of tool inventory logs. An observation of the secure tool storage found all tools are kept on a shadow board for easy identification. Class A tools are secured and inventoried three times a day. Class B tools are checked and inventoried daily. These tools are currently marked with a blue marker for easy identification, noting they are class B tools. The

inventory logs were reviewed for the issuance and return of issued tools. An interview of the maintenance staff confirmed the protocol for any missing tools. All tools are clearly marked for identification for staff in the event a tool should become missing. Seven youth case management records were reviewed, and each indicated each youth was trained on the safe use of tools during the admission process. Seven staff pre-service training records were reviewed, and documented staff had received training on the safe use of tools.

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

The program has policy and procedures regarding youth tool handling and supervision which indicates all youth will complete an assessment completed prior to being issued tools. Seven youth case management records were reviewed, and each were found to include risk assessments which authorized youth to use class B tools only. Five staff were interviewed, and each reported youth are only allowed to utilize mops and brooms. Seven youth were interviewed, and each reported youth are allowed to use mops and browns, while one reported youth were allowed to use rakes and other gardening tools, such as a shovel. The program reported the garden is a new project at the program; therefore, they could not produce risk assessments which allowed youth to utilize the class A tools.

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 policy and procedures regarding outside contractors which indicates the Facility Administrator (FA) or a designee should provide the outside contractor with a notice of tool/equipment instruction form prior to any contract work occurring and to ensure the contractor signs the form signifying the review of instructions. The FA/designee is to inspect the area once the work is complete and document completion of the final inspection on the notice of tool/equipment form. Multiple forms were reviewed and compared to invoices. On October 8, 2018 an invoice from Best Plumbing Company was reviewed and compared to the outside contractors sign-in sheet. The dates on the invoice and the contractor sign-in sheet matched and the contractor sign-in sheet had been completed and signed by the contactor along with the FA's signature confirming the policy was being followed.

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

The program has policy and procedures regarding fire, safety, and evacuation drills. The policy and Continuity of Operations Plan (COOP) indicates fire drills and COOP drills will be conducted on a monthly basis on each shift. The Facility Administrator also reported these drills occur on a monthly basis. A review of the program's drill binder confirmed fire drills had been completed monthly on each of the shifts. Fire evacuation routes are clearly posted in every dorm, administration and school building along with in the dining hall. Seven youth were interviewed, and each confirmed they had been instructed on what to do in case of a fire and five confirmed drills are conducted on a monthly basis while two remembered them happening but could not

recall the frequency. Five staff members were interviewed and confirmed they had each participated in multiple drills during the annual compliance review period, including fire and COOP 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.	

The program has policy and procedures regarding the Continuity of Operations Plan (COOP). The COOP was reviewed and approved by the Department on November 1, 2018. The COOP plan addresses the alternative housing plans, these plans were also approved by the department. The Facility Administrator (FA) was interviewed and indicated the COOP plan is located in the administration conference room and in master control. During the annual compliance review, the program's storage of on-hand supplies to maintain continuous operation and services during an emergency situation was observed. The supplies are currently stored in the kitchen area.

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

The program has policy and procedures regarding storage and inventory of flammable, poisonous, and toxic items which indicates all such items shall be secured and inaccessible to the youth, and at no time shall the youth handle these items. During the annual compliance review, all items were observed to be secured in a locked building on the program grounds and inaccessible by youth. The maintenance staff is the only one who has access to the secured building. A continuous inventory list is kept for all items with the correct amount of supplies on hand. The inventory list was compared to what supplies were on hand. The Safety Data Sheet (SDS) was kept with each individual sheet with the materials. The program also has an SDS binder with each item's picture attached to an SDS sheet. Chemicals used in the kitchen are checked in and out daily and the chemicals are tracked three times a day, breakfast, lunch, and dinner. The chemicals in the kitchen were compared to the items on hand and the inventory list with the correct amounts confirmed. Each SDS was kept with an individual inventory sheet.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has policy and procedures regarding youth handling and supervision of flammable, poisonous, and toxic items and materials. The program maintains strict control for such items

and secures all materials in the program maintenance shed. Seven youth were interviewed, and each confirmed youth are not allowed to handle any flammable, poisonous, toxic items and materials. The Facility Administrator (FA) was interviewed and confirmed youth are not allowed to handle such items, nor do they clean up or dispose of any bio-hazardous materials, bodily fluids or human waste. During the annual compliance review, youth were observed cleaning up the administration area and kitchen using class B tools (brooms and mops). The staff maintained control of all chemicals and supervised youth wiping or mopping surfaces.

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

The program has policy and procedures regarding disposal of flammable, poisonous, and toxic items which states all hazardous material needing to be disposed of are prepared according to the Occupational Safety and Health Administration (OSHA) standards. The program has a current chemical disposal sheet to track disposal; however, the Facility Administrator (FA) reported there have not been any disposals during the annual compliance review period. The program provided a copy of an Oil and Grease Prevention Program Registration Certificate, the certificate was effective on September 1, 2017 and expires on August 31, 2019. This certificate allows the program to discharge wastewater into the Orange County (OC) sanitary sewer and treatment system in accordance with the wash water characteristics as listed in the OC use ordinance. The program utilizes outside contractors, Environmental Enterprises of Florida and Perma-Fix of Orlando, for proper disposal of all kitchen grease and bio-hazardous waste. The program's maintenance staff has been properly trained on how to prepare the items for proper disposal.

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

The program has policy and procedures regarding recreation and leisure activities. The program employs a recreation therapist who holds a bachelor's-level degree in sports management satisfying the staffing requirement in the program's contract. The program has an activity schedule posted throughout the program and was observed to be following the schedule. The activity schedule included indoor/outdoor activities, education, group counseling, meals, medication pass, hygiene, wake-up/bed times, recreation, and relaxation/reading/writing time. The program has a separate recreation calendar, updated on a monthly basis. The recreation therapist creates a wellness plan for each youth. Seven youth were interviewed, and each confirmed physical activities and leisure activities are provided for youth daily for a minimum of one hour. The youth described leisure activities included basketball, football, four-square, and indoor activities such as card games, movies, board games, and indoor exercise. Five staff were interviewed and confirmed youth receive daily recreation activities indoor/outdoor at a minimum of one hour a day.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has policy and procedures regarding visitation and communication with the youth's family members. The program provides visitation for youth on Saturday and Sunday from 1:00 p.m. to 3:00 p.m. A review of the visitation logs verified visitation takes place every weekend. Youth at the program are permitted to have telephone contact with pre-approved contacts, the phone calls are ten minutes a week at a minimum and youth can earn additional phone call time. A review of the youth's telephone logs indicated the youth are receiving these calls as required. The program provides the youth with two envelopes and stamps a week and the youth are allowed to receive unlimited mail from pre-approved contacts. The mail is reviewed and searched for contraband prior to being given to the youth in front of the youth and then documented on the mail log. The program has a provision in their contract allowing them to compensate family members, when needed, to cover travel expenses for visitation. An interview of the Assistant Facility Administrator (AFA) confirmed the program has not had to

compensate a family member during the annual compliance review period for visitation expenses. The program has an alternative arrangement for visitation in the event families are not able to attend regularly scheduled visitation days. Seven youth were interviewed, and each confirmed they were given the opportunity to communicate with family members either by telephone, email, or visitation.

5.24 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 and procedures confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

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

5.26 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 and procedures confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

Program Name: Orlando Intensive Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Orange County / Circuit 9
Review Date(s): January 8-11, 2019

MQI Program Code: 7281
Contract Number: 10145
Number of Beds: 16
Lead Reviewer Code: 77

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.12 Restorative Justice Awareness for Youth	1.17 Advisory Board
2.15 Treatment Team Meetings (Formal and Informal Reviews)	5.10 Vehicles and Maintenance
5.14 Youth Tool Handling and Supervision	