STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Orlando Intensive Youth Academy

True Core Behavioral, LLC.
(Contract Provider)
3150 39th Street
Orlando, Florida 32839-3209

Review Date(s): August 20-23, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tamara Mahl-Adkins, Office of Program Accountability, Lead Reviewer (Standard 1)
Jamilia Bacchus, Office of Program Accountability, Regional Monitor (Standard 2)
Cedric Cliatt, Melbourne Center for Personal Growth, Executive Director (Standard 5)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 3)
Kamille Payne, Office of Program Accountability, Regional Monitor (Standard 4)
Rowena Rose, Department of Juvenile Justice, Educational Coordinator (Standard 2)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 5 and Interviews)
Sherri Wilson, Office of Program Accountability, Government Operation Consultant II (SPEP)

Program Name: Orlando Intensive Youth Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Orange County / Circuit 9
Review Date(s): August 20-23, 2019

MQI Program Code: 1166
Contract Number: 10145
Number of Beds: 16
Lead Reviewer Code: 156

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 Initial Background Screening *	2.09 Performance Plan Development, Goals and Transmittal *
2.08 Youth Needs Assessment Summary (YNAS)	2.14 Incorporation of Other Plans Into Performance Plan
2.13 Members of Treatment Team	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Orlando Intensive Youth Academy is a sixteen-bed program, for twelve to eighteen-year-old males, located in Orlando, Florida. The program is operated by TrueCore Behavioral Solutions, LLC., through a contract with the Department. The program provides the following services: mental health overlay services (MHOS) and substance abuse overlay services (SAOS). In addition, the program fosters each youth by providing evidenced based delinquency curriculum Thinking for a Change (T4C), and Impact of Crime (IOC), gender-specific delinquency and treatment programming for boys Young Men's Work (YMW), and 24:7 Fathering Handbook, as well as additional treatment services provided: Life Skills Training, Teen Relationships, Living in Balance (LIB), Anger Management for Substance Abuse/Mental Health Clients, 100 Interactive Activities for Mental Health and Substance Abuse Recovery, Strategies for Anger Management, Life Skills 225, Skillstreaming the Adolescent, Creative Therapy, Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents (TFB), the Passport Program: A Journey Through Emotional Social, Cognitive and Self-Development and Don't Let Your Emotions Run Your Life for Teens, and individual and family counseling sessions.

Program administration is comprised of a facility administrator, assistant facility administrator, program director, case management supervisor, human resources manager, director of clinical services, health services administrator (registered nurse), and administrative assistant. Case management services are provided by the case manager supervisor, four case managers and two transition services managers. Mental health staff at the program includes a director of clinical services, two licensed clinicians, four therapists, and one recreational therapist. The psychiatrist, psychologist, and two certified behavior analysts are contracted service providers. The psychiatrist is on-site once a week. Medical services are offered from 7:00 a.m. to 7:30 p.m. seven days a week and are provided by six registered nurses, one of which is considered the health services administrator (HSA). The doctor is a contracted position and is on-site at a minimum of four hours a week. Educational services are provided on-site by the Orange County School Board.

The layout of the program includes: one large H-shaped building housing all offices, modules and kitchen, as well as master control: a pavilion attached to the maintenance building serves as a sheltered recreational area, and there are portables and permanent education buildings which are utilized by the school personnel. The program has fifty operational cameras, and three more which are not functioning, which the program has submitted a work order to have them repaired. At the time of the annual compliance review, the program had fourteen vacant positions; one physical plant manager, one non-licensed part time therapist, eight youth specialist I, two youth specialist II, one non-licensed therapist, and one staff mentor.

Strengths and Innovative Approaches

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

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

Standard 1: Management Accountability

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

The program's facility operating procedures (FOP) states the Central Communications Center (CCC), Staff Verification System (SVS) module, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results, and complete agency personnel record must be reviewed prior to the hire date. The FOP also stated any volunteer/mentor/intern shall be background screened unless the person assists or interacts with the youth on an intermittent basis for less than ten hours a month. The program human resources staff developed their own form to ensure all documentation is completed and reviewed for all new hires.

A total of fourteen staff were reviewed regarding initial background screening. Each staff had been hired or rehired since the last annual compliance review. All of them had a background screening completed prior to the hire date and the criminal history had been reviewed; none required an exemption or were hired from Department employee to provider employee. Three of the fourteen had a break in service. All of the staff had been added to the program's employee/volunteer roster in the clearinghouse system. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and was sent to the Background Screening Unit (BSU) on December 7, 2018. The teachers are paid by the school board and received an annual screening on January 10, 2019.

Eight of fourteen staff were direct care staff and applicable to receive the pre-employment assessment tool/Ergometrics. All eight received the assessment and the passing score was maintained in the employee record. In six of the eight staff the preemployment assessment tool was completed after the staff were hired and in the other two it was completed on the date of hire. The program's FOP, as well as the program's contract states a pre-employment assessment tool is to be completed prior to hire for direct care staff.

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 had two eligible staff for the five-year rescreening. Each rescreening was submitted to the Clearinghouse at least ten business days prior to the five-year anniversary; both were cleared.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trama responsive practices.* • *The program shall complete or schedule a TRACE self-assessment.*	

The program has a Facility Operating Procedure (FOP) stating all staff shall immediately report any knowledge or suspicion regarding an incident of abuse or harassment having occurred in the program to the Florida Abuse Hotline or if the youth is eighteen years old or older, the Central Communications Center (CCC). Staff are to verbally notify the on-duty supervisor once the call to the Florida Abuse Hotline has been made, as well as the reason for why the call has been made, this is not required if the person has made an anonymous call. Staff then complete an internal incident report form and forward the completed form to the assigned supervisor once the call has been made.

The program had eleven CCC reports of which two were applicable for complaints against staff; one of which was an incident of alleged physical abuse, which was substantiated, and the staff

was removed from youth contact immediately, as well as, after conclusion of an investigation, terminated.

The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment in May of 2019; the staff sign an employee handbook at the time of hire; they provide trauma responsive training to all new employees as part of the pre-service training; and the Florida Abuse Hotline and the CCC phone numbers were posted throughout the modules and the common areas for staff and youth to see.

The facility administrator (FA) was interviewed and indicated all staff and volunteers of the program are to adhere to the Department's rule relating to the reporting of incidents, as well as the program procedures for reporting incidents which are not required to be called in to the CCC. The FA ensures any matter requiring reporting to the CCC is verbally reported within two hours of the incident or learning of the incident. If there is doubt at any time as to whether an incident or event is reportable, the presumption shall be the incident or event is to be reported.

Five youth interviews indicated they feel safe at the program. One youth said staff watch him because he is one of the smallest; another indicated he does not feel in danger; one more indicated because he can handle his own he feels not in danger; and the last said staff will protect and talk to youth, help him complete his goals, and encourage him to do well. All five stated they never had to call the Florida Abuse Hotline and indicated staff are respectful when speaking to them.

All five staff interviews indicated the process for allowing staff and youth to call the Florida Abuse Hotline and the CCC to report suspected abuse is to notify a supervisor; three said to allow youth to make the call; two mentioned the supervisor making the call; and one stated the staff are allowed to call. The staff also mentioned to never refuse a youth to call the Florida Abuse Hotline; the supervisor will notify the FA and assistant facility administrator and they make the call; and for staff to dial the number for the youth.

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

The program had two Central Communications Center (CCC) reports which were complaints against staff. One of which was an incident of alleged physical abuse, which was substantiated, and the staff was removed from youth contact immediately, as well as, after conclusion of an investigation, terminated. The other report was unsubstantiated.

The facility administrator interview indicated incident reporting is covered during pre-service and on the job training, the phone numbers are posted throughout the program's living areas and the information is incorporated in the daily management meetings.

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

The program had a total of eleven Central Communications Center (CCC) reports in the last six months. A sample of five reports were reviewed. All five of the reports were called into the CCC within the required two-hour time frame and were documented in the logbook.

The program indicated the reason why there had been an increase in CCC reports during this annual compliance review period is many of the CCC's were medical in nature; illnesses such as strep throat, viral infections, abdominal pain, and similar ailments were determined to require outside intervention.

The facility administrator interview indicated a separate file of all incident reports is maintained and has a system is in place to track all incidents. Any allegation of non-consensual/consensual sex or coerced youth-on-youth sexual abuse or sexual assault is reported to the CCC and local law enforcement. The provider has a zero-tolerance policy in regards to any form of abuse. All staff are told to immediately report any knowledge or suspicion regarding an incident of abuse or sexual harassment which has occurred in the program. They are also required to report any retaliation against youth or other staff who reported an incident, and any staff neglect or violation of responsibilities which may have contributed to an incident/retaliation.

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

The program had a total of thirty-eight Protective Action Response (PAR) incidents in the last six months, five of the incidents were reviewed. All reports were completed by the end of the staff member's workday and included statements from all staff involved. In one of the five, the PAR resulted in an injury to the youth, the CCC was contacted within the required two hours, and a PAR medical review was conducted. All five of the reports were reviewed by a PAR certified instructor/supervisory staff and a post-PAR interview was conducted with the youth by the administrator or designee within thirty minutes after the incident occurred. The administrator or designee reviewed the PAR incident report within seventy-two hours of the incident and a copy of the report was then filed in a centralized record within forty-eight hours.

The program provided a monthly summary of all PAR incidents to the Department by the fifteenth of each month for the last six months. The program's PAR rate during the annual compliance review period was 6.06, which is above the statewide Residential PAR rate of 1.59. The program had only four PAR reports during the last annual compliance review period. The program indicated the reasoning for the increase in PAR reports from the last annual review period is a large number of the physical interventions can be contributed to the admission of one youth. The program and Department developed an amendment to add specific services and

additional staffing to address the needs of one youth. The program's PAR plan was approved by the Department on March 28, 2019.

The facility administrator interview indicated the process for monitoring PAR incidents and use of force is to inquire during the daily management meeting if any physical restraints have occurred, to document findings on the daily morning management meeting minutes, review the PAR report, including the Post-PAR interview and if applicable, the PAR Medical Review findings, and the staff mentor's review, 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, he ensures all engaged staff and designated supervisory staff review the tape as part of the review process with him, upload the video related to any level 2 or 3 physical intervention to the G-drive and email the director of the Office of Staff Development and Training once the video has been uploaded. Also, he is to email all related PAR paperwork to the chief operating officer, regional director, general counsel, chief compliance officer, director of clinical services and the director of the Office of Staff Development and Training, review and sign internal incident reports for compliance with requirements, and file in a centralized log. If applicable, he also initiates corrective action, including abuse reporting, Central Communications Center (CCC) reporting and law enforcement notification, before the report is finalized, and file the PAR report and any attachments in a centralized file within forty-eight hours of being signed.

All five youth interviews stated they have never observed another staff refusing a youth to call the Florida Abuse Hotline or using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth.

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

Five eligible staff were reviewed regarding pre-service training. All five completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention/intervention, emergency procedures, child abuse reporting, prison rape elimination act (PREA) and active shooter training in the first few weeks of their employment prior to the 180 days of hire. The program's contract also specified the new hires to complete training in stress management, gender responsive services, positive reinforcement techniques and strategies, emotional/behavioral development of children/adolescents, risk factors for delinquency and treatment, physical development and common health issues, restorative justice, risk factors and triggers relating to history of victimization, post-traumatic stress disorder, victimization, exploitation, domestic violence trauma, recovery issues, universal precautions, bloodborne pathogens, risk factors/triggers relating to homicidal risk and homicidal prevention, immediate access to emergency medical, mental health/substance abuse services, program treatment model and the Massachusetts Youth Screening Instruments - Second Version (MAYSI-2), where applicable. All five staff received the required training. The staff also received training in grievance process, infection control, exposure control plan, behavior management system, intended and safe use of tools, mental health and substance abuse treatment services, as well as sex offender training. All of the instructors delivering PAR, CPR and first aid had the required training and the program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training, including course names, descriptions, objectives, and training hours for any instructor led training, on January 16, 2019. Four of the five staff's training was documented in

the Department's Learning Management System (SkillPro); the remaining staff had three trainings not documented in SkillPro but were able to provide documentation on training completion.

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

Five eligible staff were reviewed regarding in-service training. All five staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), protective action response (PAR) update, professionalism and ethics, suicide prevention, as well as grievance process, emergency response and emergency drills, infection control, bloodborne pathogens, exposure control plan, behavior management system, mental health and substance services training. The five staff had the required twenty-four hours of in-service training. One of the staff was applicable for supervisory training and received eighteen hours of training in the areas of management, leadership, personal accountability, employee relations, and communication skills. The program's contract specifies supervisory staff shall complete forty hours of in-service training a year; this had been noted at the last annual compliance review and a deficiency had been assigned regarding the same training year; therefore, no deficiency is being assigned at this time. The program has addressed this issue for the 2019 in-service training year.

All of the instructors delivering PAR, CPR and first aid had the required training, as well as all licensed nurses having current certificates in CPR with AED.

The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training, including course names, descriptions, objectives, and training hours for any instructor led training, on January 16, 2019. The program has an annual in-service training calendar, which is updated as changes occur. The program provided a list of staff considered to be direct-care staff.

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's facility operating procedures indicated the assistant facility administrator shall provide training to all program staff on the grievance process, facility operating procedure for grievances and required documentation with the staff pre-service training.

The five pre-service and five in-service training records indicated all staff received the required grievance process and procedures training.

A review of documentation indicted the grievance process includes the informal phase in which the youth can speak to a staff about the concerns or issues, and if not resolved can fill out a "speak out" form. If the form is not sufficient, the youth can decide to complete a grievance form which is collected on a daily basis from the box in each unit/module. The forms are provided to administration within twenty-four hours to determine if an issue violates the youth's rights or if it does not affect them. The grievance officer will meet with the youth within forty-eight hours. If the issue is not resolved, the grievance will be provided to the facility administrator, who will investigate and speak to the youth within forty-eight hours.

The program had two grievances since the last annual compliance review, both were reviewed. All grievances are maintained for a minimum of twelve months.

One of five staff interviews indicated the grievance form is placed in the grievance box when completed and the program director checks the box daily and discusses the issues during the daily management meeting; the youth is seen within twenty-four hours, and youth and staff will sign the form when in agreement. Another staff said the youth can request a form any time but did not know about possible timeframes regarding the different phases. The third staff stated a grievance is turned into the supervisor, the supervisor will attempt to resolve the issue, if not the assistant facility administrator will address the grievance. Another staff mentioned the youth get their own forms and fill them out and put it in the grievance box. The last staff indicated the administrator addresses the grievances.

Five youth interviews indicated one did not remember timeframes but knew the grievance was answered in one day; another said never he had filed a grievance; one completed a grievance to ask for new shirts/socks, but no one came to talk to him, but the assistant facility administrator came and provided the items. He further indicated he did not sign anything, and this was done a week later. One youth said the forms are located on the wall, but he was not able to explain the process because he has not filed a grievance since being at the program.

The facility administrator interview indicated all youth shall be treated fairly, respectfully and without discrimination and enjoy all constitutional rights afforded to them under both state and federal law. Filing a grievance shall not result in retaliation or barriers to services. There is no time limit for a youth to file a grievance, and there is no requirement prohibiting a youth from filing a grievance without first using the informal complaint and resolution steps. The grievance process shall include an external level of control. Program staff shall encourage informal resolution of complaints at the lowest possible level and encourage two-way communication between staff and the youth; however, all youth shall have access to formal grievance procedures which allows them to grieve actions, errors and omissions violating their rights. He ensures youth wishing to file a grievance are provided with the proper forms, assistance and instructions on the preparation and submission of the grievance. He also ensures all staff are trained on the requirements of this policy. Youth shall not be subject to reprisal for use or participation in the grievance procedure. Any allegations of this nature are thoroughly investigated by him and he designates a staff person to serve as the program's grievance officer responsible for receiving and investigating grievances. Copies of the policy or a complete summary of the policy are posted in locations accessible to the youth. He or designee maintain all youth grievances, both resolved and active, in a file for a period of one year from the date the grievance was submitted.

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

The program had eight trainers currently delivering several different delinquency intervention models; Teen Relationships, Young Men's Work (YMW), Impact of Crime (IOC), and Thinking for a Change (T4C). All staff completed the training in the specific intervention they were delivering. The program is providing youth with the contractually required services and the written descriptions address the delinquency interventions strategy utilized. The program provides a minimum of sixty percent of planned programming or activities during the youth's awake hours and a review of the group sign-in sheets indicated the services are delivered as indicated.

A review of five youth records indicated four of the five youth were involved in a delinquency intervention, which is evidenced-based and addressed an identified need; the remaining youth started an intervention but due to missing several sessions while being at a detention center, has to await the next group starting. Four of the five youth did not have a performance plan, until recently, which addressed an identified priority need, but the four youth were still involved in a delinquency intervention.

The program director was interviewed and indicated youth are matched to staff/counselors/case managers and intervention groups by conducting a review of comprehensive evaluations and previous history prior to admission. A staff member's education and work experience are considered when determining which staff would deliver life skills training or groups, by screening their educational background and the staff must be trained according to the Department's standards. T4C, IOC, and Life Skills Training (LST) are evidenced-based delinquency intervention models being implemented to address the priority needs of youth.

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

The program provides the Teen Relationships and Skill Streaming curriculum as a life and social skills intervention service addressing communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management and critical thinking, including problem-solving and decision-making skills. The youth are matched to intervention groups by conducting a review of comprehensive evaluations and previous history prior to admission. The program delivers one curriculum once a week for two sessions a day and the other once a week for one session a day. A review of sign in sheets indicated the interventions are provided as indicated.

Five youth interviews indicated they participate in mental health groups, Young Men's Work (YMW), doing worksheets and watching movies; Life Skills, Impact of Crime (IOC), during which they engage in discussions to prevent crime; 100 interactive activities, where they complete worksheets, watch movies related to the topic; and substance abuse groups, including

discussions about the harmful effects. The youth also indicated they have learned the following skills participating in the groups: walking away from problems, not always verbally responding all the time, how to improve self-esteem, coping skills such as breathing, and how drugs harm. All five said they have been able to practice the skills learned. One youth called him a name and he just ignored him, another used believing in himself to avoid a fight, one more used the coping skills taught, a fourth used the breathing when he gets angry/sad/annoyed and the last said he received IOC, where he learned how to control behavior because when he first got to the program was unable to control anger, now he has used techniques to control his anger.

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

The provider's contract requires Impact of Crime (IOC) to be delivered as a service to youth to address restorative justice practices.

All of the facilitators for the IOC groups had the required training. A review of the program's activity schedule indicated the group is delivered two days a week for one hour each, which is delivered as indicated according to a review of group sign-in sheets.

A review of five youth records indicated four were participating in IOC; the remaining youth had been in detention on several occasions; therefore, has to start a new group when it is being delivered.

An interview with program staff indicated the program provides guest speakers who have been victims of crime, through the education department, to speak with youth, regarding how their lives have been impacted as a result of being a victim. They also have youth who have been placed on privilege suspension for behavior issues, disturbances, or property damage. They earn their way off of suspension early by being able to identify the behaviors, which placed them on suspension, and discuss what they have learned from these behaviors. They are also required to identify how they will handle themselves in order to prevent future behaviors. The program also provides opportunities to complete community service hours which are assigned by the treatment team; to participate in off campus projects, such as helping feed the homeless as a means of reparations of harm caused, and also giving back to the community. The restorative justice practices the program provides assist youth in accepting responsibility for harm they have caused, challenging them to recognize and modify their irresponsible thinking, teaches them about the impact of crime on victims, their families, and their communities, exposes them to victim's perspectives through victim speakers and provides them opportunities to plan and participate in reparation activities.

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

The provider's contract indicates the required services for gender-specific programming are to be Young Men's Work (YMW) and 24:7 Fathering Handbook. The program provides the YMW and 24:7 Fathering Handbook curriculum, as well as playing football, teaching them how to wear a tie, and healthy sexuality. The activity schedule provides gender-specific programming; which a review of the sign in sheets validated is delivered according to the schedule.

The facility administrator was interviewed and indicated the program uses YMW and 24:7 Fathering Handbook curriculum to address gender-specific programming needs.

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's facility operating procedure indicates the case manager places a youth on the permanent security alert system if there is a history of escapes or attempted escapes, the youth is classified as a predator, sexual or otherwise, a history of sexual aggression, sexual assault, or sexual victimization of others has occurred, a history of related assaultive, or threatening behavior toward youth or staff persons. The case manager is to document applicable alert status on the admission classification form and the alert communication board, as well as immediately enter the specific security alert into the Department's Juvenile Justice Information System (JJIS) system. The staff mentor is to review the previous two shifts with incoming staff during shift report and ensure all youth on alert status are reviewed, including new admissions. The youth care workers are able to place a youth on security alert status. They shall notify the staff mentor on duty, who is then responsible for notifying the assistant facility administrator (AFA). The AFA shall remove youth from alert status following completion of applicable screening or discussion with youth's intervention and treatment team as warranted and update alert communication board once youth is taken off of alert status, ensuring communication with staff mentor and all requirements of the security alert are met.

A review of five youth records indicated the program alerts in JJIS and on the internal alert log where consistent and when required, the removal or downgrade was updated in both systems.

The facility administrator was interviewed and indicated the formalized procedure was in place with the healthcare staff, to review the important medical issues pertaining to the youth at the program, in the morning management meeting, which is conducted every business day, and the

admission classification documents, on the day of admission. The internal alert process is for the program to maintain a continually updated, internal alert system which is easily accessible to program staff and keeps them alerted about youth who are a security or safety risk, including escape risk, suicide or other mental health risk, medical risk, sexual predator risk, and other assaultive or violent behavior risk. This system shall alert program staff when there is a need for specific follow-up or precautionary measures or more vigilant or increased levels of observation or supervision is needed, and by assisting staff when making treatment or safety and security decisions.

Five staff were interviewed and indicated the staff are made aware of youth's alerts during briefings, morning management meetings, the alert binders, and face sheets.

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

The program separates the youth records into an individual healthcare record and an individual management record. The file tabs in the individual management records contained the youth's name, the Department of Juvenile Justice Information System Identification (DJJID) number, date of birth, county of residence, as well as committing offense. The individual management record was also divided into legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous sections. All records reviewed were labeled "Confidential", as was the locked room they were stored in and the cabinets they were kept in.

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

The program's facility operating procedure indicated the assistant facility administrator or designee will meet with the youth advisory board members, and as part of the meeting receive input from youth related to recreation and leisure activities. The agenda, minutes and sign-in sheets shall be documented for each meeting and maintained in a binder for reference.

A review of the youth advisory board meeting minutes, agenda and sign-in sheets indicated the advisory board meets on a monthly basis; the last six months were reviewed, the February minutes could not be located. The program has youth complete youth surveys on Survey Monkey once every quarter to solicit input.

Three of five youth interviews indicated the use of "Let's talk" for idea suggestions, one indicated they can write down a suggestion on a piece of paper to provide to the staff and another said staff came in the cottage a couple of weeks ago and asked what are some changes they would like to see in the program.

The facility administrator was interviewed and indicated the use of the youth advisory board and the "Let's Talk" form are being utilized as a form for youth to provide input, as well as youth surveys.

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

A review of the last six months of advisory board meeting minutes, agendas and sign-in sheets indicated the board met on a quarterly basis. The advisory board members consist of law enforcement representatives, the judiciary, business community, school board, faith community, lesbian, gay, bisexual, transgender, questioning, intersex (LGBTQ) community, as well as victim advocate partners. The program provided recruitment efforts for parents/guardians of prior youth involved with the system.

The facility administrator was interviewed and indicated the community advisory board meets quarterly and includes representatives from a local Narcotic Anonymous/Alcoholic Anonymous Group, Project Bridge, Yoga for Kula, and a teacher from a specialized program. The community advisory board provides information about services which the youth can benefit from once released.

The team interviewed one of the board members who indicated she was a new board member and had participated for the first time in the last board meeting. She stated the board provides her involvement into the program activities by listening to her concerns or questions during the meeting.

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

The program's policy and procedures indicated the facility administrator shall maintain one copy of the program's policy and procedure manual at all times.

The program conducts all campus wide meetings to inform staff of pertinent information. A review of the monthly all campus wide meeting minutes was conducted, which included information/reports received by the Department. The program also conducted daily management meetings to discuss program systems and data, as well as collected parent/guardian and youth surveys quarterly on Survey Monkey to obtain feedback to make necessary changes to the program; one result of such survey was the change in their food vendor.

The facility administrator was interviewed and indicated the program has currently seventeen vacancies. To address staff turnover and morale issues, as well as what is completed regarding retention planning, the company hosts job fairs and recruiting events, as well as having an open walk-in schedule for potential hires. The company also offers incentives for winning employee of the month and sign-on bonuses. Furthermore, parent/guardian and youth surveys are used by the program regarding outcome data and this data is reviewed by corporate prior to distributing to the program. Performance outcome report results are then considered and discussed amongst the management team. Any reports published annually by the Department is analyzed by management and it allows for the program to track trends and discuss in-house systems. The program conducts monthly mandatory all campus meetings, staff mentor meetings, and

daily shift briefings for every shift to inform staff of important development or changes within the program.

Five staff were interviewed and indicated staff meetings are held monthly; one said there are also daily management meetings. The staff stated safety/security issues, mental health drills, medical, dietary alerts, the Comprehensive Accountability Report (CAR), escapes and the corrective action steps are discussed. All issues related to the facility, previous meetings, youth attacking staff and how to deal with this type of situation, medical, and gang updates, ratio, precautionary observation information, monthly awards, documentation, ten-minute checks, staff encouragement, staff of the month, and if there are new employees are discussed at these meetings.

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

The programs facility operating procedure indicates each employee of the program shall be evaluated once annually by an authorized person specifically designated to conduct the evaluations. The evaluations shall be placed in the employee record and be given to the employee. There shall be a discussion with the employee, in a conference, with the manager/supervisor conducting the evaluation.

A review of the program's job descriptions indicated each staff member's performance standards are clearly identified. The five staff evaluations reviewed reflected those standards in the evaluation, which were completed annually.

The program's key personnel, as outlined in the contract, are being maintained. The program did have a vacancy for the recreational therapist from June to August 2019, but it was filled two weeks prior to the annual compliance review.

The program director was interviewed and indicated staff are evaluated after their first ninety days and annually thereafter.

Five staff were interviewed and two indicated they had been at the program for less than a year and where unable to state how often staff performance evaluations are being conducted. One of the remaining three stated evaluations are completed every six months and the other two said annually.

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

The program has a written policy and procedures regarding recreation and leisure opportunities for youth. The program employed a recreation therapist, as required by their contract, during the annual compliance review until June 2019. A new recreation therapist was hired in August 2019. Both of the staff have a bachelor's-level degree in either sports management or recreation. The program's activity schedule outlined a block of time for daily large muscle activity. A separate recreation therapy schedule was found to depict activities during recreation time, which included basketball, football, four square, dodgeball, soccer, incentives, and awards. In addition, the program has leisure time which is time allotted for youth to engage in their chosen leisure

activities such as letter writing, reading, church, and board games. Youth are encouraged through recreation, leisure, and recreation therapy to explore interests and engage in constructive leisure activities. Different incentive events are held to reward youth who have achieved good grades in school and good behavior in the program. The events were facilitated by the recreation therapist. Youth who earned off-campus trips enjoyed different activities such as the Pro Bowl experience at Disney World, a trip to the aquarium, and a trip to the theatre. All recreation and leisure activities are geared toward helping youth to develop social and cognitive skill development while also fostering teamwork and communication. During the program tour, a covered pavilion was observed to help protect youth from potentially hazardous weather while allowing youth opportunities for outdoor large muscle activity. Staff were also observed offering youth water while at outdoor recreation. Each youth's treatment plan included a wellness goal. The program's contract requires the recreation therapist to be a part of the treatment team; however, prior to the recreation therapist's resignation in June 2019, there was no documentation they attended either of the two applicable treatment team meetings.

The program utilizes a monthly student advisory board to allow youth the opportunity to provide feedback into programming. In addition, youth are surveyed quarterly by the program to give feedback into programming, including recreation opportunities.

Five youth were interviewed and each reported they receive varied opportunities throughout the day for mental and physical exertion for at least an hour each day. The youth provided examples of recreation activities they engaged in, such as basketball, football, kickball, four square, soccer, weights, and jump rope.

Five staff were interviewed and each confirmed the youth receive recreation each day and are offered a variety of opportunities.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures to address initial court notifications and contacts to parents/guardians. The program is required upon a youth's admission to submit a notification within five days to the committing court, and the juvenile probation officer (JPO). Additionally, within twenty-four hours of admittance, to complete a phone contact to the parent/guardian and mail a letter with pertinent information to the youth's parent/guardian within forty-eight hours. Five youth case management records were reviewed. All records contained supporting documentation on completion of required communications to each youth's parent/guardian, JPO, and committing court, in advance of the required timeframes.

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

The program has a written policy and procedures to address each admitted youth is oriented on the programs rules, procedures, schedule, and applicable services. Upon a youth's admission a youth handbook is provided outlining in detail all pertinent elements emphasized in the Department's rule. The program uses an orientation checklist to ensure all required topics are addressed with the youth including services available, daily schedule conspicuously posted to allow easy access for youth, expectations and responsibilities of youth, written behavioral management system, including rules governing conduct and positive and negative consequences for behavior, availability of and access to medical and mental health services and access to the Florida Abuse Hotline or the Central Communications Center (CCC). The orientation also contained the program's zero tolerance policy regarding sexual misconduct, including how to report incidents or suspicions of sexual misconduct; special accommodations are available to ensure all written information about sexual misconduct policies, including how to report sexual misconduct, is conveyed verbally to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled, right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures. The items considered contraband including illegal contraband, possession of which may result in the youth being prosecuted, performance planning process involving the development of goals for each youth to achieve, dress code and hygiene practices, procedures on visitation, mail and use of the telephone, expectations for release from the program, including the youth's successful completion of individual performance plan goals, recommendation to the court for release based on the youth's performance in the program, and the court's decision to release, as well as community access, grievance procedures, emergency procedures, including procedures for fire drills and building evacuation, facility tour and general layout of the facility, focusing upon those areas which are and are not accessible to youth, assignment to a living unit and room, treatment team and a staff advisor or youth group and medical topics were part of the orientation. A review of five youth case

management records revealed on the day of admission the youth signed a document acknowledging receipt of a youth handbook and completion of an orientation.
During the annual compliance review period, there were no new admissions scheduled; therefore, no observation of an orientation process was completed.

Five youth interviews confirmed completion of an orientation within twenty-four hours of admission to the program.

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

The program did not have any youth eighteen years or older since the last annual compliance review period; therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures addressing youth classification factors, procedures, and reassessments for activities. The program procedure includes the utilization of a standard classification form to identify vital information for assigning a youth to a living unit, sleeping room, and youth group or staff advisor. This form highlights pertinent information, such as the youth's demographics, physical characteristics, maturity level, and identification or suspected risk factors for suicide, medical, escape and/or security. The program has an internal alert log which is updated on a daily basis and is signed by all staff at the beginning of their shift to acknowledge a review of all alerts.

Five youth case management records were reviewed. All records included the standard classification form completed including physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. Four of the five youth were applicable for identified or suspected risk factors. Each youth alert was maintained by the program internal alert system and was entered into the Department's Juvenile Justice Information System (JJIS). One exception was noted. On April 16, 2019, Florida Department of Juvenile Justice Prison Rape Elimination Act (PREA) policy and procedures FDJJ 1919 was updated. One of the added requirements notes prior to a youth room assignment a new Victimization and Sexually Aggressive Behavior (VSAB) must be completed in JJIS. One of the five youth records were applicable for implementation of this new process but was not completed until the second day of the annual compliance review. The program is a non-secure program, which provides opportunities for youth to participate in

work-projects and off-campus activities. The program conducts monthly reassessments of each youth in the program to determine eligibility. A review of the program's risk assessment binder confirmed completion of a risk assessment for consideration with increase in youth privileges for each of the five youth.

An interview with the facility administrator was conducted, which revealed a classification meeting is held with all applicable staff involved in provision of services for the youth. This classification meeting is responsible for considering all factors in assigning a youth to a living unit and sleeping room.

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

The program has a written policy and procedures in place addressing gang identification and notification to law enforcement and school district. Five youth case management records were reviewed; one was applicable for gang involvement. The program was able to provide one other applicable youth for possible identified gang related activities. In one of the two applicable records, the youth was identified as a documented gang member prior to admission to the program. A notification letter to law enforcement and the juvenile probation office (JPO) was sent on the day of admission; however, the school district was not notified until one month later. The program acknowledged the findings noting there was an oversight; however, the lead teacher did receive verbal notification of the youth's alert as education actively participates in the program's daily morning management meetings, wherein alerts are discussed. The other youth had a recent suspected gang affiliation alert placed in the Department's Juvenile Justice Information System (JJIS) by a gang liaison officer from another Circuit eleven days prior to the annual compliance review. On the first day of the annual compliance review, the program became aware of the alert and immediately sent out a notification letter to law enforcement, JPO, and school district. The program's practice is for the director of case management to pull all alerts on each youth monthly and review them with the management team. Each youth had a documented gang alert in JJIS and the program's internal alert system.

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

The program has a written policy and procedures to address implementation of gang prevention and intervention strategies for youth identified in gang related activities. The program maintains a gang binder, which contained all activities completed with the gang identified youth. The program utilized the Gang Resistance and Drug Education (GRADE) curriculum as a selected gang intervention, which is facilitated monthly by the trained case management director.

Five youth case management records were reviewed; one was applicable for gang identification. The program was able to provide one other applicable youth for possible gang identification. One of the two youth case management records revealed an Individual Performance Plan (IPP) addressing the need for gang awareness and intervention services was added during the IPP update, which was completed eighty days late; not the initial IPP. A review

of the monthly gang group sign-in sheet revealed the youth participated every month since admission to the program. The other youth had been identified as a suspected gang affiliate only a few weeks prior to the annual compliance review and had not yet begun intervention activities; however, the youth's IPP had been updated with gang goals and he was scheduled to participate in the next group. The program provided the opportunity for each youth to attend a needs assessment and performance plan meeting to provide input into areas which needed to be addressed and verified their input and review of goals identified by signing the IPP.

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

The program has a policy and procedures in place to address completion of a Residential Assessment for Youth (RAY) assessment and reassessment.

The Department launched a new assessment tool titled Residential Assessment for Youth (RAY). The previous assessment tool utilized was the Residential Positive Achievement Change Tool (R-PACT). The Department communicated to contracted programs the RAY must be completed for each youth admitted to a program after April 8, 2019; however, the RAY was not available to the program for use until May 6, 2019.

Five youth case management records were reviewed, revealing three were applicable for completion of an initial RAY. The program was required to complete initial assessments for each youth within thirty days of admission. For one of three applicable youth, the RAY was twelve days late, in one other it was four days late, and the third had the RAY completed prior to the thirty-day requirement. The program acknowledged the oversight. The other two of the five youth were applicable for completion of a R-PACT; both were conducted in advance of the timeframe.

None of the five youth case management records were eligible for a RAY reassessment. Two of the five youth who had an initial R-PACT had an updated RAY. All five youth RAY assessments were maintained in the Department's Juvenile Justice Information System (JJIS) with a copy in each youth's official case record.

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

The program has a written policy and procedures to ensure within thirty days of a youth admission a Youth Needs Assessment Summary (YNAS) is completed.

Five youth case management records were reviewed. In three of the five youth records, the YNAS was not completed within the required timeframe. The first youth was thirteen days late, the second seven days late, and the third three days late; the remaining two were completed on

time. The program acknowledged the oversight. All five youth records contained the YNAS documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures addressing the Individual Performance Plan (IPP) development, goals, and transmittal.

In three of five youth case management records, the youth's IPP was created after thirty days of admission. The first youth IPP was fourteen days late, the second thirteen days, and the third five days. The other two were completed within thirty days of admission. In all five, the IPP was created after the initial assessment was completed and developed with input from the youth, treatment team leader, administrative representative, living unit representative, educational and treatment staff, and where applicable the Department of Children and Families (DCF) case worker. All IPPs were signed by the youth, intervention and treatment team leader and the parent/guardian. In two of the five, the recreation therapist was to be part of the development of the IPP, but there was no input documented and no signature captured. All five IPPs outlined the individualized goals identified during the initial assessment process, the top three criminogenic needs, and youth and staff responsibilities to complete each goal. Three of the five youth IPP's did not have transition activities, target court-ordered sanctions, and a specific delinquency intervention added to their respective IPP, and one of the three did not have the required gang intervention outlined until two days prior to the annual compliance review. The program acknowledged the findings of the first youth goals being added eighty days late, the second ninety-seven days, and the third one hundred and ten days late. In all five, a copy was provided to the youth; in addition, the plan was forwarded to each youth's parent/guardian and/or the DCF case worker, the juvenile probation officer (JPO), and the committing judge within ten days.

Five youth interviews were conducted, which revealed all were able to explain their goals in detail and noted obtaining a copy of their IPP.

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

The program has a written policy and procedures to address the revision of each youth's performance plan when determined necessary by the intervention and treatment team.

Five open and three closed youth case management records were reviewed. All eight youth had an initial Residential Assessment for Youth (RAY) completed in May 2019; therefore, a RAY reassessment was not required. Each of the eight revisions to the Individual Performance Plan (IPP) were based on newly acquired/ revealed information and demonstrated progress towards completion of goals. The three closed youth records contained IPP revisions needed to facilitate transition activities during the last sixty days of stay in the program.

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

The program has a written policy and procedures to address the completion of performance summaries and the transmittal of the summaries. The program is required to complete performance summaries within ninety-days from the completion of the youth's Individual Performance Plan (IPP) and develop the release summary at least forty-five days prior to the youth's release from the program.

Five open and three closed youth case management records were reviewed, all containing a ninety-day summary completed within the required timeframe. Each record contained a performance summary detailing all vital elements; such as, overall treatment progress, academic input, level of motivation and behavior, interactions with peers and staff, overall behavior adjustment to the program, significant positive and negative events. All eight youth were provided the opportunity to review the IPP, document their comments, and receive a copy. Each summary included designated signatures from the youth, treatment team leader, and facility administrator, and the original copy was maintained in their respective record. The three closed youth records contained completed performance summaries prior to one youth release and two youth discharged from the program; in addition, justification for release or discharge. All eight records contained copies of each youth respective summary with a written correspondence sent to the juvenile probation officer (JPO), the committing court, the parent/guardian or where applicable the Department of Children and Families (DCF) case worker within ten days of completion. Each of the three youth closed records contained a justification for release sent with a Pre-Release Notification (PRN) to the JPO at least forty-five days prior to the anticipated release and a signed copy maintained in each youth record. There were no records objected by the court or applicable for the sexually violent predator program. Once the program obtained approval from the court for release the program mailed letters to each of the three parents/guardians to inform of the anticipated release dates. All three applicable exit assessments were completed upon approval notice of release.

Two of five youth interviewed were not applicable. The remaining three reported having copies of their performance summaries.

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

The program has a written policy and procedures to address facilitation and encouragement of parent/guardian involvement/participation in the case management process.

Five youth case management records were reviewed for parental involvement in case management services. A parent handbook detailing a description of the program services as well as the policies and procedures was mailed out to each parent/guardian. The program documented all attempts made of parent/guardian involvement in the case management process through mail and phone contacts. Treatment team meetings, family therapy sessions, family day, and visitation provide the program opportunities to facilitate and encourage parent/guardian involvement. Each youth record contained documentation validating parent/guardian participation in the assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. The program included encouragement of parent/guardian participation by phone or provision of written or verbal input, when unavailable to attend meetings. Parent/guardian involvement also included mailing copies of documentation as it relates to youth's progress in the program and to obtain required signatures. During the annual compliance review, three youth treatment team meetings were observed. One parent/guardian was unavailable to participate, and the program could not leave a message due to the mailbox being full. Two parents/guardians were readily available and participated in the meeting.

An interview with the facility administrator confirmed parent/guardian involvement in case management processes include case managers communicating through phone and mail correspondence.

Five youth were interviewed, confirming the program maintains phone and mail communication practices to promote parent/guardian involvement in treatment team meetings and other case management processes.

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

The program has a written policy and procedures to ensure each youth is assigned a treatment team. In all five case management records reviewed, the treatment team members included the treatment team leader, the youth, an administrative representative, the living unit representative, the treatment staff, written input of the educational and nursing staff, a Department of Children and Families (DCF) case worker where applicable, the juvenile probation officer (JPO), the parent/guardian, and where applicable the transition services manager. The program policy requires the recreational therapist to provide input regarding youth's progress on the wellness goal to the youth's therapist for inclusion into the monthly treatment team. The recreation therapist position was vacant from June to August 2019. Three out of the five youth records required written input from the recreational therapist for the month of May 2019. Two out of the three youth had no supporting documentation regarding written input from the recreation therapist providing or overseeing provision of intervention services as required, nor a signature.

The third youth formal treatment meeting progress notes included a quote from the recreational therapist; however, there was no physical written input from the recreation therapist in the youth record. In all five records, the JPO and the youth's parent/guardian/DCF case worker, as well as other pertinent parties were invited and encouraged through advanced notification to participate in the treatment team meeting.

Three youth treatment team meetings were observed. During one treatment team meeting, the JPO notified the program of the inability to attend the meeting due to another obligation and requested a return call. In another the parent/guardian did not answer the phone and the program was unable to leave a voicemail due to the mailbox being full.

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

The program has a written policy and procedures to address incorporating the youth's treatment into their performance plan. Three of five youth case management records reviewed did not have the mental health/substance abuse treatment, academic, and the wellness and safety plan incorporated into their individualized performance plan. Each required plan was added to the three youth performance plans two days prior to the annual compliance review. The program had one Department of Children and Families (DCF) applicable youth. The youth did not have the DCF care plan added to the performance plan until two days prior to the annual compliance review. The program acknowledged the findings of the first youth's other plans being added to the performance plan eighty days late, the second ninety-seven days, and the third one hundred and ten days late. In the other two youth case management records, the plans were added to the initial performance plan. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a policy and procedures to address formal treatment team meetings and informal progress reviews. The program assigns each youth to a treatment team, which includes various program area staff responsible for providing, or overseeing provisions of intervention and treatment services for the youth. The delegated treatment team members participate in the youth formal treatment review at least once every thirty days and applicable members in one bi-weekly informal progress review.

Five youth case management records were reviewed, which contained the completed documentation of formal and informal meetings conducted within the required timeframes. All five records treatment team meetings included documentation on required elements: youth name, date of review, comments from treatment team members, brief synopsis of youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, reassessment results, and the youth was able to demonstrate skills learned.

An observation of three youth treatment team meetings was conducted. All youth demonstrated their skills learned from the program. All required program treatment team members were present, except for education staff who provided written input. Two of the three youth parent/guardian and juvenile probation officer (JPO) were present or on the phone, and actively participating with follow-up questions to the program and youth. One youth parent/guardian was unavailable, and the program was unable to leave a message due to a full mailbox. One JPO was unavailable to participate in the meeting and requested a return call. During each youth treatment team meeting, all members in attendance actively participated in discussing the youth's overall performance and progress in the program. The program provided a copy of all three observed treatment meetings, which included all the required signatures and elements. Each youth anticipated release date was reviewed in the Department's Juvenile Justice Information System confirming required updates to the information.

Five youth interviews confirmed the program providing each youth the opportunity to demonstrate learned skills. Four of the five youth indicated their program and treatment progress was reviewed with them.

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

Three closed records were reviewed, each contained the required documents including a sample application, résumé summarizing education, calendar with an appointment for Career Source Center, appropriate documents with essential information for the youth to obtain employment and the youth's parent/guardian and juvenile probation officer (JPO) being aware of the youth's vocational plan. One of the records did not have a sample application; counselor stated the youth worked on post-secondary education and employment.

The program offers Type 2 career education programming services appropriate to the age group, educational abilities and goals, as well as the length of stay and custody characteristics of the youth it serves. The career education services and assessments are offered through the Orange County Public School System addressing communication, interpersonal, and decision-making skills.

The lead teacher interview indicated the following career education services and assessments are offered to youth in the program: résumé building (cover page, résumé, and references), Florida Food Handler's Certification (responsible handling and preparation of food), Florida Ready to Work (math application, reading for information, locating information), ICT – Internet Communication Technology, IBA- Internet Business Associates, Typing Web (Proficiency in typing), test of adult basic education (TABE) testing (requirement for certain jobs and training programs), ASVAB Testing – Armed Services Vocational Aptitude Battery, assessed monthly, GED (General Education Diploma)Ready/GED (the program is an approved administration site for GED assessments). The teacher furthermore indicated students receiving high school diplomas will receive diplomas from their home school, also job application training and completion, and cold call interviews with potential employers. Each student has a full portfolio which highlights their career services certificates and assessments. These documents are filed in the administrative portable for each student. Employability skills and job interview information is documented with the education advocate. Teachers and program assistants usually do not attend treatment team meetings being treatment team meetings are held during school hours. However, if a teacher wants to attend a treatment team meeting coverage will be provided. The ESE (exceptional student education) support facilitator will attend treatment team meetings.

The interview with the facility administrator indicated the youth are offered GED and Safeserv for career/vocational services.

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.	

Students are attending school for 250 days of instruction, distributed over twelve months, a minimum of twenty-five hours weekly, with less than ten hours for teacher planning/training. A review of the logbook showed there is a pattern during first-period, classes are starting twenty to twenty-five minutes later than the scheduled time, not effecting the minimum of required hours a week of educational instruction provided to the youth. Students receive credit for the educational and training experience provided.

The lead teacher interview indicated there are four periods of class sessions a day on Monday, Tuesday, Thursday and Friday from 7:30 a.m. to 2:50 p.m. and on Wednesdays 7:30 a.m. to 1:00 p.m.

The youth interview results indicated three of five stated there is a lot of interruptions during educational instruction due to the weather or escape situations. Two said there are no interruptions during educational instruction.

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

Three closed case management records reviewed had an individual education transition plan developed based on the post-release goals, with a specific plan for continuation of education and/or employment. The youth, parent/guardian, instructional personnel, Department personnel, post-release school district personnel, certified school counselor, registrar or designee were involved in the development of the plan. The education transition plan addressed the services and interventions based on the student's assessed educational needs and post-release education plans; the educational placement was based on the individual needs and performance of each youth and included specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services in all three records. All of the records had employability as a transition goal and the plan included provisions for continuation of education and/or employment, a sample employment application, a résumé, an identification card, information for a local Career Source Center, appropriate documents to obtaining employment upon leaving the program, and documentation the youth's case manager and parent/guardian were made aware of the plan, documents and post-release discharge plan. One of the records did not have a sample application; counselor stated the youth worked on post-secondary education and employment.

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

The program has a written policy and procedures to ensure the treatment team is planning for a youth's successful transition to the community upon release from the program. The policy outlines transition planning processes, transition conference, and a Community Re-entry Team (CRT) meeting to be conducted within at least sixty days prior to a youth's projected release from the program.

A review of three closed youth case management records, revealed a CRT meeting, transition and exit conference was conducted within the required timeframes. Two of the three youth records included an email/outlook invite from the supervising juvenile probation officer (JPO) for youth and case manager participation in the CRT meeting. One youth's JPO mailed the CRT meeting invitation to the program which was maintained in youth record. The program mailed invitation letters for all three youth parent/guardian and JPO to attend the transition and exit conferences. The program educational staff and transitional staff were invited by e-mail correspondence to all conferences. The attendees for each conference included the youth, the treatment team leader, the program director, and other pertinent treatment team members; in addition, written input from educational staff. One youth did not require input from education staff due to obtaining a General Education Diploma (GED) prior to entry to the program. Each youth actively participated in the development of their respective transition plan. The program reviewed, documented and discussed necessary revisions to the performance plan, in addition, identified transitional activities, target dates, and identified persons responsible for completion of goals. All three youth records contained required signatures of attendees in meetings and mailed copies sent to those not in attendance. One youth's JPO was present in person for the transition conference, one JPO attended the meeting by telephone, and the signed copy of the plan was returned to the program and another JPO was unable to attend the meeting; however, provided written input and emailed acknowledgement of receiving a copy of the transition plan from the program.

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 program has a policy and procedures to address the assembly of an exit portfolio for a

youth being released back into the community. Three closed records were reviewed for completion of an exit portfolio. Each record contained an exit portfolio including a state-issued identification card, copy of the youth's transition plan, calendar with dates, times, and locations of follow-up appointments in the community, a résumé, applicable educational records and/or vocational certifications. One youth did not require educational records due to already having a General Education Diploma (GED) prior to program admittance; however, did have vocational certificates earned while in the program. The exit portfolio information was forwarded by educational staff to the receiving school district for the two applicable youth. All three youth did not have a copy of a social security card and birth certificate in their portfolio. Two of the three youth already entered the program with their state-issued identification card; therefore, obtaining a social security card and birth certificate was not necessary. The program provided documentation of one attempt made to obtain documents from each of the three youth's parent/guardian. The program staff sent a copy of each youth's exit portfolio to the supervising juvenile probation officer (JPO). In all three records, the youth signature acknowledging receipt of their exit portfolio was maintained by the program.

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.	

The program has a written policy and procedures to address an exit conference for each youth. A review of three closed youth case management records revealed each exit conference was held at least fourteen days prior to youth discharge/release from the program. Each record included a mailed letter notification to the juvenile probation officer (JPO) of youth's release prior to the program conducting an exit conference. The exit conference for each youth was conducted separately from the Community Re-entry Team meeting. The youth, treatment team leader, parent/guardian, JPO for two youth, and other pertinent team members attended each exit conference. The program documented written input from education and all attendees who participated telephonically on the signature line. All three exit conferences contained a summarization of pending transition goals, finalized plans for the youth release, dates and signatures of attendees. A review in the Department's Juvenile Justice Information System (JJIS) confirmed the date of admission and termination correlated with the youth's records.

Standard 3: Mental Health and Substance Abuse Services

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

The program has policy and procedures addressing the designated mental health clinician authority (DMHCA). The position description includes the incumbent will act as the facility's mental health and substance abuse authority, provide at least one hour of clinical supervision a week for each unlicensed mental health therapist, ensure compliance with overlay requirements, proper completion of documentation and integration of a mental health delivery system which meets all state and federal guidelines, maintain technical and administrative duties, provide testing, individual, group, and family therapeutic activities, research, and participation in overall institutional programming and administration. The DMHCA is available on-call twenty-four hours a day, seven days a week for emergencies.

Interviews with other staff indicate the DMHCA is a licensed clinical social worker (LCSW) who is on-site forty hours a week, conducts clinical supervision for the non-licensed clinicians, sits on the facility management team, meets with the facility administrator daily in management meetings and meets with the psychiatrist, psychologist, and certified behavior analyst during their weekly visits to the program. The DMHCA provides direct care services such as initial behavioral interview, administration of the initial risk assessment tools, completion of Assessment of Suicide Risk (ASR), mental health and substance abuse evaluation and treatment plan, and guides execution of the mock suicide drills. The DMHCA also carries a small case load and provides individual, group, and family therapy when required. The DMHCA's license expires on March 31, 2021.

During a portion of the annual compliance review period, the DMHCA was on extended maternity leave; however, the DMHCA duties were completed by the corporate regional clinical director (a licensed clinical social worker), other regional licensed clinicians, and licensed clinicians already on-staff at the program. The review team found no gap in administrative oversight of clinical services during the DMHCA's leave period.

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

The program has policy and procedures addressing licensed mental health and substance abuse clinical staff. The program utilized the services of eight licensed staff to provide mental

health or substance abuse services. The program provided a copy of each clinician's license including for each contracted provider. The program contracts with a licensed psychologist to provide services. Each of the nine clinicians hold a clear and active license in her/his field with the Department of Health, Bureau of Medical Quality Assurance, expiring on March 31, 2021.

In addition, the program contracts for the services of a certified behavior analyst. The company provided services through two of the contractor's staff. Each of the two behavior analysts held current credentials with the Certification Board for Behavior Analyst.

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

The program has policy and procedures addressing non-licensed clinicians. The program listed five non-licensed clinicians providing services each of whom hold a master's-level degree in the field of counseling, social work, psychology, or a related human services field. Two of the non-licensed staff were registered with the Department of Health, Bureau of Medical Quality Assurance as a mental health counselor intern. The facility is licensed under Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. The program maintained documentation the licensed mental health clinician provided on-site one hour of face-to-face clinical supervision weekly to each non-licensed clinician providing mental health and substance services for the annual compliance review period. None of the non-licensed staff were applicable for completion of an Assessment of Suicide Risk (ASR) training.

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

The program has policy and procedures addressing mental health and substance abuse admission screening. The program utilizes a number of screening tools at admission to determine needs for further assessment. All youth are screened with the following tools: Massachusetts Youth Screening Instrument, Second Version (MAYSI-2), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and Assessment of Suicide Risk (ASR). Other screening tools include the following: Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Adolescent Psychopathology Scale – Short Form (APS-SF), Trauma Symptom Checklist for Children (TSCC), Reynolds Adolescent Depression Scale 2 Short Form (RADS-2SF), and Structured Assessment of Violence Risk in Youth (SAVRY). Procedures also include review of the commitment packet information, reports, and records. A licensed clinician conducts an initial clinical interview with each youth documenting a review of all available records.

Five youth records were reviewed for mental health and substance abuse admission screening. Each of the five youth received a screening by a trained staff utilizing the MAYSI-2 on the day of admission and included a review of all available information. All five instruments were scored on the Department's Juvenile Justice Information System (JJIS). One of the MAYSI-2s did not

identify the screener; however, the hard copy of the instrument in the youth record identified the screener as a licensed clinician who was also trained in administration of the MAYSI-2. Each of the five instruments indicated a need for further assessment, and two of them identified a youth at risk of suicide. Each of the MAYSI-2 instruments was completed by a licensed clinician although it is not required and a consultation with the DMHCA was documented on the mental health/substance abuse referral summary.

The program procedures do not include completion of a referral resulting from risk indicators on the MAYSI-2, since the same staff completing the screening instrument conducts the ASR. Procedures also require each youth to receive an ASR within twenty-four hours of admission regardless of the results of the screening instruments and to receive a new comprehensive mental health and substance abuse evaluation within thirty days of admission. Staff interviews indicated, and record reviews confirmed each youth receives an ASR regardless of the outcome of the MAYSI-2. A review of each youth's admission ASR revealed the assessment was completed by the same clinician who completed the MAYSI-2.

The facility administrator was interviewed and indicated the program utilizes the ASR, MAYSI-2, and SASSI as a screening process to identify youth at risk for mental health/substance abuse problems and suicide.

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

The program has policy and procedures addressing mental health and substance abuse comprehensive evaluations. The procedures include each youth receives a new comprehensive mental health and substance abuse biopsychosocial evaluation within thirty days of admission.

Five youth records were reviewed for completion of mental health and substance abuse comprehensive biopsychosocial evaluations. Each record included a new mental health and substance abuse comprehensive evaluation completed by a licensed clinician within thirty days of admission and signed by all required parties, after consent was obtained for substance abuse services. The reviewed evaluations contained all required elements, including identifying information, reason, diagnostic impression/formulation, background information, behavioral observations, mental status exam, discussion of findings, interview procedures administered, patterns of alcohol and drug use, impact of alcohol and drug use, risk factors for continued use, and recommendations.

Interviews with administrative staff revealed the comprehensive assessment is completed within twenty-one days of intake. If a youth presents with symptoms of emotional disturbance or mental illness which were not initially identified, a mental health referral is completed by either youth or attending staff to a mental health therapist to determine his need for additional mental health assessments or treatments.

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

The program has policy and procedures addressing mental health and substance abuse treatment. Program procedures indicate the composition of treatment teams is documented in the youth handbook and youth are introduced to the treatment team members during the admission process.

A review of five youth records for mental health and substance abuse treatment revealed each record contained a properly executed Authority for Evaluation and Treatment (AET) form and signed Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records form. Each record also contained counseling therapy progress notes on a form which included all required elements. In all five, the youth was assigned to a treatment team upon arrival to the program and the members included the youth, program administration, living unit representative, and other pertinent staff.

All five youth received treatment interventions in accordance with their applicable mental health and substance abuse treatment plan including individual, group, and family therapy. Each youth received interventions including substance abuse, mental health, skills building, youth relationships, and gender-specific activities. Groups consistently included no more than ten youth for mental health interventions and no more than fifteen youth for substance abuse interventions. All clinicians providing groups were master's-level therapists with appropriate training in the applicable intervention.

All five youth interviews indicated they were participating in groups and receiving specialized therapies. One youth further indicated he was participating in substance abuse groups.

Four of five interviewed staff indicated they do not facilitate any mental health or substance abuse groups. The fifth indicated being a licensed therapist and facilitated numerous groups. All five interviewed staff indicated only therapists facilitate group.

The team observed group therapy on Thursday afternoon conducted in the common area of the living unit. The clinician facilitating the intervention was prepared, utilized a written guide, and distributed a handout to all participants. Youth volunteered to read specific sections of the handout and were actively engaged in the discussion. The observed therapy session began on time and lasted one hour. Direct care staff supported the youth session with supervision and redirection when indicated.

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

The program has policy and procedures addressing treatment and discharge planning. The process includes each youth receives an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. The discharge planning process begins at admission.

Administrative interviews revealed the mental health plan for the program is reviewed yearly, updated as needed, and approved by the designated mental health clinician authority (DMHCA), facility administrator, and the regional clinical director. The DMHCA along with the mental health therapist reviews all the youth's documentation received during the intake process including all outside and inside assessments (Massachusetts Youth Screening Instrument, Version Two, comprehensive mental health and substance abuse evaluation, psychiatric evaluation, and Department comprehensive assessment). The youth needs are determined collaboratively with the multi-disciplinary treatment team and goals and objectives are developed considering presenting symptoms and expressed needs.

A review of five youth records revealed each youth received an initial mental health and substance abuse treatment plan on the day of admission including all required elements and signed by the licensed staff completing the form, as well as all treatment team members. Three of the youth entered the program already on prescribed psychotropic medication. Two of the three initial treatment plans did not include the youth's applicable medication or frequency of medication monitoring. One applicable initial treatment plan included the youth's medication and frequency of medication monitoring.

All five youth records contained an individualized mental health and substance abuse treatment plan completed within thirty days of admission and signed by all required parties. All the plans were documented on a form similar to the Department form containing all required elements. Three applicable plans included psychiatric services including medication and frequency of monitoring by the psychiatrist. All five treatment plans prescribed services including individual therapy once a week for thirty minutes, group therapy once a day, seven days a week for sixty minutes, and family therapy once a month for thirty minutes. A review of case notes revealed the program provided services consistently according to each youth's individualized treatment plan. Each record contained documentation the treatment plan was mailed to the parent/guardian requesting signature and returned to the program. The program conducted formal treatment team meetings weekly in which treatment plans were reviewed. A review of five youth records found each youth's treatment plan received a review. There was a total of seventeen treatment plan reviews in the five records. Each of the reviews were within the thirty-day requirement.

Three closed youth records were reviewed for mental health and substance abuse discharge planning. Each of the three reviewed records contained a mental health and substance abuse discharge plan summary completed prior to the exit conference detailing services needed after discharge. Youth records consistently documented invitation to all required parties to the exit conference and a review of the mental health and substance abuse discharge summary. Records also contained documentation each of the three youth, juvenile probation officer (JPO) and parent/guardian received a copy of the summary at 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 policy and procedures addressing specialized services, specifically intensive mental health. The licensed mental health professional is on-site five days for forty hours a week. She provides one hour weekly of clinical supervision for non-licensed clinicians. There were two counselors assigned to youth, both of whom were licensed clinicians. A review of staff schedules revealed a mental health clinician provided services on-site seven days a week. Neither of their caseloads exceeded twelve youth.

The psychiatrist is on-site weekly, and a licensed psychologist and a board-certified behavior analyst are both on-site weekly. A registered nurse (RN) staff is on-site seven days a week. The program provides individual counseling one day a week, group counseling seven days a week, and family counseling once a month. Group counseling also includes psychosocial skills training and psycho-educational groups. Youth with co-occurring substance abuse disorders receive substance abuse services. An additional amendment provided for a behavior analyst to provide services to one specific youth weekly in addition to other youth requiring such services. Psychiatric services included psychopharmacological therapy and psychiatric evaluation services.

An interview with the program director indicated the program provides specialized treatment services for the youth including a board-certified behavior analyst.

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

The psychiatrist sign-in sheets indicated he was on-site weekly and usually on Fridays. During July the sign-in sheets indicated the psychiatrist was on-site July 1, 2019 and the next time was July 12, 2019 leaving an eleven-day gap. However, services were provided within each week. Program staff indicated the psychiatrist was on leave during the period and all youth were seen within the required timeframes. The psychiatrist holds a clear and active license in the State of Florida.

An interview with the psychiatrist revealed he provides direct services on-site weekly and is available twenty-four hours seven days a week for consultation. He meets face-to-face with the program director and designated mental health clinician authority (DMHCA) as the need arises. The psychiatrist indicated the licensed nurse is physically present with him when he meets with the youth weekly providing medication monitoring. He indicated his role in coordination and implementation of the psychiatric services included each visit he meets with the DMHCA, nurses, therapist and other program staff to discuss any behavioral issues pertaining to the youths to be seen. An interview with the DMHCA revealed she or one of the licensed therapists meets with the psychiatrist each week prior to his providing psychiatric services to discuss the youth to be seen.

Five youth records were reviewed for psychiatric services. All five records contained an initial psychiatric interview completed within seven days of admission including all required information. Three of the youth were already on psychotropic medications upon admission. Nursing staff contacted the psychiatrist electronically and the medication was continued by the psychiatrist in each case. The three applicable youth initial psychiatric evaluations were completed on the required form including page three indicating the medication, dosage and frequency as well as applicable parent/guardian phone consent. A review of three applicable records revealed each youth received medication monitoring every thirty days. The medication, dosage, and applicable treatment goals were found in each youth's individualized mental health and substance abuse treatment plan.

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

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

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

Five youth records were reviewed regarding provision of suicide prevention services. Each of the five youth received an Assessment of Suicide Risk (ASR) during the admission process and within twenty-four hours of intake. Four of the youth were not considered a suicide risk and were stepped down to standard supervision upon recommendation of the licensed clinician completing the ASR. One of the four youth was recommended to continue on precautionary

observation with constant supervision until a follow-up ASR was completed. A precautionary observation log was started, the facility administrator/designee was notified of the findings by the licensed clinician. Documentation of the consultation was found on each ASR.

Two of the five records contained documentation subsequent to admission the youth was placed on suicide precautions including constant supervision. One of the two youth received an ASR from a licensed clinician the following day and within twenty-four hours and was stepped down to close supervision until stepped down to standard supervision. The other of the two youth was placed on one-to-one supervision and a precautionary log maintained until transported to a local hospital. At the hospital the youth was Baker Acted from which he returned to the program several days later. Upon readmission to the program the youth was immediately placed on precautionary observation/constant supervision until seen by a licensed clinician who completed an ASR within twenty-four hours. The ASR recommendations included the youth could be stepped down to close supervision. Documentation of the consultation was found on each ASR. In all three records the parent/guardian and juvenile probation officer (JPO) were notified of the youth's potential suicide risk.

Each of the three youth on close observation received a mental status exam (MSE) as required by program procedures by a clinician who recommended step down to standard supervision. The recommendation was discussed with the facility administrator/designee and documented. A review of logbooks revealed the program consistently documented the time youth were placed on and time removed from precautions or close supervision.

The monitor observed one of the two suicide response kits, this one maintained in master control, which contained all required tools. The program also has a review process for serious suicide attempts or serious self-inflicted injury. The program documented a multidisciplinary review for one applicable youth incident. The program followed all internal procedures and the results were reviewed by administration and corporate personnel.

Five staff were interviewed regarding what actions they take if a youth expresses suicidal thoughts. All five indicated they would be responsible to notify mental health staff and the supervisor and document their actions. Four of the five interviewed staff indicated they would provide constant sight and sound supervision. One staff indicated they would call medical and one staff indicated they would search the youth and the room for sharp objects. All five interviewed staff identified a knife for life is maintained in medical and four indicated a knife for life was maintained in master control and the staff break room.

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

The program has policy and procedures addressing suicide prevention services. The suicide precaution logs were reviewed for three applicable youth. Each of the three logs were maintained for the duration the youth was on suicide precautions. The appropriate level of supervision and observations were documented in real time and did not exceed thirty-minute intervals. Although there were provisions for documenting warning sign observation, none of the three logs were applicable. Each of the three suicide precaution observation logs included safe housing requirements and were reviewed and signed by each shift supervisor and a mental

health clinical staff. Written procedures include the mental health clinical staff signature on precautionary logs is indication the staff provided on-going mental health support to the youth.

Interviews of all three youth who were on suicide precautions revealed staff were with them always, never being left alone.

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

The program has policy and procedures addressing suicide prevention training. A review of five pre-service and five in-service training records revealed each staff received the required six hours of suicide prevention training during the annual compliance review period. The program maintains documentation of four non-licensed mental health clinical staff training in Assessment of Suicide Risk (ASR). A review of mock suicide drills revealed drills were conducted on each quarter including a cut-down exercise for all shifts. A review of sign-in sheets revealed more than fifty-percent of all staff participated in at least one mock suicide drill semi-annually involving a cut-down exercise.

An interview with administration indicated the program provides training or mock drills for staff, which includes emergency response to suicide attempts or self-inflicted injury.

Four of the five interviewed staff indicated they had participated in a suicide drill in the past twelve months.

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

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

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

The program has policy and procedures addressing crisis intervention services. Procedures include staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. None of the five reviewed records included a crisis assessment. The interview with the designated mental health clinician authority (DMHCA) indicated the program had no instances in which a crisis assessment was completed.

A review of five youth records found documentation one youth received a crisis intervention from the designated mental health clinician authority (a licensed clinical social worker), which was conducted and documented in progress notes. Staff documented youth's emotional condition, thought patterns, and changes during the intervention, youth language, body aspect, and level of agitation. The clinician attempted to negotiate a safety plan, but the youth refused; so, staff negotiated for youth to discuss issues with another trusted clinician; however, the program did not complete a crisis assessment documenting the intervention.

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

The program has an emergency mental health and substance abuse services plan separate from the crisis intervention plan in place which received an annual review on July 19, 2019. The plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services including Baker Act and Marchman Act, documentation, training (including mock drills), and review.

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

The program has policy and procedures addressing Baker and Marchman Acts. None of the five youth records reviewed contained documentation a youth had received a Baker or Marchman Act; however, staff interviews indicated a youth had been Baker Acted at a local hospital after being sent there for serious self-injury. Upon the youth's return to the program he was immediately placed on suicide precautions/constant supervision and a precautions log begun.

The youth was seen by a licensed mental health clinician within twenty-four hours and stepped down to close and later to standard supervision.

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.	

A review of the program's policy and procedures revealed the designated health authority (DHA) is responsible for the coordination of all healthcare at the program, administrative duties, seeing youth, and being available to communicate with the program twenty-four hours a day for emergency medical concerns.

The program has a subcontract with an osteopathic physician to serve as the program's DHA. The DHA has an unrestricted licensed in the state of Florida, with an expiration date of March 31, 2020. The DHA is board certified as a family physician. A review of the DHA sign-in logs found the DHA was on-site each week during the annual compliance review period, except for one week. The one week in which the DHA was not on-site, a provider employed doctor, who has an unrestricted license expiring January 31, 2020, covered for the DHA. The sign-in sheets document the time the DHA arrived on-site and the youth the DHA saw while on-site; however, the DHA did not document the time out on any of the logs.

An interview with the DHA confirmed their responsibilities and availability to the program.

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

The program has written facility operating procedures (FOP) which address all health-related procedures and protocols at the program.

The designated health authority (DHA), facility administrator (FA), and psychiatrist, when applicable, signed all health-related FOPs on November 27, 2018. A cover page was found for June 25, 2019, in which the DHA and FA acknowledged they reviewed the FOPs for the year. A written review and authorization for all standing orders was found by the DHA on June 25, 2019 and the nursing protocols on July 8, 2019. The nurses review the FOPs annually, with the last review documented with a cover page and signatures of all nurses between June 20, 2019 and August 13, 2019. One new healthcare staff was hired during the annual compliance review period and documentation of the nurse's on-the-job training was provided, which covered a comprehensive clinical orientation to the Department's health care policies and procedures by the program's health services administrator.

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.	

Five youth Individual Healthcare Records (IHCR) were reviewed for a valid Authority for Evaluation and Treatment (AET). Four of the IHCRs included a valid copy of the AET and one IHCR included a valid court order for a youth in the custody of the Department of Children and

Families (DCF). All AETs were valid for as long as the youth is under any type of supervision and all copies of parental notifications were maintained behind the AET/court order in the IHCR.

The health services administrator (HSA) was interviewed and reported the juvenile probation officer (JPO) for each youth is responsible for obtaining a valid AET or court order prior to the youth arriving at the program.

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

Five youth Individual Healthcare Records (IHCR) were reviewed for parental notification. Two youth were applicable for over-the-counter medication consents, one youth had significant changes to medication, one youth required off-site emergency care, one youth was taken to off-site medical appointments, and four youth required a new medication. All notifications were sent as required in writing and verbal consent was obtained when applicable and documented in the youth's IHCR. For each verbal consent, a witness was included on all telephone calls. One youth was in the custody of the Department of Children and Families (DCF) and had a valid court order for treatment. All notifications were sent, and consents obtained by the DCF caseworker. Three youth were applicable for prescription of psychotropic medications while in the program. Each of the three youth's IHCRs included documentation consent was obtained prior to starting any new medication, anytime medication was significantly changed, or if the medication was discontinued. In one instance, the program was not able to reach the parent/guardian; however, the program did not start the new medications until a written consent on the Clinical Psychotropic Progress Notes (CPPN) was obtained. All changes in psychotropic medication were documented on page three of the CPPN forms and mailed to the parent/guardian. Each of the five reviewed records included up-to-date shot vaccination records which were verified on the day of admission. None of the youth required or were given any vaccinations while in the program. Two youth IHCRs documented a consent form was mailed to the parent/guardian for recommendation of a flu shot; however, consent was not obtained, and the vaccination not administered.

The health services administrator (HSA) was interviewed and reported vaccination records come with the youth when they are admitted in most instances but can be obtained through the Department of Health's Florida Shots program if needed. The records are verified during the admission process and if a youth has an exemption form, the parent/guardian is to provide a copy which is then filed in the IHCR.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and each included a Facility Entry Physical Health Screening (FEPHS) form completed on the day of admission by a registered nurse (RN). One youth was applicable for a change in custody while in the program and a FEPHS form was found completed by a RN on the day the youth returned to the program.

The health services administrator interview indicated RNs complete the FEPHS.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and each documented the youth received an orientation to healthcare services at admission. A review of the orientation packet provided to each youth documented all required topics were covered. Included in the orientation packet is a list of healthcare contacts which was verified as accurate. Each youth signed a form acknowledging they received orientation verbally and in writing and the IHCRs included a Health Education form documenting each reviewed topic.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and there was evidence the designated health authority (DHA) was notified of the youth's admission regardless of the youth's health status. One youth was identified with a chronic condition at admission and there were progress notes in which the DHA issued standing orders for the chronic conditions until the youth could be seen by the DHA. None of the youth were identified as in-need of emergency response. The notifications were each made telephonically and documented on an admission progress note.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and each included a new Health-Related History (HRH) form completed on the day of admission by a registered nurse (RN). Each HRH was completed prior to the Comprehensive Physical Assessment (CPA) and there was evidence the designated health authority (DHA) who completed the CPA reviewed the HRH.

The health services administrator interview indicated RNs complete the HRH.

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

The program has a written policy and procedure regarding the completion of a Comprehensive Physical Assessment (CPA) and requirements for documentation of any deferred or refused parts of the exam. In addition, there is a policy and procedures in place for Tuberculosis screening (TB) and testing which is in compliance with the Center for Disease Control (CDC) and Occupational Safety and Health Standards (OSHA).

Five youth Individual Healthcare Records (IHCR) were reviewed and each included a new Department CPA form completed by the designated health authority (DHA), who is an

osteopathic physician, within seven days of admission. Each CPA was completed as required and any part of the exam which was deferred was documented as required. A chronological progress note was found to reflect each CPA. In each record, the Department Problem List was updated as required. Each of the five IHCRs included documentation a Tuberculin Skin Test (TST) was completed within the last year and the results recorded on the CPA and Infectious and Communicable Disease (ICD) form. The youth were assessed prior to placement in the general population. None of the youth required further testing or procedures.

The health services administrator was interviewed and reported the CPAs are completed by the DHA within seven days of admission and annually. In addition, each youth is screened for TB at admission and the youth is to have a TST test annually.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and documentation was found each youth was screened for sexually transmitted infections (STIs) upon admission. None of the youth were referred for further testing due to being tested while in Department custody prior to being admitted to the program. There was evidence in each of the five IHCRs the youth was offered counseling, testing, and treatment for human immunodeficiency virus (HIV); however, none of the youth consented. The program was able to provide one additional youth record for the review period who consented to HIV and received testing, as well as pre and post-test counseling by a certified HIV counselor. The consent was maintained in the IHCR. The counseling was documented on the youth's Health Education record. The youth's results were kept in the IHCR in a sealed envelope marked as confidential. The youth did not sign a consent to release the results to anyone else and the results were not documented in the program's alert system.

Five youth were interviewed, and each reported they could request to be HIV tested.

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

The program has a written policy and procedures which outline the requirements for the Sick Call process including for sick call to only be completed by a registered nurse. The program provides sick call to youth twice a day, seven days a week; however, the program's process is for youth to request to see the nurse or the doctor when on-site and they are seen immediately as episodic care instead of through an official Sick Call Request.

Five youth Individual Healthcare Records (IHCR) were reviewed and none were applicable for sick call. The program was able to provide one youth with sick call for the annual compliance review period. The youth did not have additional sick calls with the same complaint or pain with which the staff was unfamiliar. The incident was documented as required on the Sick Call Request form, which was filed in the youth's IHCR, logged on the Sick Call Referral Log, and on

the youth's Sick Call Index. During the program tour, the sick call hours were found to be posted in the youth dorm and a box was found on the wall for youth to submit sick calls with Sick Call Request forms stocked nearby for youth access. One sick call incident was observed during the annual compliance review. The youth gave consent for the encounter to be observed. A registered nurse conducted the sick call in the nursing office with the direct care staff accompanying the youth to the office but remaining outside of the door to ensure privacy. The nurse identified themselves, asked the youth what brought them in, and examined the youth. The youth was provided treatment and education, electronically signed the Sick Call Referral form, and was escorted back to programming by the direct care staff.

Five staff interviews were conducted, and each staff reported the nurse checks Sick Call forms and conducts sick call and one staff reported the supervisors checks the Sick Call forms at night when medical is not on-site. The health services administrator confirmed when nursing staff is not on-site the supervisors are responsible for checking the sick call boxes.

Five youth were interviewed and two reported they can be seen for a sick call immediately, one youth reported they are seen within one day, and two youth reported they submitted sick calls but were never seen. When the program was informed of the answers they offered the youth sick calls; however, the youth reported they did not need to be seen, might have submitted the sick call in detention, and would have asked the nurse if they needed to be seen.

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

The program has a written policy and procedures regarding episodic and emergency care which outlines services are available to youth twenty-four hours a day. Five youth Individual Healthcare Records (IHCR) were reviewed and four were applicable for nineteen incidents of episodic care. Each episodic care incident was conducted by a registered nurse (RN) and documented in problem-oriented format in chronological notes maintained in the youth's IHCR. Each incident was found on the program's Episodic Care Log.

The program maintains seven first aid kits and two suicide response kits. Each kit was verified during the annual compliance review to contain all approved contents. All supplies were up-to-date. Documentation was found to support the nursing staff checks the first aid kits and documents the expiration dates of all contents on a monthly basis. The program has one automated external defibrillator (AED) which was verified as being in working order during the annual compliance review. The instruction guide is maintained with the AED. The batteries and pads were up-to-date and documentation was found to support nursing staff checks the AED on a monthly basis.

The program completed medical drills each month on all three shifts, each of which included a detailed narrative and demonstration of cardiopulmonary resuscitation (CPR), first aid, and/or AED use. Five pre-service and five in-service staff training records were reviewed and each included documentation the staff completed training in emergency procedures, first aid, and CPR/AED; all nursing staff had current certification in CPR with AED training. Documentation was provided the supervisory staff were trained during the annual compliance review period in epinephrine auto-injector usage and medication self-administration in the event a youth needed a medication while the nursing staff was not on-site. The program maintains emergency numbers in the medical office, inaccessible to youth, which includes the Poison Information Control Center.

Five staff were interviewed and each reported they are able to call 9-1-1 if needed.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and one was applicable for five instances of off-site care. Parent/guardian notification and the Summary of Off-Site Care form was found for each of the five instances, including any discharge instructions. The designated health authority (DHA) reviewed each of the forms and all follow-up for the youth was scheduled and completed as necessary. The program has a system to track any follow-up care to ensure appointments are scheduled and attended.

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

Five youth Individual Healthcare Records (IHCR) were reviewed and none were applicable for chronic conditions. One youth was identified with a chronic condition at admission; however, the designated health authority (DHA) ruled out the condition during the Comprehensive Physical Assessment (CPA) and the Department Problem List was updated. The program had one youth applicable for chronic conditions and periodic evaluations during the annual compliance review period. The youth was placed on the chronic condition list and was seen every sixty days by the DHA for a periodic evaluation with no lapses in care and a specialized treatment plan. The periodic evaluations were documented in the youth's IHCR in both a nursing note and physician note.
An interview with the facility administrator and DHA confirmed the nursing staff maintain a chronic conditions list to track necessary periodic evaluations. In addition, the DHA sees the youth for periodic evaluations every sixty days, more often than the required ninety days.

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

The program has a written policy and procedures which outline the process for the disposal of medications. Any regular medications are stored and inventoried and then sent back to the pharmacy at the end of the month. All controlled medications are stored and inventoried and then destroyed by the consultant pharmacists when on-site once a month. This process was confirmed through an interview with the health services administrator (HSA).

Five youth Individual Healthcare Records (IHCR) were reviewed and three were applicable for admission with medications. A prescription verification was found for each of the prescriptions and maintained in the youth's IHCR. For each of the applicable youth, the psychiatrist was contacted for orders to continue the medications upon admission until the youth could be seen. All medications for the youth were given pursuant to a current, valid order or prescription. Each

of the five youth reviewed were applicable for receiving over-the-counter prescriptions which were administered pursuant to the designated health authority's (DHA) orders. None of the youth were in restricted housing during the annual compliance review period. Each youth had a current and previous Medication Administration Record (MAR) which was maintained in the youth's IHCR reflecting all medications administered to youth. Each medication entry was initialed by the nurse and none of the reviewed entries were completed by non-healthcare staff. No medication administration lapses or errors were found. The nursing staff documented daily side effect monitoring for each youth on medication. Any refusals were documented on the youth's MAR and a refusal form was filed in the youth's IHCR. The Six Rights of Medication Administration are verified for each youth during medication pass.

Medication pass was observed during the annual compliance review. A registered nurse (RN) completed the medication pass utilizing the program's medication cart in the nursing office. The cart was organized, and the RN verified the Six Rights of Medication Administration for each youth. None of the medications were pre-poured. The program stores all medications and sharps in the locked nursing office and locked medication cart. The stock sharps are maintained in locked cabinets and all working sharps are kept in the locked medication cart. Oral, topical, and injectable medications are stored separately, as required. Any controlled medications are stored in a locked box in the medication cart and any refrigerated medications are kept in a designated fridge.

Three of five youth interviews indicated the nurse provides them medication while two reported they do not take medications.

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

The program has a written policy and procedures regarding requirements for the storage and inventory of medications and sharps. The policy accounts for the destruction of medication through the program's pharmacy and the procedures in the event there is a discrepancy in the medication or sharps counts. In addition, the policy requires nursing staff to conduct shift-to-shift counts of controlled medications; however, the program did not have controlled medications during the annual compliance review.

All medications and sharps are kept in the locked nursing office. The stock sharps and over-the-counter (OTC) medications are maintained in locked cabinets and all working sharps, OTC medications, and youth medications are kept in the locked medication cart. Any controlled medication is kept in a separate locked box inside the medication cart. Topical and oral medications are divided and any refrigerated medications are kept in a designated fridge. All storage areas and the medication cart are clean and well-organized. Weekly and perpetual inventories were found for all stock medications and sharps. Perpetual inventories were found for all youth medications and working OTC medications and sharps. Three OTC medications, three sharps, and two youth medications, neither of which were a controlled medication as the program did not have controlled medication on-site during the annual compliance review, were conducted. Each of the counts matched the inventory.

An interview with the health services administrator (HSA) confirmed the program's processes for the destruction of medication and procedures for instances of medication or sharp

discrepancies. The nursing staff who discovered the discrepancy would immediately notify additional parties, including the Central Communications Center (CCC), and an investigation would be initiated.

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

The program has a written infection control and exposure control policy, procedures, and plan in place. The infection control procedures include all required topics, including a comprehensive process for needle-stick exposure. The program provided documentation they offer Hepatitis B vaccinations to all employees and staff have access to protective equipment. The exposure control plan included all required topics and was written in accordance with Occupational Safety and Health (OSHA) standards, as well as being reviewed and signed annually by program administration. There was evidence to support Universal Precautions are followed by all staff. There were no events in which the local health department, Center for Disease Control (CDC), or Central Communications Center (CCC) needed to be notified of an infectious diseases or youth/staff needing to be quarantined; however, the program has procedures in place to maintain a separate record for any exposed youth/staff. All five pre-service and five in-service staff training records noted exposure control plan training. All five reviewed youth records indicated the youth received infection control training documented on the day of admission in the orientation packet.

The facility administrator was interviewed and reported the exposure control and infection control plans are maintained in the nursing office and accessible to staff as needed.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures addressing active supervision of youth. The program's staff to youth ratio is one to eight and one to eight during awake and sleep hours. Staff were observed during daily activities, such as school recreation, meals, breaks, and line movement. On all four days observed the staff maintained active supervision, as well as interacting positively with the youth, and consistently applying the behavior management system (BMS). Staff members were asked for the number of youth they were supervising during various times of the day and the count was accurate. The daily schedule was posted and available to youth in each living unit/dorm, accounting for a full schedule of activities.

Several staff were asked to explain the procedure when they cannot reconcile youth count. The staff stated supervision would be called, all youth movement would stop, count would be done and if needed a search conducted.

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

The program has a policy and procedures outlining the behavior management system (BMS), which is clearly written, and includes all the required elements.

The program's BMS is given to each youth upon their admission, during orientation to the program and is posted in the dorm. Each of the five pre-service and five in-services staff training records documented training on the BMS, as well as the education staff completing BMS training, in addition to having an agreement with the program. During regular treatment team, the youth's positive and negative behaviors are discussed, but if necessary, special treatment teams are held to address harmful behaviors.

The five youth interviews indicated they received rewards such as home pass, monthly awards, canteen, extra time on weekly phone calls, food from an outside restaurant, and movies. One of the youth reported the BMS is a poor system, especially for youth who are not complying with the program rules, one reported the BMS is fair and three reported it being very good.

Five staff interviews indicated the BMS includes the point system, level system and rewards, as well as the BMS being posted on each dorm and youth are told about it during orientation. The

staff reported the youth can review their point sheets upon request, they are told during treatment team and the case manager oversees the BMS. The five staff reported youth rewards are canteen, home pass, trips of campus and monthly awards, and youth have nothing taken away from them as a consequence.

The facility administrator was interviewed and indicated a review of the positive performance system (PPS) daily/weekly is utilized to monitor rewards, as well as consequences. The BMS implementation is monitored through management meetings, and staff evaluations to ensure it is done fairly and consistently.

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

The program has a policy and procedures outlining the behavior management system (BMS), including providing feedback to staff regarding the implementation of the BMS, as well as a process for staff and youth communication regarding the BMS. The program's BMS does not include increased length of stay, denial of youth rights/services, promotion of group punishment, punishment of youth by other youth and confinement. The provider's contract specified all required parties involved in the development, implementation, and on-going maintenance of the BMS.

Each of the job descriptions for positions at the program included implementation of the BMS. The BMS included the process for staff to explain to youth reason for consequences and for youth to explain his behavior and discuss alternative acceptable behavior. The program has room restriction; however, has not used this since the last annual compliance review. Each of the five pre-service and five in-services staff training records documented training on the program's BMS.

Each of the five youth interviews indicated they are not allowed to punish another youth and they were able to describe the BMS, such as the level and point system, as well as rewards and sanctions. All five reported for getting into a physical altercation the consequence would be early bed time and suspension of rewards/privileges. Each of the interviewed youth reported staff are consistent when giving rewards.

The facility administrator interview indicated the program uses the positive performance system (PPS). This system is to foster compliance with the program rules and teach youth alternative pro-social methods of dealing with problems utilizing both rewards and a system of progressive discipline. The rewards and consequences are monitored through daily and weekly review of the PPS. Staff are monitored on the BMS through management meetings and staff evaluations.

Five staff interviews indicated youth are informed of consequences through the daily point system, treatment team meeting and they can explain their behavior. Each of the five staff reported supervisors will monitor implementation of the BMS individually or during shift briefings.

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

The program has a policy and procedures regarding ten-minute checks. The program has fifty-three cameras, with fifty working at the time of the annual compliance review and only recording thirteen days. The facility administrator reported video is maintained for thirteen days. Documentation was provided regarding a work order submission to resolve the 13 day recoding issue. A review of four days of video footage and logs, totaling eighteen checks, was conducted covering both third (10:00 p.m. – 6:00 a.m.) and second (2:00 p.m. – 10:00 p.m.) shift. The staff used flashlights to look into each room occupied with a youth and checks were documented in real time. The program conducted six-minute checks, instead of ten-minute checks with no discrepancies noted.

Each of the five staff interviews confirmed staff conduct six-minute checks.

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

The program has a policy and procedures relating to census, counts, and tracking. The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. A review of logbooks indicated the program conducted and documented resident counts at the beginning of each shift, after each outdoor activity, and when youth were temporarily off campus. The program maintained a chronological record of events as they occurred, tracked daily census information including the total daily census counts, new admissions, releases, and youth temporarily away from the program.

Five interviewed staff indicated how youth counts are conducted and what will happen when there is a discrepancy, including emergency counts. One staff stated at 9:30 a.m., 12:00 p.m. and 3:00 p.m. (throughout the day), during shift change joint counts, and informal counts are conducted. Another said all movement is stopped when there is a discrepancy, as well as random head counts being completed throughout the shift. Another staff stated three head counts are conducted each shift and if there is a major incident they do a count immediately (no movement or radio transmission until clear). The fourth staff said counts are done at the beginning and end of each shift and another staff indicated counts are announced over the radio randomly.

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.	

A review of logbooks indicated they were bound with numbered pages, entries were made with ink, errors were struck through with a single line, dated and initialed by the person correcting the error, and none were obliterated. All entries included date, time of the event, name of staff/youth involved, brief description of event, name of the staff making entry and signature. The shift report was documented in the logbook for incoming shifts, and staff sign and date acknowledging review of the information. The logbooks also documented perimeter checks, population counts, admissions and releases, escape incidents, presents of law enforcement on-site, emergency situations, special youth supervision instructions, Central Communications Center (CCC) and Florida Abuse Hotline calls, and a copy is kept at a minimum of forty-eight hours in living area.

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

The program has a policy and procedures in place regarding key assignment, inventory and tracking of keys, secure storage of keys, procedures addressing missing or lost keys and reporting and replacement of damaged keys.

A review of the key inventory was conducted and the key rings in use matched the inventory and tracking of the keys. Two staff, assigned with permanent keys, were observed to have the correct keys issued to them. The program has a key box which is secured at all times in master control and the master control operator collects and distributes the keys. The program utilizes a staff sign in/out log for the daily tracking and reconciliation of keys. Three staff key rings were compared to the inventory and key log; all three had the appropriate keys in their possession. The program did not have any lost or missing keys in the last six months.

An interview with the master control operator indicated only certain staff have access to restricted keys for medical, youth/staff records, and youth property lockers.

Five staff interviews indicated all staff keys are given to master control upon entry and personal keys are securely stored. One of five staff stated a chit/token is provided to visitors upon entry in the program, there is a daily tracking log for keys, if a key is lost/stolen no one can leave the program, a Central Communications Center (CCC) call would have to be made if not found, program keys are assigned to staff and there is an inventory of keys. Four staff said youth do not have access to keys and three indicated to notify master control of missing keys, and the facility and youth are searched for missing keys. Two staff said if a key is damaged a work order will be completed.

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

The program has a policy and procedures addressing illegal contraband and specifying prohibited items, clarifying what constitutes illegal contraband, avoiding introduction of contraband into the program, as well as consequences of such, documentation of incidents, staff training, searches of the program, actions taken when contraband is discovered and involvement of law enforcement, as well as incoming and outgoing mail being searched in the presence of youth.

During orientation the youth is provided with the illegal contraband procedure, including a list of illegal contraband and prohibited items. A review of three search violation reports had documentation of contraband searches. The program maintains disposal information of contraband and searches are documented on the search reports, occurring at a minimum of once a week.

The facility administrator (FA) interview indicated all contraband, illegal drugs, weapons or other illegal contraband items or materials will be turned over initially to the FA who will document the custody trail and preserve the contraband items as evidence pending a possible criminal investigation. In all instances involving the confiscation of illegal contraband, the confiscated item will be tagged or placed in an evidence bag with a facility statement (detailing the date, time, and location of the item). The contraband items will then be turned over to local law

enforcement authorities and a criminal report is filed. All contraband will be stored in the locked evidence cabinet in the FA's office until it is turned over to law enforcement or properly disposed of.

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

Youth searches were observed throughout the annual compliance review. On the first day of the review, two youth were searched in the administration building; however, staff did not pat down the ankle or foot area nor direct the youth to remove their socks. During a separate occasion staff were observed patting down youth including youth's ankle and feet area before and after transports, as well as after recreational activities and meal times. Observations of youth searches were conducted before and after groups/transportation/education and returning from off-campus activities. Staff were observed giving youth instructions, as well as explaining the reason for the search, the searches adhering to the Protective Action Response (PAR) training manual, as well as the appropriate number of staff and gender being present, maintaining the youth's dignity and minimizing stress and embarrassment for the youth.

Five interviewed youth indicated during movements they are searched, one mentioned upon admission, three stated after meals and two after outside activities. Five staff were interviewed and indicated youth are searched during every movement and one staff also stated when probable cause exists.

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

A review of two vehicles was conducted; both had received an annual inspection with no deficiencies noted and staff indicated seatbelts being utilized consistently by youth and staff. The vehicles transporting youth had documentation regarding vehicle maintenance, both were locked while not in use, had fire extinguishers in the vehicle, an approved first aid kit, seat belt cutter, window punch, appropriate number of seat belts, and youth are not attached to any part of the vehicle during transport. Random checks of personal vehicles at the facility were conducted and all vehicles were locked and secured.

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

The program has a policy and procedures in place for transporting youth with all the Department requirements, which included not leaving youth unsupervised in a vehicle and not letting a youth drive a vehicle.

A transport was observed of two youths, one male and one female staff, to conduct an off-site visit. The staff had a current driver's license, they took a program issued phone with them, everyone was wearing seatbelts upon departure and the youth were not attached to the vehicle with any other part than the seat belt. Random checks of personal vehicles at the facility were conducted and all vehicles were locked and secured.

Five staff interviews indicated cellphone and radios are provided during youth transport and staff are not allowed to use their personal vehicles to transport youth.

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

The program has a policy and procedures in place outlining who is responsible for conducting weekly security audits and safety inspections, the development and implementation of corrective actions warranted as a result of safety and security deficiencies, and internal system to verify deficiencies are corrected.

A review of safety and security audits indicated they were completed every seven days. The facility administrator interview indicated the process in identifying and tracking safety and security deficiencies are to complete perimeter checks per shift and completing weekly safety and security checklists.

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

The program's policy and procedures addressed the issuance, inventory, and control of equipment and tools.

Tools were observed securely stored when not in use, marked for easy identification, and they were inventoried prior to being issued for work and following work activities. A review of the daily sign in/out tool inventory indicated all tools were accounted for and the documentation contained the tool description, time out, and time in along with the staff who signed them out. A daily inventory of sharp-edged tools is conducted, as well as a monthly tool inventory for non-sharp tools occurred.

Five youth interviews indicated they all use mops and brooms, three stated using a hammer under staff supervision, one stated fixing a light, help fixing a lawn mower because they cut the

grass under staff supervision, two having used a screwdriver, and one said having used a rake and scrub brush.

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

The program has policy and procedures for supervision requirements when youth use tools, to include an assessment to determine youth's risks to self and others, ratio requirements, tool distribution and collection, and search criteria during work projects.

A review of five youth orientation checklists indicated all five were trained on tool usage and had a risk assessment completed.

Three of five staff interviews indicated youth using mops and brooms, two stated youth do not use tools other than using class B tools, and if youth use other tools they have to be approved.

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

The program has a policy and procedures regarding outside contractors, including all required elements.

The program uses written notification and guidelines for outside contractors to sign in and log tools brought on-site. The form includes tools checked in upon arrival and departure, tool restrictions, youth being restricted from the work area and missing tool follow-up. A review of nine invoices being compared to the sign-in logs, each of the nine had a corresponding notification and guidelines for outside contractor signed by the vendor and facility staff.

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 a policy and procedures regarding the Continuity of Operations Plan (COOP) which includes directions on how often drills are to be conducted. According to the program's COOP, evacuation, major disturbance/terrorism, bomb threat, hostage, chemical, severe weather and emergency response drills are to be conducted monthly for each shift.

The program had documentation drills were conducted monthly according to the COOP, on each shift. The documentation included the type of drill, date and time, brief scenario, participants and findings/recommendations. During the facility tour, it was observed the evacuation routes and egress plans were posted throughout the program. Each of the fire extinguishers were inspected annually.

The facility administrator reported drills are conducted three times a month for fire and medical drills, monthly for mental health, and others are annually.

Five staff reported participating in weather, bomb threat, hostage situation, chemical spills, escape, fire, medical, and mental health drills.

Three of the five interviewed youth reported being instructed on what to do in case of a fire, the remaining youth report they were not instructed.

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

The program has a policy and procedures in regard to the Continuity of Operations Plan (COOP).

The COOP was submitted and signed by the facility administrator on March 25, 2019, the program's regional director and the Department of Juvenile Justice residential services on August 13, 2019. The COOP is located in master control for easy staff access and included alternative housing plans in the event of evacuation, emergency contacts, drills, and responsibilities. Master control also maintains a binder which included a hard copy record on each youth with the required documentation. The facility administrator reported the COOP is located in master control.

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 addressing the storage and inventory of flammable, poisonous, and toxic items and materials.

All flammable, poisonous, and toxic materials are stored in a secure area inaccessible to youth and the inventory matched the actual items the program had on hand. A review of the flammable cabinet weekly check sheet documented weekly checks being completed for the last six months. The checklist included several different chemicals, as well as the information on the chemical acute effects on the eyes, skin, inhalation, and ingestion. The program has a list of staff positions which are allowed to handle these materials on the door where the materials are kept.

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

The program has policy and procedures addressing youth handling and supervision for flammable, poisonous, and toxic items, and materials.

The program maintains strict control of the flammable, poisonous, and toxic items and materials, with only certain staff having access to them. Youth are not allowed to use, handle or clean up dangerous or hazardous chemicals, as well as bio-hazardous materials.

Four of five youth interviews indicated youth do not use chemicals or cleaning products, one stated having used paint; painting the shed outside of the program. One youth stated staff spray the chemical and youth wipe it down.

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

The program has a policy and procedures addressing disposal of flammable, poisonous, caustic, and toxic items, including in the event of a chemical spill. Staff having first knowledge of the event shall immediately contact master control and the staff mentor. Master control will immediately order an evacuation of the spill area, if necessary. Master control in conjunction with the facility administrator (FA) or administrative duty officer, determine whether outside assistance is needed.

The program's FA, assistant facility administrator and program director are authorized to dispose of flammable, poisonous, caustic, and toxic items. The program's maintenance staff have been trained on how to properly dispose of bio-hazardous material.

Hazardous liquid waste is stored in a hazardous materials storage area and liquid waste, like dirty mop water is disposed of in the plumbing drains. Kitchen liquid waste is disposed of in the kitchen and grease is placed in a separate container.

The program disposes of flammable, poisonous, caustic, and toxic items according to the Occupational Safety and Health Administration (OSHA) standards. The program utilizes outside contractors, Environmental Enterprises of Florida and Perma-Fix of Orlando, for the proper disposal of all kitchen grease and bio-hazardous waste. The program did not have any items in need of disposal for this annual compliance review period.

The maintenance personnel interview indicated material will be taken to one approved waste disposal site or removed by an approved disposal agency. When necessary the fire department will be called to remove hazardous materials.

The FA interview indicated at no time shall a toxic or caustic substance be disposed of by pouring on the ground, flushing into sewers or any other unsafe method; proper disposal as per biohazard guidelines is required; do not ever mix hazardous chemicals, except as directed by the Material Safety Data Sheet (i.e. dilution); ensure all hazardous materials needing to be disposed of are prepared for proper disposal as per the OSHA Standards; ensure caustic acids or explosives are not utilized or stored at this program; take chemicals in need of disposal to Environmental Enterprises of Florida or Perma-Fix of Orlando; and maintain a copy or list of the items disposed of.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures in regards to youth receiving visitation and communication while in the program. The visitation schedule is posted throughout the program. The program provides opportunities for visitation to occur when the parent/guardian is available. The program maintains an approved/unapproved phone, mail and visitation list for each youth in the program. The youth and staff sign a log acknowledging receiving phone calls and mail. Each youth is assigned a day when they are to receive their weekly phone call. There is a separate visitation sign in/out log. This information is kept in a binder for staff to review when needed. During the annual compliance review, youth received incoming mail, but the review team was unable to observe the outgoing mail process. The case manager opened the incoming mail and reviewed the content in front of the youth.

Each of the five youth interviews reported being able to communicate with family members by mail, during visitation, and telephone calls.

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

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

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

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

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

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

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

The program maintained a safety plan for each youth which included warning signs, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences.

A review of five youth records validated all had a safety plan which incorporated recommendations from previous/current clinical assessments/screening instruments and incorporated trauma responsive practices. In four of five, the plan was jointly prepared by the youth, parent/guardian, and program clinical staff. In one the parent/guardian was not involved. In all five, the plan was reviewed by staff who had contact with the youth and each plan was maintained in an easily accessible location. In all five, the safety plan was completed within fourteen days upon admission and was updated every thirty days.

Five youth interviews indicated three were involved in the development of their safety plan a couple of weeks ago with the therapist. One youth stated the case manager helped him and another said he just did one, read and signed it.

Five staff were interviewed and three indicated they are available for staff to review if a youth starts displaying negative behaviors. One stated they do not know where the plan would be located, and another said the therapist reviews it with youth and the clinical director reviews it with the therapist.