STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okaloosa Youth Academy

Gulf Coast Treatment Center, Inc.

(Contract Provider)
4555 Straightline Road
Crestview, Florida 32539

Review Date(s): May 11 - 15, 2020

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:

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 1 & 3)
Jill Foy, Office of Program Accountability, Operation Review Specialist (Standard 3 & 4 & 5)
Tara Frazier, Office of Program Accountability, Operation Review Specialist (Standard 2)
Ken Phillips, Office of Program Accountability, Operation Review Specialist (Interviews & Standard 5)

Program Name: Okaloosa Youth Academy
Provider Name: Gulf Coast Youth Services
Location: Okaloosa County / Circuit 1
Review Date(s): May 11 - May 15, 2020

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

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Okaloosa Youth Academy is a non-secure residential commitment program which serves sixty male youth between the ages of thirteen and nineteen years old. The program is contracted through the Department with Gulf Coast Youth Services, Inc., located in Crestview, Florida. The program is co-located with Crestview Sex Offender Program. The management team consists of a program director, two assistant program directors, food service manager, five dietary workers, two maintenance personnel, a recreation specialist, a transition specialist, four case managers, a director of nursing, three registered nurses (RN), a designated mental health clinical authority (DMHCA), and five therapists. The provider also has an agreement with a designated health authority (DHA) and a psychiatrist. The DHA is contracted to be on-site for a minimum of two hours weekly and is on-call twenty-four hours a day and seven days each week. The psychiatrist is required to be on-site twice monthly and is also available twenty-four hours a day. The program had three vacancies for youth care workers and one master control operator at time of the annual compliance review. The program offers Mental Health Overlay Services (MHOS) and Substance Abuse Overlay Services (SAOS). The youth at the program participate in a variety of delinquency intervention groups; Impact of Crime (IOC), Life Skills Training (LST), Thinking for a Change (T4C), Anger Management Life Skills (ARISE), Seven Challenges, and Moral Reconation Therapy (MRT). In addition, gender specific programming, which includes Boys Council and Fathers in Training (FIT). The educational services at the program are provided by the Okaloosa County School Department. Youth will attend school five days a week and have the opportunity to earn credits as well as certifications within the vocational component, Home Builders Institute, Inc. (HBI). The program is comprised of three youth housing units, in which two are designated to house the Okaloosa Youth Academy population. The remaining one is designated for the Crestview Sex Offender Program youth. The program has a master control room, which is operated by a master control operator who is responsible for documenting daily events within the logbook and reviewing the video surveillance system. The program has eighty-nine cameras, with eighty-seven currently operating at the time of the annual compliance review.

Standard 1: Management Accountability

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

There was a total of nine staff requiring an initial background screening. All the initial background screenings were completed prior to hire. A criminal history report was reviewed as part of the staff members hiring practice. None of the nine staff initial background screenings reviewed, required an exemption prior to working with youth. Five of the nine staff were direct care applicants and were reviewed for completion of a pre-employment assessment. Each of the direct care staff had a passing score on the pre-employment assessment tool.

Documentation of the pre-employment assessment tool was found in each of the staff records reviewed. The provider added each employee/volunteer to the clearinghouse employment roster. In three applicable records reviewed, a background screening was completed when a provider employee is hired by another contracted provider company. The program currently does not have any person who assist or interacts with youth on an intermittent basis for less than ten hours and/or may have access to confidential information. The program has a written facility operating procedures which outlines practices taken should a need to submit a background screening for volunteers, mentors, and/or interns interacting with youth on an intermittent basis. An Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit and signed December 23, 2019.

Teachers who are paid by the school board, or funding provided by the school board or Department of Education, received an annual screening, which was completed and signed on January 7, 2020. The hiring practice and documentation of each applicant involves reviewing Central Communications Center (CCC) person involvement history report, the Staff Verification System (SVS) module within the Department's Juvenile Justice Information System (JJIS), and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) results. The provider has a written program operating procedure, which outlines the hiring authority process for employment.

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.).	

There was a total of four staff requiring a five-year background rescreening during the annual compliance review period. Each of the staff member's five-year rescreening was completed every five years. The reviewed background rescreenings were submitted to the Department's Background Screening Unit (BSU)/Clearing House at least ten business days prior to the staff member's five-year anniversary date. The program reported not having any volunteers, mentors, and/or interns who required a five-year rescreening since the last annual compliance review.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *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 had a total of twenty-eight Central Communications Center (CCC) calls since the last annual compliance review. Three of the twenty-eight were allegedly related to physical, psychological, or emotional abuse. A minimum sample of five CCC incidents were reviewed; two of which had no substantiated findings, two were found to have substantiated findings related to physical, psychological, or emotional abuse, and one incident was still under investigation. Seven staff personnel records were reviewed for adherence to the program's code of conduct. The staff personnel records contained a signed copy of the code of conduct. A walk-through of the program, during the annual compliance review, observed postings of numbers for

the CCC and the Florida Abuse Hotline. The program has a written facility operating procedures (FOP), which addresses incident reporting requirements and child abuse reporting procedures. Reporting of child abuse by staff: Any staff member with the knowledge or suspicion of an incident of child abuse is occurring or has occurred has the obligation as a mandated reporter to report the incident to the Florida Abuse Hotline. The employee will complete an information report regarding the incident and forward the information report to the program director as a courtesy, it is suggested the employee inform the program director. Reporting of child abuse by a youth: In the event a youth wishes to report abuse, the youth will, at the earliest possible time, be afforded the opportunity to contact the Florida Abuse Hotline. The following steps are to be followed by the shift supervisor: If the youth makes a request to a youth care worker (YCW) to make an abuse call, the YCW will contact the shift supervisor immediately to inform him/her of the request by the youth to make an abuse call. All youth shall have unimpeded self-reporting access to the Florida Abuse Hotline and/or the CCC. This means the youth does not need permission from anyone to make a call to the abuse hotline and does not need to explain why he wants to call the Florida Abuse Hotline. No attempt to discourage or intimidate the youth from calling the hotline shall be made, and the youth shall not suffer any consequence or reprisal for calling the hotline. All youth over the age of eighteen, will be allowed to report alleged abuse to the CCC. Interviews were conducted with seven youth. All seven youth stated they felt safe at the program. None of the youth reported ever having been stopped from reporting abuse to the Florida Abuse Hotline or CCC (if eighteen years or older), since they have been at the program. Each of the youth stated, the staff are respectful while talking with them and other youth. Each youth was asked if they had heard staff use curse words when speaking with them or other youth and how often; all seven youth replied, never. Interviews were conducted with seven staff. Staff explained the process for allowing staff and youth to make contact with the Florida Abuse Hotline or CCC to report suspected abuse. The staff also stated, they have never observed a co-worker tell a youth they could not contact the Florida Abuse Hotline. All the staff interviewed stated they have never observed a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. An interview with the program director confirmed the program's policy includes professionalism and work ethic expectations, as well as disciplianary actions. The program director reports any allegations of physical abuse, threats or profanity toward a youth are investigated by management staff. The program director indicated any incidents listed as reportable on the CCC checklist are reported within two hours of the incident or immediately if there are allegations of suspected abuse. The program director confirms youth will receive phone calls to the Florida Abuse Hotline as requested, and any youth reporting to the Florida Abuse Hotline will be reported to the CCC.

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

The program had a total of twenty-eight Central Communications Center (CCC) calls since the last annual compliance review. There were three of the twenty-eight, which were allegedly related to physical, psychological, or emotional abuse. A total of five incidents were reviewed. Two of the five incidents reviewed were found with substantiated findings related to physical, psychological, or emotional abuse. One of the five CCC incidents, did contain a finding of substantiated for improper supervision. One of the five CCC incidents was found to be unsubstantiated. The fifth CCC incident reviewed was still under investigation. The program provided internal investigations for each of the incidents reviewed. There is evidence based

upon documentation provided, which supports management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program director responded when asked, how do you ensure staff and youth are knowledgeable in contacting the Florida Abuse Hotline and CCC, do you incorporate the results into management meetings; he replied: Abuse reporting is discussed with youth at intake, is included in their student handbook, and is posted on all dorm bulletin boards. Staff are trained during the new hire process regarding abuse reporting, complete annual training regarding abuse reporting, and a refresher training on abuse reporting through staff 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 twelve Central Communications Center (CCC) calls in the last six months. A minimum sample of five CCC reports were reviewed. In all five reports reviewed, the CCC was notified within two hours of the program becoming aware of the incident. There were no indications of any internal incident reports and/or grievances which should have been reported to the CCC. The program has seen a decrease in the total number of reportable incidents to the CCC; the program had sixteen CCC reports for the previous six-month period and twelve total CCC incidents over the past six-month period. The program director was also asked to explain the program's incident reporting process, he replied: Any incidents listed as reportable on the CCC checklist will be reported within two hours of the incident. Any reports of abuse or suspected abuse will be reported to the Florida Abuse Hotline and CCC immediately. Youth will receive phone calls to the Florida Abuse Hotline as requested, and any youth reporting to the Florida Abuse Hotline will be reported to the CCC.

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

The provider has had two Protection Action Reports (PAR) interventions within the last six months. Both PAR intervention reports reviewed were completed by the end of the staff member's workday. Each of the PAR reports included statements from all staff involved. None of the PAR interventions reviewed required the use of mechanical restraints. None of the PAR interventions resulted in any injury to a youth or staff. None of the PAR interventions documented any allegations of abuse made by youth or staff. Each of the PAR reports had a review completed by a PAR certified instructor or supervisory staff. One of the reports indicated a PAR medical review was necessary. There was supporting documentation the youth was seen by the on-site nursing staff. The reports indicated a Post-PAR interview was conducted with the youth by the administrator, or designee, as soon as possible, but no longer than thirty-minutes after the incident. Each of the PAR reports were reviewed by the administrator, or designee, within seventy-two hours of the reported incident, excluding weekends and holidays. A copy of the PAR reports is placed in the program's centralized file within forty-eight hours of being signed by the administrator. The program submits a monthly summary of all PAR

incidents to the Department by the fifteenth of each month. The program's PAR plan was approved by the Department. The program has not had an increase in the number of PAR since the last annual compliance review. The program's PAR rate during the annual compliance review period was 0.45, which is below the statewide residential PAR rate of 2.28. The program director confirmed PAR incidents are documented, reported to the Department, and program management conduct camera reviews of all PAR incidents.

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.	

A sample of seven staff training records were reviewed for pre-service and certification requirements. All were certified within 180 days of their respective hire dates. The seven staff completed a minimum of 120 hours of pre-service training. Each of the staff completed the following pre-service training: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) training. In addition, the staff completed professionalism and ethics (to include standards of conduct), suicide prevention/intervention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) training. The seven staff also included evidence of completion for contract specific training in areas of restorative justice, gender specific services, post-traumatic stress syndrome, and stress management. The program also provided the following enhanced treatment need specialized training for staff working with youth who are or with Mental Health Overlay and Substance Abuse Treatment Overlay Services. All seven staff training records reviewed indicate completion of training requirements within the Department's Learning Management System (SkillPro). All instructors are qualified to deliver training provided. The program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training, which includes course names, descriptions, objectives, and training hours for any instructor-led training based on the above topics. The pre-service training plan was submitted, October 2, 2018.

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.*	

A sample of seven staff training records were reviewed for in-service training requirements. A sample of four direct-care and three supervisory staff were selected for review. The seven staff reviewed received at a minimum of twenty-four annual training hours. All seven staff reviewed, received cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED) training for calendar year 2019. Each of the staff completed Protective Action Response (PAR) update training. Staff also had training in professionalism and ethics (to include standards of conduct), and suicide prevention training. Each of the three supervisory training records reviewed, included at a minimum eight hours of additional training in areas specific to management, leadership, personal accountability, employee relations, communication skills, and fiscal training. All instructors are qualified to deliver training provided. 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 based on the above topics on October 2, 2018. The program has an annual in-service training calendar, which is updated as changes occur. The provider hires youth care workers (YCW) and YCW IIs, which are staff considered to be direct-care staff and included in the staff-to-youth ratio. Three licensed nursing staff were found to have current certification in CPR with AED.

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

The program's written policy and procedures includes training requirements of the grievance process. A review of a sample of staff training records determines they have received the required training on the program's grievance process and procedures. The program's grievance process includes an informal phase, formal phase, and appeal phase. The informal phase is if a youth decides they wish to grieve a situation which has occurred, they may approach the staff on duty at the time of the situation and informally attempt to resolve the grievance. Those grievances involving allegations of sexual abuse, the youth may fore go this avenue. The formal phase is if the youth determines the resolution from the informal phase was unsatisfactory, the youth will obtain a grievance form from a mailbox located next to the locked grievance box and complete the form. Upon completion of the grievance form, the youth will drop it into the locked grievance box. The box will be checked by a staff member designated by the program director five days a week. The grievance forms will be logged and forwarded to the staff member's supervisor for review and response.

Any grievance alleging sexual abuse will be forwarded immediately to the program director. The supervisor will interview all parties concerned and will render a written response to the youth within seventy-two hours of receiving the grievance. The youth must sign the grievance form acknowledging receipt of a written response and whether the grievance was resolved or not if the youth is satisfied with the response, the grievance is filed. If the youth is not satisfied with the response and the supervisor cannot support the grievance, then the supervisor will initiate the appeal phase. The appeal phase is if the supervisor cannot support the grievance, the supervisor will automatically forward the grievance to the program director. The program director or designee will render a final decision within seventy-two hours of receipt of the grievance. The program maintains copies of the grievances for the past twelve months. A minimum of five grievances were reviewed. Each grievance contained the nature of the grievance. Each of the grievances reviewed documented the informal phase. The grievances documented date of the grievance and date of response conducted at the formal phase. Four of the five grievances documented the grievances were resolved at the formal phase. The fifth grievance went through the appeal phase and was resolved at this level. All five reviewed grievances were responded to, within specified timeframes (according to the program's written policy and procedure). In accordance with the program's written policy and procedures, staff ensure any youth requesting to file a grievance be given the proper forms, assistance, and instructions on the preparation and submission of the grievance. Seven youth interviewed were able to explain the program's grievance process. Six of the seven youth replied they had never written a grievance. Each of the seven youth interviewed reported they can ask for assistance when completing a grievance form. Seven staff interviewed were able to explain the program's

youth grievance process. The program director was interviewed and explained the program's grievance process.

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.	

Ten staff reviewed have been trained in a specific delinquency intervention model. All training reviewed for each staff noted the staff's date of training. Each these staff personnel records noted their level of education. Each of the staff reviewed, had a number of years of experience working with adult or juvenile offenders. Administration considered the education and work experience when determining staff delivery of delinquency intervention services. A review of the provider's contractual agreement revealed the required services to be Impact of Crime (IOC), Life Skills Training (LST), Thinking for a Change (T4C), Anger Management Life Skills (ARISE), Seven Challenges, and Moral Reconation Therapy (MRT). LST is an evidence-based practice curriculum. The IOC, MRT, Seven Challenges, and T4C curriculums are a promising practice type curriculum. The ARISE curriculum is a practice with demonstrated effectiveness curriculum. A review of the program's activity schedule determined the program provides structured, planned programming or activities at least sixty-percent of the youths' awake hours.

A review of group sign-in sheets demonstrate groups are delivered as indicated on the program's youth activity/group schedule. A review of sample staff training records was conducted, each of the seven staff were trained on evidence base-based strategies. Seven youth were reviewed for involvement in a delinquency intervention which is evidence-based, promising practice, a practice with demonstrated effectiveness, and any other intervention approved by the Department. Each of the seven youth were participating in at a minimum one of the program's delinquency interventions. Each of the youth was involved in a delinquency intervention addressing an identified priority need. The youth's performance plans addressed an identified priority need. The program director reports staff members are selected for delivery of life skills training or groups based on their background of facilitating training, groups, or mentoring sessions.

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 youth at the program receive life and social skill intervention services, which specifically address, at a minimum: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking (to include problem-solving and decision making) skills. The program's process to determine services delivered, is accomplished through a youth needs assessment, which will identify youth with physical or developmental limitations and specialized training will be developed to meet the limitation of the youth. All youth at the program will be provided with social and life skills training on a daily basis, either informally through casual, everyday conversation with and observation of staff and providers

who role model and reinforce appropriate social skills, and through more structured and intentional counseling.

A review of the provider's contractual agreement, revealed the required delinquency intervention services to be Impact of Crime (IOC), Life Skills Training (LST), Thinking for a Change (T4C), Anger Management Life Skills (ARISE), Seven Challenges, and Moral Reconation Therapy (MRT). These delinquency interventions engage youth in life and pro-social experiences, which allow youth to make appropriate informed decisions. A review of the program's activity schedule demonstrates youth are in receipt of life skills education, training, and/or groups as required. A review of group sign-in sheets was conducted and determined the program's life and social skills are delivered according to the program's group/activity schedule. The clinical director reports being responsible for the oversight of all aspects for the mental health and substance abuse programs, clinical supervision to all non-licensed therapists, and auditing of youth clinical records for compliance standards. Seven youth were interviewed and asked if they participated and what groups and activities do you do in your groups. The youth provided input to those groups they were in and what they have learned while participating. Additionally, each youth described the new skills or behaviors they had been taught while in groups.

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 contract addresses services for youth concerning restorative justice implementation at the program. The restorative justice activities are planned to assist youth accept responsibility for harm they have caused by their past criminal actions. Also, teaches youth about the impact of crime on victims, their families, and their communities. The restorative justice philosophy is built to expose youth to each victims' perspectives through victim speakers. In addition, provide opportunities for youth to plan and participate in reparation activities intended to restore victims and communities. Seven staff training records were reviewed, each had required training for restorative justice awareness. A review of the program's activity schedule demonstrates youth are in receipt of restorative justice awareness groups and activities. A review of group sign-in sheets was conducted and determined the program's life and social skills are delivered according to the program's group/activity schedule. Seven youth records were reviewed for delivery of services to increase accountability for criminal actions and harm to others. All seven youth reviewed are in receipt of restorative justice awareness services. The program director was interviewed and asked to explain what types of restorative justice groups/activities are provided to the youth, he replied: Impact of Crime (IOC) groups are held on Tuesday, Wednesday, and Thursday, for an hour. The youth regularly participate in community service activities. In addition, youth are exposed to victim perspective through victim speakers thorough IOC groups. All youth receive these services prior to completion of the program.

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.	

A review of the provider's contractual agreement for gender specific programming is Boys Council and Fathers in Training curriculums. The program demonstrates a program model

which addresses the needs for a male population. The program designs specific service delivery, based on the common characteristics of its male population, whereas all youth are eligible for Boys Council and those youth identified as being fathers are provided with Fathers in Training services. The program's activity schedule provides gender-specific programming. A review of sign-in sheets for gender-specific programming, demonstrates the program is delivering according to the program's group/activity schedule. An interview with the program director was conducted, which revealed the program addresses the needs of the males at the program with Boys Council and Fathers in Training curriculums.

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

The program has a written policy and procedures in place to provide a continually updated alert system which is easily accessible to program staff and keep them informed of youth who may have medical risks, suicide or other mental health risks, safety, security or escape risk, aggressive behavior, or sexual predator risks. According to the written policy and procedures, upon admission and at any other time which information is ascertained, information concerning a youth's medical risk, suicide or other mental health risk, safety, security or escape risk, aggressive behavior, or sexual predator risks are communicated to staff. Alert rosters were observed to be maintained in the kitchen, medical office, master control, program director's office, and on the staff bulletin board by the copy machine. Seven youth were reviewed for alerts. All seven youth were applicable for either a medical, mental health, or security alerts. Alerts were verified and updated by appropriate program staff upon the youth's admission to the program. The program's internal alerts were observed to be consistent with the Department's Juvenile Justice Information System (JJIS). Alerts were observed to be entered, closed, and/or updated by appropriate personnel. Five of the seven staff interviewed reported alerts are kept in master control and two reported alerts are discussed during shift briefings. The program director reported alerts are reviewed through JJIS and during department meetings, which are held biweekly. Additionally, case management and medical notify the control room and appropriate staff members upon admission or when changes are made. The program director reported appropriate departments enter applicable alerts and management reviews all alerts and ensures notifications are made.

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 youth records for healthcare, mental health, and case management. The youth individual management record included a file tabs which contained, youth's name, Department of Juvenile Justice identification number, date of birth, county of residence, and committing offense. The youths' individual management record contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous section. All youth records were labeled "Confidential." All official youth case records are secured in a locked file cabinet or a locked room. The program clearly identifies any file cabinet used to store official youth case records as "Confidential."

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

The program has a formal process to promote constructive input by youth. The program solicits input from youth through peer advisory boards, which are conducted monthly. A suggestion box, which is accessible and checked daily and through youth surveys. The program has a written facility operating procedures which addresses practices for solicitation of youth input. Seven youth were interviewed, each agreed the program has a process allowing youth to provide input about what happens at the program. The program director confirmed youth use the grievance process or youth request forms to openly address any concerns or issues regading systemic issues impacting the residential community. In addition, youth are allowed to make recommendations to improve conditions and enhance quality of life through, Town Hall Meetings, Peer Advisory Board, Request forms, and open access to program director and assistant program directors.

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.	

The program has a community advisory board which meets at least ninety to 120 days. A review of sign-in sheets, agendas, and minutes from advisory board meetings were reviewed. There was documentation to support where the program director actively solicits active involvement from law enforcement, judiciary community, other community partners, business community, school board, and faith community. The program director also recruits victim advocate and a parent whose child was previously involved in the juvenile justice system. The review team member contacted a board member to determine level of involvement in program activities; she has received numerous emails and phone calls soliciting her attendance for meetings, however, presently she has been unable to attend due to other work commitments. She is however enthusiastic with wanting to participate and attempt to provide support when she is in attendance. The program director was interviewed, he stated, community advisory boards convene quarterly and is scheduled based upon availability of members. Members include community providers, law enforcement, education, local businesses, and local faith groups.

Members also provide various opportunities for youth in the community to work with the community to enhance the availability of opportunities to youth within the program. Recommendations for community involvement and employment have been utilized as identified by board members.

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

A review of youth and parent/guardian surveys were conducted for program planning. The Comprehensive Accountability Report (CAR) and Monitoring and Quality Annual Compliance report are published reports related to the program, which is generated by the Department of Juvenile Justice annually. The results of the reports and surveys are incorporated into program planning; results are shared with staff during all staff meetings conducted at a minimum monthly. Monthly staff meetings afford both management and staff to communicate openly regarding findings of reports and surveys conducted. Sign-in sheets demonstrate staff are in attendance to staff meetings held monthly. The program director ensures provisions for staffing, to include at a minimum a system of communication to keep staff informed and give opportunities to provide input and feedback pertaining to operation of the program. In addition, staff incentive and retention planning including steps to minimize turnover and improve employee morale, which is addressed in the program's written facility operating procedures (FOP). A review of the contract found two separate amendments for staffing retention bonuses. In addition, the program utilizes gift cards as rewards for staff, staff appreciation, and employee of the month. The program's FOP provides those practices utilized for staff communication, opportunities to provide input, and feedback on the program's operations. Other staff incentives include recognition for perfect attendance, above and beyond performance, monthly drawings, and cookouts. Currently the program has three youth care worker and one master control operator vacancies. Shift briefings are conducted on each shift daily. Management meetings are held weekly with department heads. All staff meetings are held at a minimum monthly. Shift supervisor meetings are conducted monthly.

Seven staff were interviewed; each described when and how often staff meetings are held. Staff also shared what topics are discussed and how valuable and informative the meetings are. Five of the seven staff agreed they are briefed on any annual reports and/or youth and parent/guardian survey results. One staff stated they have not been here at the program long. The seventh staff did not provide any comments. The seven staff reported they felt good to very good concerning how effective they believed communication is amongst the staff at the program. Each of the seven staff provided feedback and supported having the ability to provide input and feedback into the program operations. The program director was interviewed and asked to explain program problems with staff turnover and morale; he replied: Incentive programs are utilized to address potential turnover and morale issues, these include: employee of the month, perfect attendance awards, etc. The program director stated all data from surveys/reports is reviewed and changes made for program planning and assessment purposes. In addition, all data is reviewed by management staff and information is disseminated to staff members as appropriate. Input from staff members is utilized for potential improvements from published reports. This is accomplished through meetings which are conducted as follows: staff meetings are held monthly, supervisor meeting is held monthly, informal management team meetings are held biweekly, and daily shift briefings are utilized to keep staff abreast to daily changes.

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

The program has a written facility operating procedures (FOP) to determining the system for evaluating staff, performance standards, and frequency of evaluations. The FOP identifies staff evaluations occur annually. Evaluations for new hire staff are conducted during the orientation process (every thirty days) up to 180 days of the staff hire date. A review of job/position descriptions demonstrated staff member's performance standards are clearly identified. A review of staff performance evaluations demonstrated they are completed as outlined in policy (annually). Staff are evaluated annually on established performance standards. Performance standards match job descriptions for each staff. The program's required positions are maintained and performed as outlined in the contract. The program director was interviewed and was asked to explain the annual evaluation process for staff; he replied: All staff members receive annual evaluations from the appropriate supervising staff member. These evaluations assess areas of strength and for improvement of each staff member and allow the supervisor and staff member to set goals for the coming year. Seven staff were interviewed and asked if they had received a formal evaluation of their performance, based upon their performance standards. Staff agreed they had been in receipt of a performance evaluation.

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

The program has an activity schedule, which provides for daily recreation and leisure type activities. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook documents activities is occurring according to the program's activity schedule. The program's written facility operating procedures (FOP), provide activities based on the developmental levels and needs of the youth in the program. Activities include a choice of leisure and recreation options. Youth are encouraged to explore interest. Youth are engaged, when allowed, in constructive use of leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. In addition, mental health and substance abuse groups and individual therapy promote youth to address pro-social and cognitive skill development. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury. Observation of recreational activities, along with the activity schedule, concluded the program is providing on-going activities and adherence to schedule. The program contract has one recreational therapist position. The recreational therapist credentials were reviewed and approved. A review of youth's individualized performance and/or treatment plans demonstrated therapeutic activities are included. The program has a formal process to promote constructive input by youth. Seven youth were interviewed, each of the youth agreed there are physical activities and leisure activities provided for at least one hour. In addition, the youth agree they are provided with varying degree of mental and physical exertion throughout the day. Seven staff were interviewed and provided an example of amount of time and types of indoor and outdoor activities youth engage in.

Standard 2: Assessment and Performance Plan

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

Seven case management records were reviewed for initial contacts to parent/guardian and court notification. In all seven records, the program notified the parent/guardian by telephone within twenty-four hours of admission, as well as in writing within forty-eight hours of admission. All seven records had notification to the court and juvenile probation officer (JPO) within five working days of the youth's admission.

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

Seven case management records were reviewed for youth orientation. All seven youth completed orientation on the day of admission. The orientation included services available at the program, daily schedule, expectations and responsibilities of the youth, the behavioral management system, availability and access to medical and mental health services, access to the Florida Abuse Hotline and/or the Central Communications Center (CCC), zero-tolerance policy for sexual misconduct, how to report sexual misconduct, and right to be free from sexual misconduct. The orientation also includes items to be considered as contraband, performance planning process, dress code and hygiene practices, procedures for visitation, mail, and telephone, expectations for release, community access, grievance procedure, emergency procedures, program tour, assignment to a living unit, and medical topics as outlined in Chapter 63M-2. The program did not have any intakes scheduled the week of the annual compliance review. Seven youth were asked if orientation began within twenty-four hours of admission and all stated yes. These same seven youth said the orientation included going over the program rules, expectations, and schedules.

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

One of the seven case management records were applicable for this indicator, so two additional applicable case management records were reviewed. All three records applicable for this indicator had written consent obtained from youth eighteen years of age or older before providing or discussing information with a parent/guardian or Department of Children and Families.

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 written policy and procedures in place which outlines the program's classification process. Seven case management records were reviewed for classification factors, procedures, and reassessment for activities. All seven records initial classification date was also the date of the youth's admission. All seven records initial classification factors included, physical characteristics, age, maturity level, and identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization from previous Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB)s. None of the seven records had a new VSAB completed and entered into the Juvenile Justice Information System (JJIS) prior to room assignment. The classification also included suicide risk, medical risk, escape risk, security risk, and a review of the JJIS alert list.
All seven youth had a reassessment completed which gave each youth an increase in privileges or freedom of movement. Six of the seven youth had a reassessment for participation in work projects or other activities involving tools or other instruments. The seventh youth had not been at the program long enough to receive this reassessment. Two of the seven youth had a reassessment for participation for off-campus activities. The program's internal alert system consists of medical staff obtaining information regarding food allergies, restrictions, special diet needs, medical conditions, medical allergies, and other environmental allergies. A Special Dietary Request form is completed by the nurse and posted in the kitchen. This information is all placed on the Medical Alert Roster as well as all chronic medical problems or conditions, which is posted in the Nurses Office, Control Rooms, Dietary Services, Education Department, therapist, recreation aide, program director, and case managers. These alerts are posted, deleted, and changed as necessary by the nurse. If a youth is placed on a mental health alert, the therapist and shift supervisor notify the control room operator to make an entry into the logbook and make a mental health alert status on the dry erase board in the control room. If a youth is deemed to be a flight risk, the youth's name will be added to the Flight Risk List, which is posted by each exit door. The program director was asked how certain factors are considered when assigning youth to a living unit. He replied all rooms are single bed and they are placed based upon program assignments and adjustments are made as needed to accommodate special needs. This process is assessed with the treatment team.

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.	

Two of the seven case management records were applicable, so an additional record was reviewed. All three applicable records notified the youth's local law enforcement of suspected gang activity, as well as the program's school principal. All three youth had previous gang alerts

entered into the Department's Juvenile Justice Information System (JJIS) by the juvenile probation officer (JPO) prior to placement at the program.

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

The program has written policy and procedures in place for early detection, deterrence, and speedy reporting to local law enforcement agencies. The policy does not address the opportunity for a youth to develop a plan to dis-affiliate with a criminal street gang.
Two of the seven case management records were applicable, so an additional record was reviewed. The program utilized Impact of Crime (IOC) for gang prevention and intervention strategies, as well as gang intervention worksheets. All three applicable youth participates in IOC and each youth's performance plan includes a goal and objective related to gang intervention strategies for the youth to complete prior to release from the program.

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.	

Seven case management records were reviewed for Residential Assessment for Youth (RAY) and reassessments. All seven records had the initial RAY assessment completed within thirty days of admission and the assessments are maintained in the Department's Juvenile Justice Information System (JJIS). One youth has not been at the program for ninety days, so was not applicable for a reassessment. Five of the six remaining applicable youth had a RAY reassessment completed within ninety days of the initial RAY. The sixth youth had the RAY reassessment completed nine days late. All six applicable records maintained the RAY reassessments.

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

Seven case management records were reviewed for completion of a Youth Needs Assessment Summary (YNAS). All seven were completed within thirty days of admission and documented in the Department's Juvenile Justice Information System (JJIS).

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

Seven case management records were reviewed for performance plan development, goals, and transmittal. All seven records had the individualized performance plan developed within thirty days, but after the initial assessment, of each youth's admission. The following individuals were present during all seven youth's development of the individualized performance plan, treatment leader, youth, administrative representative, treatment staff, and educational staff. Two of the seven records had Department of Children and Families (DCF) caseworkers. In both cases, a message was left for the DCF worker requesting their involvement. All seven records had signatures from the youth and treatment leader. All other pertinent parties place their input prior to the meeting either verbally or written. The program sends a copy of the performance plan to the parent/guardian, court, and juvenile probation officer (JPO), but does not require the parent/guardian to sign the signature sheet and return to the program. All seven individualized performance plans included goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment, the top three criminogenic needs, and delinquency interventions which will decrease criminogenic risk factors and promote strengths, skills, and supports to reduce the likelihood of reoffending. Four of the seven records had applicable court ordered sanctions placed in the individualized performance plans. The remaining three youth did not have any court ordered sanctions. All seven performance plans contained transition activities targeted for the last sixty days of the youth's anticipated stay, each youth and staff responsibilities to complete goals, and target dates for goal completion. All seven records had a transmittal letter sent to the court and JPO within ten working days of the plan being completed. Five of the seven youth had the plan sent to their parent/guardian, while the other two youth had the plan sent to their DCF caseworkers within ten working days. Seven youth explained the treatment team process as monthly with case managers, therapists, JPO, education, administration, and/or parent/guardian to discuss grades, progress, and behavior. Six of the seven youth interviewed stated they received a copy of their performance plan. The seventh youth said he did not care about having a copy.

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.	

Six of the seven case management records were applicable for revision to the youth's performance plan. The seventh has not been in the program for ninety days. All six applicable records had a performance review completed every ninety days based upon each youth's demonstration of progress toward completing a goal. Five of the seven records were applicable

for revisions to the individualized performance plan to facilitate transition activities during the last sixty days of the youth's stay. The sixth and seventh youth were not eligible.

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.*	

Six of the seven case management records are applicable for this section of the indicator. The seventh youth has not been in the program for ninety days. All six applicable records had a performance summary completed every ninety calendar days following the signing of the initial performance plan. All six performance summaries included the youth's status on each goal, overall treatment progress, academic status and credits earned, behavior, level of motivation/readiness to change, interaction with peers and staff, overall behavior adjustment to the program, significant positive and negative events, and justification for release. In all six performance summaries, each youth is allowed to read and add comments prior to signing, the youth is provided a copy of the summary, and the original is filed in each youth's case management record. In all six performance summaries the treatment team leader, the staff who prepared the summary, program director, and youth signed and dated each summary. All six summaries were sent to the court and juvenile probation officer within ten working days. Four of the six youth had the summary sent to their parent/guardian, while the other two youth had the summary sent to their DCF caseworkers within ten working days. All six youth were provided a copy of the summary. Three of the seven records are applicable for this section, release summary, of the indicator. All three records had the release summary and Pre-Release Notification (PRN) sent to the juvenile probation officer at least forty-five days prior to each youth's planned release. All three are retained in each youth's case management record. One youth was approved and the program provided written notification to the youth's parent/guardian of the planned release. However, a Residential Assessment for Youth was not completed upon the approval of the youth's planned release. Seven youth were asked if they received a copy of their performance summary and six stated yes, while one said no.

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 utilizes many methods to encourage parent/guardian involvement in case management services. During the assessment process, the case manager will call the youth's parents/guardians to gather more information on the youth and ask their opinion on what they believe needs to improve with their child. Each month the case manager will send letters to the parents/guardians with the treatment team schedule. The program also sends an email, if possible, to each parent/guardian inviting them to participate in the treatment team meeting through Zoom. If the parent/guardian is unable to attend the meeting, the case manager will work with the parents/guardians to give written or verbal input prior to the meeting. Prior to

COVID-19, the program was hosting family days for parents/guardians to come spend time at the program with the youth and staff. Seven youth were asked if their parents/guardians are involved in their case management plans and all seven said yes. The program director as asked how the program encourages parental involvement in case management. He replied parent/guardian surveys, input forms, treatment teams, and regular contact with the parents/guardians.

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

The members of the program's treatment team include the following, treatment team leader, youth administrative representative, treatment staff, juvenile probation officer (JPO), parent/guardian or Department of Children and Families (DCF) caseworker, program's gang prevention specialist, and transition services manager. The living unit representative, recreational therapist, and education staff are not always physical present but do give input either verbally or written. Medical staff do participate in treatment team if the youth is on medication. In all seven case management records reviewed, all parties were invited for the treatment team. In four of the seven records, all parties participated in the treatment team. The fifth youth, the JPO was left a message but did not participate, the sixth youth, the DCF caseworker was left a message and did not participate, and the seventh youth, the post-commitment counselor was left a message, but did not participate.

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

Seven youth case management records were reviewed for incorporation of other plans into performance plans. In all seven records the initial performance plan (IPP) references/incorporates the academic plan and a separate treatment plan. The two applicable youth also have the IPP to reference/incorporate the Department of Children and Families care plan.

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.	

Seven youth case management records were reviewed for formal and informal treatment team meetings. All seven youth had a formal review held at least every thirty days. All seven performance reviews included the youth's name, date of review, any comments, 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, Residential Assessment for Youth, and an opportunity for the youth to demonstrate a skill he has learned at the program. All seven case management records had documentation in the case record reflecting informal reviews were conducted monthly with the youth and case

manager. All seven informal reviews included the same information as the formal review, excluding meeting attendees and the RAY Reassessment results instead of the RAY. The program did not have any treatment team scheduled the week of the annual compliance review. Seven youth were asked, and confirmed staff review youth's performance and progress toward goals. These same seven youth also said they are giving opportunities during treatment team to demonstrate skills they have learned at the program and talk about progress.

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

Five of the seven case management records were applicable for this indicator. All five records had samples of employment applications, a résumé, documentation indicating the location and hours of a local Career Source Center, and documentation the youth's parent/guardian and juvenile probation officer are aware of the vocational plan. None of the five youth had appropriate documents for obtaining employment. The case manager has asked for the documentation but has yet to receive it. The program offers a Type 2 educational programming. The career education programming includes communication, interpersonal, and decision-making skills. The program's vocational and career education program is appropriate for the educational abilities and goals of the youth in the program. The career education programming is appropriate for the length of stay and custody characteristics of the youth in the program. Each youth participates in the CORE curriculum and is required to maintain passing grades, display appropriate behavior, and participate in the classroom. During school, youth complete My Career Shines, which is an assessment to help determine job interests, as well as completing sample job applications and a résumé. The program also gives youth the opportunity to earn Safe Staff certification. The program director advised Home Builders Institute (HBI), carpentry, woodshop, credit recovery, employability skills training, and opportunities for outside employment are also available at the program.

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

The program operates the educational services through the Rader Group, Inc. under the supervision and direction of the Okaloosa School District on a year-round basis. The program provides two hundred and fifty days of educational and vocational instruction over a twelve-month course, with a minimum of twenty-five hours of weekly instruction. The teachers use ten days for teacher planning/training. A review of the program's logbook and school schedule reflected the youth are attending school as scheduled. Six of the seven youth reported no interruptions during education instruction.

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

None of the seven case management records were applicable for this indicator, so three additional closed files were reviewed. All three youth had an individual education transition plan developed at admission based on each youth's post release goals. All three records had the

following key personnel involved in the transition, the youth, parent/guardian, instructional personnel in the juvenile justice education program, department personnel for youth in residential program, personnel from post-release school district, a registrar of the program's district who has access to the district's management information system. All three records contained a transition plan developed with the youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. All three education transition plans addressed the following, services and intervention based on each youth's assessed education needs and post-release education plans, recommended education placement for post-release must be based on individual needs and performance, and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. All three youth's education transition plans also included provisions for continuation of education and/or employment, completed employment applications, a résumé, a state-issued identification card, and the location and hours of a local Career Source Center. Two of the three records had documentation essential to obtaining employment. The third youth did not have a copy of his social security card. All three records had evidence the youth's case manager and parent/guardian are aware of the plan, documents, and post-release discharge plans.

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

Four of the seven reviewed case management records were applicable for this indicator, transition planning, and conference, and Community Re-Entry Team (CRT) meeting. All four records held a transition conference at least sixty days prior to each youth's targeted release date. In all four records, the following attended the transition conference, the youth, treatment team leader, program director, other team member, either in person or provided verbal or written input, juvenile probation officer, parent/guardian, education staff, and any other pertinent parties. In all four records, the following was reviewed during the conference, transition activities on each youth's performance plan, identify target completion dates, and identity persons responsible for completion. In all four records, the treatment team leader obtained attendees dated signatures representing acknowledgement of the transition goals and accountability for completion.

None of the four records were eligible for a CRT meeting, therefore, three applicable closed files were reviewed. In all three records, the case manager received an invite for the CRT meeting,

the CRT meeting was conducted prior to release, and the youth and case manager participated in the meeting.

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

None of the seven case management records were applicable, so three applicable closed records were reviewed. All three records had an exit portfolio which was discussed and initiated for each youth at the transition conference. All three portfolios contained a state-issued identification card, a copy of the youth's transition plan, a calendar with upcoming community appointments, birth certificate, educational and/or vocational certificates, educational records, school transcripts, a résumé, and completed employment applications. Two of the three records had a copy of the youth's social security card. All three portfolios were verified at the Exit Conference and given to the youth upon release. All three portfolios were forwarded by the program to the juvenile probation officer and documented in each youth's case management record.

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

None of the seven case management records were applicable, so three applicable closed records were reviewed. All three records had an Exit Conference conducted after the program notified the juvenile probation officer (JPO) of each youth's release. All three exit conferences were conducted at least fourteen days prior to release and had documentation in the case record, including the date, signatures, and a summary pending transition goals. All three records had the date of admission and date of termination verified in the Department's Juvenile Justice Information System and correlate with the program's case file. The following individuals participated in all three exit conferences, treatment team leader, parent/guardian, youth, and other pertinent parties. In two of the three exit conferences, the education representative and JPO also participated. All three exit conferences were held separately from the Transition and Community Re-Entry Team meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker who serves as the designated mental health clinician authority (DMHCA), licensed under Chapter 491, Florida Statute. A copy of the license and position description was available and reviewed. The DMHCA is on-site forty hours a week and on-call on the weekends, to provide oversight of mental health and substance abuse treatment. A review of the LMHC's license through the Florida Department of Health (DOH), Division of Medical Quality Assurance, reveals the license is clear and active through March 31, 2021. The DMHCA interview described his role in the coordination and implementation of mental health and substance abuse services at the program. The DMHCA delivers clinical supervision to all non-licensed therapist. In addition, audits clinical charts for compliance to standards. The program provides mental health and substance abuse overlay specialized services. The DMHCA provides daily communication between himself and other clinical staff at the program.

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 designated mental health clinical authority (DMHCA), ensures the one licensed clinical staff working under his supervision are performing services which they are qualified to provide, based on education, training, and experience. A review of the program's contract found the mental health and substance abuse clinical staffing was in accordance with contract and Florida Administrative Code 63N-1 and 64B19-18.0025. The program has one additional licensed mental health professional working under the supervision of the DMHCA. The licensure of both mental health professionals was reviewed and found to be current and active.

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 designated mental health clinical authority (DMHCA), assures the five non-licensed clinical staff working under his supervision are performing services which they are qualified to provide, based on education, training, and experience. A review of the program's contract found the mental health and substance abuse non-clinical staffing was in accordance with contract and Florida Administrative Code 63N-1. Documentation was found where each of the five non-licensed mental health and substance abuse non-clinical staff were receiving at least one hour a week of on-site face-to-face direct supervision by the DMHCA. Documentation of the direct supervision was recorded on a similar form, including all information of the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019). All five non-licensed clinical staff hold a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. Each of the non-licensed substance abuse clinical staff provide substance abuse services as an employee of a service provider, licensed under Chapter 397, Florida Statute.

The program provided documentation for each of the non-licensed mental health staff who have conducted Assessments of Suicide Risk (ASR). The non-licensed mental health staff each have received twenty hours training and supervised experience in the completion of an ASR. The training included administration of at a minimum, five assessments of the ASR or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional. The training was documented on Non-Licensed Mental Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 002). The program is certified under Chapter 397, Florida Statute, and expires October 30, 2020.

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.	

Seven youth records were reviewed for a mental health and substance abuse admission screening. Each contained a completed Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) administered upon the youth's admission to the program. The screening tools were each documented the staff completing the screening, along with the date and time of the initial screening. During the screening process, all available information was reviewed, which included review of the commitment packet, reports, and records from existing documentation of mental health and/or substance abuse problems. Each of the MAYSI-2 screenings reviewed, were administered on date of youth's admission to the program in a confidential manner. The screenings were completed by trained staff. The MAYSI-2 screenings were completed on the Department's Juvenile Justice Information System (JJIS). All the MAYSI-2 screenings reviewed, were completed in full. None of the seven MAYSI-2 reviewed, indicated further assessment was required. For each of the seven youth records reviewed, regardless of the MAYSI-2 findings, a referral was made when the staff believed the youth assessed to have

either a mental health need, substance abuse problem, and was a suicide risk. The seven youth had a referral for further evaluation generated. In six of the seven applicable youth reviewed, the program director was notified an Assessment of Suicide Risk (ASR) was conducted within twenty-four hours or other information obtained at intake suggested potential suicide risk. Six of the seven youth were applicable for completion of an ASR. All seven youth had a referral generated for completion of a comprehensive evaluation. A reason for referral was documented in each of the seven records reviewed. The residential program director has a written facility operating procedures (FOP), which addresses the implementation of a standardized admission and intake for mental health and substance abuse screening process. The written FOP includes a standardized screening process; review of commitment packet information, reports, and records. In addition, administration of the MAYSI-2 on the Department's Juvenile Justice Information System (JJIS). Each screening administered is conducted by a "qualified professional," and a referral made for youth identified in need of further evaluation or immediate attention when necessary. The FOP also, identified staff training in mental health and substance abuse issues and administration of the MAYSI-2. The programs FOP also, identified standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional or, when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving program. The observation of seven youth records, demonstrated the program staff conducting screening, reviewed youth's commitment packet information, reports, and records for existing documentation of all mental health and/or substance abuse problems, needs, or risk factors. An interview with the program director was conducted. The program director reports JJIS screenings are conducted at intake and therapists conduct intensive evaluations at the intake process to identify youth at risk for mental health, substance abuse issues or for suicidal risk factors.

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.	

Seven youth records were reviewed for mental health and substance abuse assessment and evaluations. All seven records reviewed were applicable for completion of a new mental health evaluation. The evaluations were completed within thirty calendar days of the youth's admission to the program. Each of the mental health evaluations were completed by a non-licensed mental health clinical staff person. The evaluations were subsequently reviewed and signed within ten days by a licensed mental health professional. The seven mental health evaluations conducted contained demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, clinical impression, and recommendations. Seven youth records reviewed for completion of a substance abuse assessment. Each of the seven youth records reviewed were applicable for completion of a new substance abuse assessment. The substance abuse assessments were completed under the program licensure; Chapter 397, Florida Statute, and contained a signed consent for substance abuse services, by each of the youth. The assessments reviewed were completed within thirty calendar days of admission. The substance abuse assessments contained a reason for assessment, relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impression, and

recommendations. Each of the substance abuse assessments conducted, addressed the youth's original referral reason.

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.*	

Seven youth records were reviewed for mental health and substance abuse treatment. Records reviewed indicated each of the youth were assigned a treatment team upon arrival to the program. Each of the youth are assigned to an on-site therapist and case manager upon intake to the program. The multidisciplinary treatment team were comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. Each of the seven records contained treatment team documentation, which validates it is comprised of representatives from administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth, and when possible the youth's parent/guardian.

Five youth were applicable for needing substance abuse treatment. Treatment provided consisted of individual, group, and family counseling, which is provided for by non-licensed substance abuse staff, who is an employee of a service provider licensed under Chapter 397, Florida Statute. Each of the applicable youth had a properly executed Authority for Evaluation and Treatment (AET) form on file. Each youth in receipt of mental health services had a documented diagnosis. Those youth in receipt of substance abuse treatment, had a signed Youth Consent for Substance Abuse Treatment forms (MHSA 012) and Youth Consent for Release of Substance Abuse Treatment Records (MHSA 013). Each youth in receipt of substance abuse services had a documented diagnosis. Mental health treatment and substance abuse treatment notes were documented on the provider's form, which contained all the required information within the Department's Counseling/Therapy Progress Note form (MHSA 018).

The review of youth sign-in sheets for mental health treatment groups, documented groups were limited to ten or fewer youth. The review of youth sign-in sheets for substance abuse treatment groups, documented groups were limited to fifteen or fewer youth. The seven youth records reviewed, contained documentation youth were involved in individual psychotherapy or counseling. As noted within each individual mental health and/or substance abuse treatment plan, youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors. On-site substance abuse group is provided for by a licensed qualified professional or a non-licensed substance abuse clinical staff, who are an employee of a service provider under Chapter 397, Florida Statute. Interviews were completed with seven youth. Six of the seven youth stated they participate in groups and are receiving specialized therapies. One youth remarked he has completed Impact of Crime and Seven Challenges groups. Interviews were completed with seven staff. Six of the seven staff responded they do not conduct nor does other direct care staff facilitate any mental health or substance abuse groups. One remaining staff was a therapist, which responded, they teach substance abuse, anger management, and ARISE groups. An interview with the designated mental health clinician authority (DMHCA)

confirmed the program provides both mental health and substance abuse overlay specialized services.

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.*	

Seven youth records were reviewed for youth treatment planning. The record's contained an initial treatment plan and each were developed on the date of the youth's admission to the program. Each of the youth contained an initial mental health treatment plan. The initial mental health treatment plans were site-specific, which included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). Five of the seven records reviewed were applicable for completion of an initial substance abuse plan. Each of the initial substance abuse plans were site-specific, which included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). Each of the reviewed initial mental health treatment plan or substance abuse plans were developed within seven days of admission to the program. The initial treatment plans were signed by the mental health clinical staff person or substance abuse clinical staff person completing the form.

All seven initial treatment plans reviewed, had been completed by a non-licensed mental health clinical staff person. Those plans were each signed by the licensed clinical supervisor, within ten days of completion. In addition, the initial treatment plans were signed by treatment team members who participated in the development of the plan. Five of the seven youth reviewed, were applicable for psychiatric needs. Each of these youth's initial treatment plans, included the youth's psychiatric needs. The psychiatric needs addressed medication and frequency of monitoring by the psychiatrist. Seven youth records were reviewed for individualized treatment plans and reviews. The youth records contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. The seven individualized treatment plans reviewed, were developed on a site-specific form, which contained all the elements of the Department's Individualized Mental Health Treatment Plan form (MHSA 016). The individualized treatment plans were completed by a non-licensed mental health clinical staff person and were subsequently reviewed and signed by the program's licensed supervisor within ten days of completion. All seven of the individualized treatment plans were signed by treatment team members who participated in development of the plan, along with the youth, and parent/guardian, when available.

Five youth were applicable for the inclusion of psychiatric services into each of their individualized treatment plans. These plans also included psychotropic medication and frequency monitoring by the psychiatrist. Each treatment plan review was conducted and documented on a program specific form which contained all the information in the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form (MHSA 017). Each

of the youth's individualized treatment plans documented prescribed services; individual, group, family, or psychiatric. Review of the youth's progress notes determined youth were in receipt of services stipulated on the treatment plan. Twenty-six individualized treatment plan reviews were documented and completed, for each of the seven youth records reviewed. Three additional youth records were reviewed for discharge planning. Each of the three discharge plans were documented on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form (MHSA 011). None of the three youth reviewed required any type of notification for suicide alert or precautions. The three mental health and substance treatment discharge summaries documented the services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. Each of the three discharge plans contained documentation had been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the mental health and substance abuse treatment discharge summary were provided to the youth, JPOs, and parents/guardians in each of the three youth records reviewed.

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

The program is contracted to provide Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The program provides individual, group, and family therapy for MHOS services at least seven days a week. In addition, therapeutic activities are provided by a mental health clinical staff person seven days a week. Psychiatric services are provided on-site at least bi-weekly. Youth with co-occurring substance abuse disorders receive substance abuse services, which is prescribed according to their individual treatment plans. A psychologist is available to provide services, as needed. Therapist caseloads average ten youth for MHOS services. The SAOS program provides urinalysis during intake, upon return from home visits, and random monthly screening. The program provides individual, group, or family therapy for SAOS services at least seven days a week. SAOS groups never exceed more than fifteen youth a group. Youth with co-occurring mental health disorders receive mental health treatment. The program is licensed under Chapter 397, Florida Statute, and a qualified licensed professional is on-site at least five days a week. A licensed psychiatrist provides psychiatric evaluations, medication management, and participates in treatment planning. Substance abuse clinical staff are on-site seven days a week. Therapist caseloads are no more than ten youth for SAOS. An interview with the program director confirms specialized services are provided for at the program. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides both mental health and substance abuse overlay specialized services.

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****	

A total of seven youth records were reviewed for psychiatric service delivery. Five of the seven youth were referred for an initial psychiatric interview. Each of the five youth were seen within fourteen days of the psychiatric referral. The initial diagnostic psychiatric interviews included, youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. Each of the five initial diagnostic interviews with the psychiatrist were documented on the Clinical Psychotropic Progress Note (CPPN). Later, each of the five youth, were in receipt of a psychiatric evaluation within thirty days of referral. Each of the psychiatric evaluations conducted reflected the elements specified in Florida Administrative Code 63N-1. Each of the youth were seen for medication review by the psychiatrist at a minimum every thirty days. Each of the psychiatric evaluations completed were documented on the CPPN. Psychiatric services are provided by a psychiatrist licensed under Chapter 485 or 459. The program holds a physician services agreement with the psychiatrist to render on-site and on-call services. The program does not employ or have a contract with a psychiatric advanced practiced registered nurse (APRN). The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist provides input to a representative of the treatment team on the psychiatric status of each youth in receipt of psychiatric services. In addition, the psychiatrist evaluation and recommendations for youth, is incorporated into the mental health clinical staff's evaluations of the youth and the youth's individualized mental health or substance abuse treatment plan. A review of sign-in sheets for the psychiatrist, confirms on-site visits during the past six months as required by contract. A copy of the psychiatrist license was reviewed and is current. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. The psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. The interview with the program's psychiatrist revealed he conducts psychiatric evaluations, individual therapy with youth, and medication monitoring. The psychiatrist states he is on-site twice a month. A review of the sign-in sheets confirm the psychiatrist was on-site every fourteen days during the annual compliance review period. The psychiatrist meets with the program's designated mental health clinical authority (DMHCA) as needed. The psychiatrist process is for the nurses, case managers, and therapists at the program, to communicate with each other regarding the youth's progress. The nurse, youth, and psychiatrist discuss the youth's issues, medications, and side effects. In addition, the youth's feelings on medication's effectiveness and how youth feels regarding his therapy.

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

The program has a written suicide prevention plan, which details suicide prevention procedures. The written suicide prevention plan included, 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. The program's written suicide prevention plan is reviewed annually.

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.*	

Six of the seven youth records reviewed were applicable for suicide prevention services. The six youth were determined to be at risk during the admission screening to the program. Subsequently, each of the youth were placed on precautionary observation and had an Assessment of Suicide Risk (ASR), completed upon admission to the program. The ASR referral was generated for each of the youth reviewed. The ASR was completed utilizing the Department's ASR form (MHSA 004). All six youth were screened and subsequently placed on standard supervision. Precautionary observation was authorized for each youth. The on-site mental health staff conducted the ASR and provide supportive services to each of the youth. None of the youth were applicable for completion of a follow-up ASR.

In each of the youth's ASR screening, a conference was held with the program director by the licensed mental health professional to reduce level of supervision. In each of the six youth records reviewed, the parent/guardian was notified of the youth's ASR results. Documentation for notification to the parent/guardian and juvenile probation officer (JPO) was found on the ASR form. The program has in place written procedures, which address notification to the JPO and the parent/guardian of a youth's potential suicide risk, as indicated by an ASR screening. Each of the six ASRs reviewed, were completed by a licensed mental health professional or clinical staff under the supervision of a licensed mental health professional. The result of the suicide risk assessment was recorded as required. Each of the youth had a completed suicide alert initiated within the Department's Juvenile Justice Information System (JJIS). The alerts were removed from JJIS once the youth was removed from PO. Placement on PO allows the "at risk" youth to participate in select activities with other youth in designated safe housing and/or observation areas of the program. Placement of a youth on PO does not limit his activity to an individual cell or restrict him to his sleeping room. Each of the non-licensed clinical staff completing ASR screenings, had documented for completion of twenty hours of training by a licensed professional on the Department's Non-Licensed Mental Health Clinical Staff Person's

Training in Assessment of Suicide Risk form (MHSA 022). There was evidence within the program logbook and on the ASR, where administrative or supervisory staff provided instructions related to the suicide risk assessment findings and suicide precautions decisions. The reviewed ASR screenings were conducted within twenty-four hours of referral. The six youth reviewed were determined not to be a potential suicide risk. The youth were transitioned directly to standard precautions. Each of the six youth had documentation on the ASR, where the licensed mental health professional conferred with the program director or designee, prior to revising the supervision level. Documentation of the actual date and time the clinician conferred with the program director or designee was found on the ASR in appropriate sections. None of the youth assessed for suicide risk were found to be in crisis. None of the youth required an ASR to be conducted outside of the program. There have been no youth at the program requiring secure observation since last annual compliance review. The program has suicide response kits on-site.

The program director has an established review process for every suicide attempt or serious self-inflicted injury, along with a mortality review for a completed suicide. This multidisciplinary review included; circumstances surrounding the event, program procedures relevant to the incident, training received by all involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Seven staff were interviewed and responded they would notify mental health staff, search youth and room for sharp objects, provide constant sight and sound, document supervision, and notify mental health staff, should a youth express suicidal thoughts. Each of the staff identified locations of the program's suicide response kits.

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.	

Six precautionary observation (PO) logs were reviewed and applicable for the six applicable youth records reviewed. All six PO logs reviewed were documented on the Department's Suicide Precautions Observation Log form (MHSA 006). The appropriate level of supervision and observations of youth behaviors were documented in real time, at a minimum of thirty-minute intervals. There were no noted or need to document warning signs in any of the six PO logs reviewed. All the PO logs were reviewed and signed by each shift supervisor. All the PO logs were reviewed and signed by mental health clinical staff. The six completed PO logs were reviewed to determine supervision, supervisory reviews, response to warning signs, and safe housing requirements were met. Each of the six PO logs documented safe housing requirements. Three youth who had been previously placed on PO were interviewed. The youth were asked while on suicide precautions, were staff with them at all times; each youth responded yes. The youth were also asked, if they were ever left alone for any period of time; each youth responded no.

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.	

Seven staff training records were reviewed for completion of suicide prevention and implementation of suicide precautions six hours annually. All staff reviewed, completed appropriate annual training requirements. Training included mock suicide drills held no less than quarterly on each shift. The program completed a mock suicide drill quarterly on each shift. A review of fifty percent of the direct care staff demonstrated participation in quarterly drills. Direct-care staff reviewed, participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR). Those staff members who are not present during a quarterly drill have the opportunity to review each drill scenario and procedures.

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

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

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 did not have any youth requiring a Crisis Assessment during the annual compliance review period or since the last annual compliance review was conducted. The program has a written crisis intervention plan and emergency mental health and substance abuse plan, which addresses those practices necessary to effectively handle youth in need of a mental status exam and a Crisis Assessment. The program utilizes the Department's Crisis Assessment form (MHSA 023), to document reasons for assessing a youth demonstrating acute psychological distress.

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 a written emergency mental health and substance abuse plan. The plan includes, immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and a review process.

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

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

Standard 4: Health Services

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

The program's designated health authority (DHA) is a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA's license expires on January 31, 2022. The DHA's specialty training is in Family Practice (with experience with adolescents). The DHA does not designate a physician assistant (PA) or advanced practice registered nurse (APRN). According to the provider's contract, the DHA is required to be on-site weekly, for two hours. A review of the visitor sign-in sheets reflected the DHA is on-site weekly, for two hours, with no evidence of instances where nine or more days passing between on-site visits, as indicated by the DHA's signature on the logs. In the event of the DHA's absence, youth are sent to the North Okaloosa Medical Center for any medical needs. The DHA is available twenty-four hours a day, seven days a week for medical concerns, emergency care, and the coordination of off-site care. The program employs three registered nurses (RN), all of who have a clear and active license. The DHA reported he is on-site weekly for on-site clinical services, sick call, policy review, and to meet with nursing staff. The DHA further reported he available twenty-four hours a day, seven days a week by phone and any important medical issues pertaining to youth are discussed weekly during the meeting with nursing staff.

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

The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and program director signs and dates all respective treatment protocols. Nursing staff reviews, signs, and dates a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by nursing staff for changes which occur between annual compliance reviews. An annual review of all FOPs and protocols is completed by the program. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies and procedures, given by a registered nurse. A copy of the health care staff orientation packet was provided by the program. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures to ensure the program provides informed consent to each youth admitted to the program and general parental authorization for health care is present and parents/guardians are notified of health care. Seven youth Individual

Healthcare Records (IHRCs) were reviewed for an Authority for Evaluation and Treatment (AET). Five of the seven records contained an AET, each stamped “copy” in red ink. One of these five youth has turned eighteen years old since his admission to the program and has signed a consent for treatment and release of information. Two of the seven youth were applicable for involvement with the Department of Children and Families (DCF) in which both records contained a court order in their IHCR. AETs are valid until the youth’s eighteenth birthday. Copies of parental notifications were maintained behind the AET in the IHCR. According to the nurse, it is the responsibility of the youth’s assigned juvenile probation officer (JPO) to provide a current AET. The nurse added the youth’s case manager is the point of content for this form if there is not a current AET.

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

Seven Individual Healthcare Records (IHCRs) were reviewed for parental consent/notification. Four of the seven records were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET), in which documentation reflected parental notification. Four of the seven records reviewed were applicable for significant changes to existing medication and none of the records were applicable for discontinuation of medication prior to entering the program. One of the seven records was applicable for a change in chronic condition in which the parent/guardian was notified. None of the seven youth reviewed were applicable for off-site emergency care. Two of the seven youth were applicable for off-site, non-emergent, medical treatment, or non-routine dental procedures in which documentation of parental notification was observed. Three of the seven youth were applicable for new medication, in which verbal attempts were observed documented in the progress notes.

The program sends written notifications, regardless of telephone notifications and staff members witness all verbal attempts and telephone conversations. Five of the seven youth reviewed were applicable for psychotropic medication. Three of the five applicable records reflected parent/guardian consent on page three of the Clinical Psychotropic Progress Note (CPPN). Two of the applicable five youth taking psychotropic medication were applicable for involvement with the Department of Children and Families (DCF), in which a court order for medical treatment was observed. Documentation for the five of seven youth applicable for psychotropic medication reflected the CPPN had been mailed out for parent/guardian signature. The program has a written policy and procedures in place to ensure immunization histories on each youth have been obtained, evaluated, updated, and if necessary, immunizations administered following the written consent by the parent/guardian and a written order by the designated health authority (DHA). Documentation reflected all seven youth reviewed had their immunizations verified through the health department and/or school records on the day of admission. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. According the registered nurse (RN), immunizations are verified on or before the date of admission to the program. In the event a religious exemption is needed, the parent/guardian will be referred to the county health department where a request will be obtained for the exemptions and the request would then become a part of the youth’s permanent record.

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

The program has a written policy and procedures ensuring all youth are screened for health-related conditions upon admission using the Facility Entry Physical Health Screening (FEPHS) form. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a FEPHS. Documentation in all seven records reflected the FEPHS was completed by a registered nurse (RN) on the day of admission for each youth. One of the seven youth reviewed reflected a change in custody since the youth's arrival, in which a new FEPHS was completed by the RN on the date of the youth's return. Documentation further reflected the designated health authority (DHA) reviewed the FEPHS for all seven youth. The nurse reported the FEPHS is completed by the admitting RN and if there is a change in custody a new FEPHS is completed upon the youth's return to the program.

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

The program has a written policy and procedures in place to provide health care orientation and education to all youth admitted to the program. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of orientation to health care services. Documentation in all seven records reflected youth received general care orientation upon admission to the program, as indicated by the youth signature and date of the healthcare orientation packet. The program's health care orientation included the following: access to medical care, sick call, medication monitoring, what constitutes and "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. Health care contacts were reviewed and observed to be accurate.

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

The program has a written policy and procedures in place to ensure the designated health authority (DHA) is notified of all youth admitted with certain conditions. Documentation in all seven Individual Healthcare Records (IHCRs) reviewed reflected documentation of the DHA being notified by telephone for each youth. The program's practice is to notify the DHA for all new admissions to the program. Two of the seven youth reviewed were eligible for notification for a chronic condition. None of the seven youth reviewed required notification for the need of emergency services. The DHA notification was documented in the chronological progress notes for each youth.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a Health Related History (HRH). All seven records contained an HRH which was completed on the day of admission by the registered nurse (RN). Documentation further reflected each HRH was subsequently reviewed by the designated health authority (DHA). According the nurse, the HRH is completed within seven days by the admitting RN.

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 procedures to ensure each youth admitted to the program will receive a Comprehensive Physical Assessment (CPA) no later than seven calendar days of admission to the program. The program uses the Department's CPA form. Seven youth Individual Healthcare Records (IHCRs) were reviewed for completion of a CPA. All seven records reviewed reflected a new CPA was completed by the designated health authority (DHA) within seven calendar days of admission to the program. Three of the seven youth were entered the program as a medical grade five, one entered as a two, and three entered as a medical grade one. Each CPA was completed in accordance with the Health Service Manual requirements. All sections of the CPA were marked with an "O" or an "X". Those sections marked with an "X" reflected comments by the DHA in the comments section of the form.

All seven youth refused the Tanner Stage portion of the examination, in which "refused", and the youth's signature were observed on the CPA in addition to a corresponding refusal form. The problem list was observed to be updated for all seven youth. The program has a written policy and procedures to ensure all youth receive an evaluation of tuberculosis status and risk upon admission to the program. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health standards. All seven IHCRs reflected each youth had a verified tuberculin skin test (TST) completed in the last year. All seven records indicated each youth received Tier I B screening was completed on the day of admission to the program. Each youth was assessed prior to placement in the general population. The results of the TST were observed to be documented on the CPA and infectious communicable disease (ICD) forms in all seven records reviewed. According to the nurse, a new CPA is required for youth who are medical grades two through five, and every two years if the youth is a medical grade one. It is the program's practice to complete a new CPA for each youth entering the program. Additionally, the nurse reported a TB screen is performed annually on every youth and if the youth has had a positive TB test in the past, a chest x-ray is performed every year.

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

The program has a written policy and procedures in place ensuring all youth entering the program are evaluated and treated (if necessary) for sexually transmitted infections (STIs). Seven youth Individual Healthcare Records (IHCRs) were reviewed for STI screening. Documentation reflected all seven youth were screened for STIs and subsequently referred for STI testing. Testing, screening, results, clinical evaluation, and diagnosis were found to be documented on the Infectious and Communicable Disease (ICD) form for all seven youth. None of the seven youth reviewed were out of the Department's custody where a re-screen would be required. Referrals for testing for each youth were documented on the STI screening form. Testing for six of the seven youth was observed documented in the youth's progress notes. The program has a written policy and procedures which specify a system is in place to address human immunodeficiency virus (HIV) issues. All seven records reviewed reflected youth were offered testing, counseling, and treatment (referral) upon admission to the program.

Three of the seven youth consented to HIV testing and four refused testing. Two of the three applicable youth who consented to testing have received testing, pre and post testing counseling. One youth who consented has not yet received testing due to COVID-19 restrictions. The outside provider was unable to come on-site and when COVID-19 restrictions are lifted, a testing/education/counseling group will be scheduled. Test results were observed filed in a confidential manner consistent with F.S. 381.004, a certified HIV counselor conducted the testing, and a youth's HIV status is never included on with the internal alerts. HIV testing is completed by the Okaloosa AIDS Support and Information Services (OASIS). Pre and post-test counseling were observed documented in the two of the three applicable youth's health education record within their IHCR. A copy of the provider's 500/501 certification was available for review. All seven youth interviewed reported they could ask for HIV testing.

4.11 Sick Call Process	Satisfactory Compliance
All youth in the program 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.	

Seven youth Individual Healthcare Records (IHCRs) were reviewed for sick call. Two of the seven youth reviewed were applicable for sick call, the program provided an additional record for review. None of the three applicable youth reviewed reflected similar sick call complaints three or more times within a two-week period. None of the three youth present with complaints in which medical staff were unfamiliar with. All three youth completed sick call request forms which were placed in a locked box and then provided to the nurse. Completed sick call request forms were observed filed with the corresponding progress note for each youth, in reverse chronological order. All three sick calls were completed by the registered nurse (RN). None of the youth were applicable for restricted housing. Sick calls were observed documented on the youth's sick call index in the IHCR as well as the Sick Call Referral log. In the event a sick call is placed when the nurse is not on-site, staff will contact the director of nursing (DON) or designated health authority (DHA) to determine the appropriate course of action. Sick call is conducted seven days a week at 11:00 a.m. and 2:00 p.m. Sick call hours and sick call forms

were observed posted and available to youth. A sick call was observed during the annual compliance review with no issues noted. All seven staff members interviewed reported the nurse responds to and conducts sick call. Two of the seven youth interviewed reported they are seen for sick call within one day and five reported they have never placed a sick call.

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

The program has a written policy and procedures in place to ensure the program maintains written healthcare procedures and practice for on-site episodic care. Seven youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Five of the seven records reviewed were applicable for episodic care. Documentation reflected four of the five applicable youth were given over-the-counter (OTC) medications. One of five youth was placed on the call out to see the designated health authority (DHA) for follow up. None of the five applicable youth reviewed were referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow up/future care observed. On-site care was provided by the registered nurse (RN) and subjective, objective, assessment, and plan (SOAP) format was observed. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months correspond with all on/off-site events observed in youth records. Emergency medical and dental care, including EMS services are available twenty-four hours a day. The program has nine first aid kits: two are assigned to the transport vans, two are kept in master control, two in the vocational building, one in the nurse's station, one in maintenance, and one in the kitchen. The first aid kits are fully stocked with designated health authority (DHA) approved contents. The first aid kits are monitored monthly by nursing staff to ensure they are secured, fully stocked, and no items have expired.

The program has one suicide response kit which is located in master control. The suicide response kit was observed to contain a knife for life, needle nose pliers, and a set of wire cutters. The program has one automated external defibrillator (AED) which is located in master control. Instructions are located inside the AED. Nursing staff inspects the AED once a month. AED inspections for the previous six months were available for review. The registered nurse (RN) performed a self-test of the AED during the annual compliance review, in which the AED was found to be operational. The AED batteries were last changed in February of 2019 and the current batteries expire in May of 2024. The AED pads were last changed on May 31, 2019 and the current pads expire in September of 2021. A review of drill documentation reflected the program has conducted drills quarterly and on each shift since the last annual compliance review. Documentation further reflected drills included the demonstration of CPR/AED semi-annually. If staff are identified to have not participated in a mock drill, the nurse will review the drills with them. The program has a list of emergency numbers, including Poison Control Information Center which are inaccessible to youth. The program has an approved list of supervisory-level, non-licensed health care staff who are able to assist youth with medication administration or use of an epinephrine auto-injector. A review of training records for these staff indicated they have completed the required training. Six of the seven staff interviewed reported they are personally allowed to call 9-1-1 if a youth has a medical emergency. One staff reported, they would not call 9-1-1 due to not having a phone but would call on the radio. All seven youth interviewed reported they can see a doctor and dentist if needed.

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

Seven youth Individual Healthcare Records (IHCRs) were reviewed for off-site care. Two of the seven youth were applicable for non-emergent off-site care. The program provided one additional applicable record for review. Parental notification was observed in all three applicable records. The Summary of Off-Site Care form was observed in all three records. Documentation reflected the designated health authority (DHA) initialed all three forms. Two of the three youth required follow-up in which the appointments were tracked using an appointment book.

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

The program has a written policy and procedures to ensure the program is proactive in providing care for chronically ill youth. Seven youth Individual Healthcare Records (IHCRs) were reviewed for chronic conditions. Three of the seven youth reviewed were applicable for a chronic condition. One additional applicable record was provided for review due to one of the three youth not being in the program long enough yet to have a periodic evaluation. Three of the four youth were identified with a chronic condition on the Program Entry Physical Health Screening (FEPHS) form. One youth's chronic condition was identified subsequent to admission. None of the four youth reviewed had a communicable disease. Two of the four youth were taking prescribed medication on an ongoing basis. Three of the four youth entered the program with a medical grade two through five. All four youth were observed to be identified as having a chronic illness on the program's internal alert roster. None of the youth reviewed were taking ant-tuberculosis medication. Periodic evaluations are tracked by the registered nurse (RN) using the chronic roster which indicates the dates in which the youth needs to be evaluated. Periodic evaluation documentation was observed in each youth's IHRC. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff. None of the periodic evaluations were conducted off-site. There was no indication of any missed or lapsed periodic evaluations in the documentation observed. The problem list for each youth was updated in accordance with the Health Service Rule 63-M. According to the designated health authority (DHA), periodic evaluations for youth with chronic conditions are conducted every three months or sooner if needed. The DHA added, nursing staff tracks the youth with chronic conditions. According to the RN, chronic conditions along with periodic evaluation dates are listed on the medical alert list. The program director reported medical issues are discussed during department meetings.

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 to document the program maintains a system of medication administration which ensures all medications are administered safely and

effectively as ordered by the physician. Seven youth Individual Healthcare Records (IHCRs) were reviewed for medication administration. Three of the seven records reviewed reflected youth were admitted to the program on prescribed medication. Prescription verification for all three youth was observed in the chronological progress note in the record. Documentation further reflected the registered nurse (RN) contacted the designated health authority (DHA) and/or psychiatrist to resume the medications. All medications were observed to have a current, valid order and are given pursuant to a current prescription. Practitioner Order forms were also observed for all three youth for continuation of their prescribed medication. None of the youth reviewed were applicable for restrictive housing. Two of the three youth reviewed were applicable for over-the-counter (OTC) medication not listed on the Authority for Evaluation and Treatment (AET) in which medication was administered according to approved protocols.

The Medication Administration Record (MAR) utilized by the program is pre-printed by the pharmacy (PharMerica). Staff initialed each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. There were no refusals observed for the three applicable youth reviewed. The Facility Entry Physical Health Screening (FEPHS) form indicted all three youth were taking prescribed medication upon admission to the program. Appropriate notifications to the parents/guardians were made for all three youth. All medications were observed to be in a separate, secure areas inaccessible to youth. All non-controlled medications (prescribed and over-the counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. Expired medication is destroyed once a month with Drug Destroyer in the presence of the pharmacist and two RNs. Medication pass was observed during the annual compliance review with no issues noted. Five of the seven youth interviewed reported the nurse give outs medication and explained the medication administration process. Two of the seven youth reported they do not take medication. All seven staff reported the nurse gives out medication and one added whoever is medication pass certified.

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

The program has a written policy and procedures in place to ensure all medications will be stored in a safe and secure manner consistent with State and Federal Law and the highest standards of professional practice. Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed separated. All controlled substances were observed maintained behind two locks, stored separately from other medications, and had a perpetual inventory.

The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications

was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed documented on the youth's individualized Controlled Medication Inventory Record. A shift to shift count of controlled medications was observed. The program maintains an approved list of supervisory level, non-health care staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. Training was observed to be completed for each staff member on the approved list. The reviewer observed the nurse inventory two youth medications, one being a narcotic/controlled medication, three OTC medications, and three sharps all of which matched the perpetual inventory. Perpetual inventories of medications and sharps for the previous six months were available for review. The nurse explained procedures for inventory discrepancies as well as secure storage and routine inventories of medication, disposal of medication, and the practice for securing controlled substances.

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

The program's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to the Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control (CDC) guidelines. The program's infection control procedures include the following: common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. Additionally, the hepatitis B immunization is available to staff. There have been no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The program or designee will maintain a separate file containing all documents for youth and staff who have experienced program exposure, as necessary. The program's exposure control plan was found to be written in accordance with Occupational Safety and Health Administration (OSHA) standards. The plan is available to all staff. The plan is reviewed and signed annually by the program director. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. The program director reported the exposure control plan is located in the control room and is reviewed yearly with staff members.

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures which addresses the supervision of youth. The policy indicates the program will promote safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging them in a full schedule of constructive activities, closely observing their behavior, and consistent application of the behavior management system (BMS). Observations were made of positive youth and staff interaction during the annual compliance review week. Youth were seen in classrooms and participating in outdoor recreation activities. Staff were seen positioning themselves in a manner to supervise youth. Staff-to-youth ratio for daytime activities is one to eight. The ratio was maintained during all observations made. Random staff were asked to provide counts of youth under their direct supervision. Each staff was able to give the accurate count of youth. The program's activity schedule was observed posted in program areas. A full schedule of activities is planned daily. Seven interviewed staff confirmed headcounts are done both formally and informally throughout the day. The staff explained the procedures of what to do in the event a miscount is made, which includes stopping all movement and begin to recount the youth.

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

The program's behavior management system (BMS) was reviewed. All appropriate parties were involved in the development and implementation of the BMS. The program has a joint plan for the BMS during school hours. An interview with the program's designated mental health clinician authority (DMHCA) stated the program provides annual refresher training for the educational staff on the BMS. Teachers also may be responsible for documenting youth behavior utilizing the same BMS as the program staff. The BMS is clearly written and is included in the youth handbook. A sample of youth case management records were reviewed which included evidence the youth signed for and received a handbook as part of their admission and orientation to the program. The handbook outlines rules governing positive and negative consequences. The program's BMS has not been changed since the last annual compliance review. The BMS includes all required components, such as maintenance of order and security, promotion of youth rights, constructive discipline, positive reinforcement, and discussion by staff of alternative behaviors youth may exhibit while promoting positive dialogue and peaceful conflict resolution. The BMS is coordinated with the youths' individual behavior plan. Postings of the BMS were observed within program areas, including youth dayroom living areas. The program's BMS addresses a ratio of 4:1 positive to negative consequences and includes a

variety of rewards and consequences. The BMS includes provisions such as a variety of incentives and rewards which are listed within the contractual agreement. These incentives include opportunities such as a token store, which youth are able to spend points earned on a variety of items offered. The program director was interviewed concerning the BMS and confirmed the program utilizes a token system to provide reinforcement for behaviors and aid youth in behavioral changes. Seven interviewed staff all summarized the program's BMS as well as name different rewards or incentives youth may receive. Seven youth were also interviewed and were able to summarize the process. The youth also gave examples of rewards they could earn. Five of the seven rated the program's BMS as very good. One rated it as fair and one rated the BMS as good.

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 written policy and procedures which outlines the behavior management system (BMS). The program's BMS documents a feedback system, which indicates youth are provided ongoing feedback concerning their programmatic behavior and will provide staff an effective means of addressing daily program problems. This will be accomplished through the use of daily points sheets which indicate the areas of accomplishment or needed improvement and through a provision of feedback regarding behavior and teaching alternative pro-social means of meeting needs. A sample of position descriptions were reviewed to confirm qualifications for staff whose job functions included the implementation of the BMS. These positions included case managers, youth care workers I, and youth care workers II. The BMS includes provisions such as a variety of incentives and rewards which are listed within the contractual agreement. All required parties were involved in the development, implementation, and on-going maintenance of the BMS.

The program director was interviewed and stated the program utilizes a token system to provide reinforcement for behaviors and aid youth in behavioral changes. Special events are provided daily as rewards for appropriate behaviors. Twelve reinforcements are provided throughout the day all allowing the youth opportunities for reward on a daily basis. Additional rewards such as risk trips, parties, and other incentives are implemented throughout daily programming. In addition, the program director stated management and treatment team members monitor and approve all consequences for fairness and appropriateness. The designated mental health clinician authority (DMHCA) was interviewed and stated educational instructors are given a refresher on the program's BMS each year. Teachers utilize the program's BMS during daily instruction. The implementation of the BMS is monitored through performance and annual evaluations. Seven interviewed staff all summarized the program's BMS, as well as give examples of various rewards and incentives youth may earn. All seven staff confirmed youth are informed of their consequences and are able to explain their behaviors through Disciplinary Report (DR) Court, which is held twice weekly. Seven interviewed youth were able to

summarize the BMS. Youth also gave examples of rewards they can earn. The youth confirmed staff were overall consistent in the use of rewards. All seven youth stated youth are not permitted to punish other youth in the program. The program does not utilize room restriction, as indicated within policy and procedures. The program's written BMS also discusses infractions, documenting consequences for violations of program rules are issued on an individual basis and do not involve the use of group punishment. Consequences and sanctions do not include the loss of regular meals, snacks, clothing, sleep, healthcare services, mental health/substance abuse services, school, exercise, correspondence privileges, contact with parents/guardians, juvenile probation officer, attorney of record, or clergy. Youth will not be subjected to corporal and/or cruel and unusual punishment. Youth are not permitted to discipline other youth in the program. Staff are required to explain to the youth reasons for sanctions imposed. Seven staff in-service and seven staff pre-service training records were reviewed and confirmed all staff had BMS training as required.

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 total of eighty-nine cameras, with eighty-seven currently operating at the time of the annual compliance review. Video recordings are stored for a maximum of thirty-days. Seven interviewed staff all confirmed checks for youth who are in their rooms during sleeping or non-punishment times are conducted at intervals of ten-minutes or less. The program has two dorm buildings which are used for the youth population. A sample of six total days, which included at least one weekend day and both dorm buildings was reviewed for completion of the ten-minute observation checks. Video observations made from the samples viewed included eight different staff members conducting checks. Multiple observation checks were observed within the six dates selected with no significant observed issues. All checks observed were completed at ten-minute intervals or within ten minutes with the exception of two checks. One was completed one minute late and the other two minutes late. Each staff was observed moving throughout the dorms using flashlights and stopping at each youth door to look into youth rooms and monitor youth during sleep hours. The corresponding observation logs were reviewed to also confirm staff documented the checks in real-time.

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 written policy and procedures to provide guidelines to account for all youth assigned to the program. According to the written policy and procedure, scheduled and unscheduled counts are performed throughout each twenty-four-hour period. Formal counts are conducted at the following times: 6:00 a.m., 10:00 a.m., 6:30 p.m., 8:30 p.m., and 10:00 p.m. The program documents formal counts as well as counts conducted after each outdoor activity and during emergency situations in the logbook. The program also documents total daily census counts, youth movements, new admissions, releases, and when youth are temporarily away from the program. Count documentation was observed in the program's logbook. All seven staff interviewed were familiar with formal and informal counts and what to do in the event of a discrepancy in count. Seven interviewed staff summarized the process of head counts as well as actions taken should a miscount occur.

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

The program has a written policy and procedures to ensure the program maintains a permanent, bound logbook to record information, emergency situations and unusual incidents. Logbooks were observed to be bound with number pages, not falling apart or missing any pages. Entries were made with black ink with no erasure or white out areas. No logbook entries were observed to be obliterated or removed. Any errors were observed to be struck through with a single line and dated and initialed by the person correcting the error. Each entry observed included the date and time of event, the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff member making the entry. The program documents the following: emergency situations, incidents, including the use of mechanical restraints, special instructions for supervision and monitoring of youth, population counts, security checks, transports away from the program, requests by law enforcement to access any youth, youth placed on controlled observation, admissions, and releases. The program does not utilize logbooks on each living unit. The shift supervisor will summarize the events, incidents and activities documented in the program logbook of their shift on a Shift Pass-On Report. The

incoming shift supervisors shall verbally brief the incoming staff on the information on the Shift Pass-On Report. Staff sign the Shift Pass-On Report indicating they have been briefed. If a staff has not been briefed, the staff will review the Shift Pass-On Report for the previous shift and sign the Shift Pass-On Report indicating their review of the report. Samples of Shift Pass-On Reports were reviewed from the scope of the annual compliance review to confirm the program's practice. A review of logbooks confirmed internal incident reports reported to the Central Communications Center (CCC) were noted within the logs.

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

The program has a written policy and procedures which outlines key storage and inventory, key issuance, and key usage by employees to ensure the security and normal operation of the program. The policy also outlines the procedures to follow in the event keys are missing or damaged. A review of reportable incidents made to the Central Communications Center (CCC) by the program for the last six months revealed no incidents involving any lost or missing program keys. The program's key storage box is located in the master control room. The room and the box itself were observed secured. Upon arrival for duty, staff sign in and are required to turn in personal keys in exchange for assigned staff keys. The master control operator then logs the key assignment, indicating the date and time, on a daily key log. The master control operator was interviewed and stated the keys are tracked each day, and prior to departure she is required to check the log to ensure all keys are accounted for. The key rings were observed hung in designated spaces within the key box which indicated the area they were utilized for. The key rings had a numerical code which corresponded with the code within the master key inventory.

A random sample of five key rings were reviewed to ensure the type of keys and number of keys on the key rings matched. Four of the five sampled matched as documented. One key ring, which belonged to the assistant program director had an extra key, which was not captured within the inventory. This key was removed, and the issue was corrected on-site. The master key inventory was also present. Permanent keys are assigned to the program director, assistant program director, maintenance manager, and administrative assistant. Restricted keys are designated within the key storage box, and they include keys for the dining hall, medical department, education, therapist, and case manager. A review of reports made to the CCC for the scope of the annual compliance review found no incidents of missing or lost keys having been reported. The master control room operator stated keys to locations which contain youth property, youth records, and medical equipment are kept in master control, and only those individuals responsible for these areas, as well as the program director, have access to them. Seven interviewed staff were all able to summarize the program's key control process.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a written policy and procedures which provides written guidelines for staff, youth, visitors, and volunteers regarding contraband. The policy outlines items considered to be contraband. The procedure aligns with the Department's recommended contraband guidelines. Youth are provided a list of contraband items within the student handbook. Each youth receives a handbook as part of their orientation and admission to the program. Youth are informed of any consequences they may receive as a result of being found in possession of contraband.

The program's contraband policy also outlines searches of the physical plant, program grounds, searches of youth, and incoming and outgoing mail. Prohibited items include cell phones, or equipment used to take pictures or recordings. The policy notates items of contraband which are illegal in nature will be turned over to the Okaloosa County Sheriff's Office for disposition and reported to the Central Communications Center (CCC). The policy further indicates staff are not authorized to give youth anything without the approval of the program director. All staff receive an employee handbook upon hire which includes Standards of Conduct. These standards outline areas for contraband to include prohibiting staff bringing into the program any alcohol, illegal or controlled substance, as well as possessing weapons or other hazardous or dangerous material. Violation of the policy or Standards of Conduct may be subsect to corrective action, up to and including dismissal. Security and perimeter searches, including searches of program areas and youth rooms are conducted daily. Documentation of these searches, which were conducted during the overall scope of the annual compliance review, were reviewed to confirm the practice. The program director reported daily searches are conducted and if found, contraband is discarded, and if necessary, law enforcement is notified for assistance in the discarding process. The program director added, if it is a reportable incident, the Central Communications Center (CCC) is notified.

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.	

Searches were observed during the annual compliance review. Staff were observed lining youth up after completion of outdoor activities and were preparing youth to move from the recreation area to the classroom. The staff-to-youth ratio was in compliance. Staff of the same gender as youth were performing searches. The staff completed a throughout pat-down search of each youth. Youth were treated with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training. An interview with seven staff and seven youth was completed. All staff and youth confirmed searches are completed prior to all youth movement.

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

The program reported having two vehicles used to transport youth. An annual safety inspection was completed for both vehicles which included any issues, repairs, or deficiencies identified. During the annual compliance review, one of the vehicles was on campus, as the other was in the mechanic shop undergoing repairs. On-site observations of the vehicle found the van secured when not in use. There were appropriate number of working seatbelts. A safety screen was present which separated the driver's compartment from the back seat. The van was also equipped with a seat belt cutter, fire extinguisher, window punch, and door to the youth passenger area which could not be opened form the inside. First aid kits assigned for each vehicle were maintained within master control. The master control operator stated the kits, along with a cell phone, are provided to the staff facilitating a youth transport.

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

The program has a written policy and procedures regarding the transportation of youth away from the secure program. The policy indicates all drivers must have a valid driver's license. The program requires secure transportation for all youth. One to five, staff to youth ratio, is required for transports. A minimum of two staff is required for transporting one youth. At least one staff is required to be of the same gender as the youth. According to the program's policy, youth are not permitted to drive vehicles; and staff are not authorized to utilize their personal vehicles when transporting youth. A youth transport was unable to be observed during the annual compliance review. The program has two vehicles used to transport youth. During the annual compliance review, one of the vehicles was on campus, as the other was in the mechanic shop undergoing repairs. On-site observations of the vehicle found the van secured when not in use. There were appropriate number of working seatbelts. A safety screen was present which separated the

driver from the back seat. The van was also equipped with a seat belt cutter, fire extinguisher, window punch, and door to the youth passenger area which could not be opened from the inside. A random check of personal vehicles was completed. All personal vehicles checked were found secured. Three random staff were interviewed, and all confirmed both staff and youth are required to wear seatbelts during transports. Staff were familiar with the staff-to-youth ratio requirement of 1:5 when transporting. Seven formal staff interviews were conducted concerning transport procedures. All seven staff stated they do not transport youth in their personal vehicles. Five of the seven staff stated they are provided communication devices when transporting youth. Two of the seven stated they did not participate in youth transports. The program maintains a staff list of all staff able to transport youth, as well as staff who are not authorized to transport. All eligible staff had evidence of possessing a valid Florida driver's license.

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

The program has a written policy and procedures for completing and documenting weekly safety and security inspections of all internal and external program areas. The procedures meet all requirements within Florida Administrative Rule. The weekly inspections are completed by the program director or designee. A sample of six weeks of inspections were reviewed which indicated the inspections were done as required. The weekly inspections were completed by the assistant program director, and documented all areas observed as well as any deficiencies identified during the inspections. The program director was interviewed and stated security/safety sheets are completed weekly and provided to the Department of Juvenile Justice for review.

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

The program has a written policy and procedures which outlines the issuance, inventory, and control of tools used at the program. The policy also outlines missing and lost tool procedures. Observations were made of areas used to store tools. These areas were secured and inaccessible to youth. All tools were marked for easy identification. Access to these areas are only accessed by the assistant program director and maintenance staff. Tool inventories were reviewed for tools issued for work as well as following work activities. The program's policy prohibits machetes, bowie knives, or other long blade knives. All tools with sharp edges were inventoried daily. Seven staff pre-service training records found evidence each staff received training in the intended and safe use of tools. Seven interviewed staff all reported youth only use mops and brooms when cleaning. Youth who are working in the Home Builders Institute (HBI) or woodshop may use other hand-held tools in these vocational classes.

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

The program has a written policy and procedures which outlines the issuance, inventory, and control of tools used at the program. Youth are given an assessment of risk for completion prior

to authorization to use tools in the program. Staff to youth ratios involving tool usage is at 1:5. Staff are required to search youth after each work period. Youth must pass a risk assessment prior to using any tools in the program. A review of seven youth records found completed risk assessments for each youth which gave authorization for tool usage. Youth who participate in the Home Builders Institute (HBI) vocational classes are authorized to use tools located in the shop, but under direct supervision of the instructor. According to the program's policy, all youth are searched after each work period. Seven interviewed staff all reported youth only use mops and brooms when cleaning. Youth who are working in HBI or woodshop may use other hand-held tools in these vocational classes. Seven interviewed youth all stated they use mops and brooms when cleaning. Two of the five youth stated they have used some hand-held tools when working in HBI.

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

The program has a written policy and procedures regarding tool control and restrictions for outside contractors who enter the secure program area. Cell phones are prohibited in the secure area. The policy indicates contractors will receive written instructions outlining the responsibilities regarding tool control and prohibition of bringing in contraband A list of all tools entering the program must accompany the approved worker and the supply of tools. Any vendor or contracted employee who does not comply with the policy will not be allowed into the program with tools. Observations of sign-in sheets for outside contractors was observed to show the tool sign-in and out process was completed. A review of project invoices was done determining the date the project in progress to match the sign-in sheets provided.

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 conducts practice drills to prepare for immediate implementation or mobilization of the Continuity of Operations Plan (CCOP) whenever an emergency or disaster situation necessitates. A review of fire drill documentation for the previous six-months found evidence the program conducted fire drills on all shifts monthly with the exception of one shift in the month of November. The drill documentation contained the type of drill, date and time, participants, a brief scenario, and findings and recommendations made. Fire evacuation routes were observed posted throughout the program areas. Fire extinguishers were inspected annually. The program director was interviewed and stated all monthly drills are completed as required. Seven interviewed youth stated they have been informed as what to do in the event of a fire. Seven interviewed staff all reported they have participated in fire drills. Six of the seven also stated they have participated in a weather-related drill.

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

The program has a Continuity of Operations Plan (COOP) which has not been changed since the last annual compliance review. The plan was last updated, reviewed, and approved by the Department on March 5, 2020. The plan addresses alternate housing plans approved by the Department of Juvenile Justice regional director. The program's disaster and COOP are combined within one plan. Observations were made of provisions for food and equipment stored accessible in the event of an emergency. In the event of an emergency or incident involving evacuation, the program director reported all youth records are collected for relocation. The records contain all required demographic information. The master control room also maintains a box of individual laminated cards containing photo identification and demographic information for each youth. The program director reported the COOP is maintained in the master control room.

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

The program has a written policy and procedures addressing items or chemicals considered to be flammable, poisonous, and toxic. The policy addresses the storage and inventory of the items. Areas used to store chemicals were observed during the annual compliance review. All areas were secured and inaccessible to youth. A total of five separate storage areas were observed. Each had a varying supply of chemicals, cleaning agents, or caustic items. All had a Safety Data Sheet (SDS) binder which included a corresponding SDS for each item with two exceptions. The maintenance office had a supply of paint spray cans which included different brands. An SDS for one brand was present, but not another. In addition, a can of Floor Break was observed in the secured closet of the kitchen. This item did not have a corresponding SDS. The program corrected this issue on-site printing and attaching an SDS for both items. A chemical inventory log was observed for each item in each location. All inventories matched the items present with one exception. For the outside shed located outside the secure program, gas and diesel cans were observed. The program's inventory sheets list the amount of fuel cans, but not the amount of fuel in stock. This issue was corrected on the inventory form on-site during the annual compliance review. Only maintenance staff and administrative staff have access to these chemical storage locations. The program director reported only the maintenance staff is responsible for handling chemicals and cleaning agents. The maintenance staff person stated each day they go into the youth living areas and prepare mop water and spray down tables and chairs for youth to wipe and mop. Youth do not directly handle any chemicals.

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's written policy and procedures for flammable, poisonous, and toxic chemical control indicates when cleaning staff should dispense the cleaning agent to the surfaces to be cleaned and the youth may wipe the surface. The program maintains all chemicals and cleaning agents within designated storage areas which are inaccessible to youth. Youth were not observed cleaning during the annual compliance review observations made. The maintenance staff person stated each day they go into the youth living areas and prepare mop water and spray down tables and chairs for youth to wipe and mop. Youth do not directly handle any chemicals. Seven interviewed youth all denied handling any chemicals. The youth stated the staff handle chemicals and the youth wipe them off. Two youth stated they have used paint, but this was when working in the Home Builders Institute (HBI) vocational class.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.

The program has a written policy and procedures addressing items or chemicals considered to be flammable, poisonous, and toxic. The policy addresses the storage and inventory of the items. Disposal procedures are also listed within the program's policy. The maintenance staff is primarily responsible for the disposal of chemicals in the program. The program director indicated only the maintenance staff is responsible for disposal of chemicals. An interview with the maintenance person revealed there have been no chemicals disposed of this annual compliance review period. Should any chemicals require disposal, the maintenance staff reported this would be done utilizing Occupational Safety and Health Administration (OSHA) standards or guidelines. Dirty mop water is disposed of through mop sinks and drains, according to the dietary supervisor and maintenance staff. Cooking grease is disposed of in a grease trap located outside the secure area. Grease disposal is accomplished by contract with Birmingham Hide and Tallow Company located in Panama City, Florida. They are contacted as needed to empty the grease disposal container behind the dietary department. The program director was interviewed and stated all items are disposed of per policy requirements, using vendors as necessary.

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 water-related activities; therefore, this indicator is rated non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures concerning visitation schedule for youth. Visitation hours are from 1:00 a.m. to 12:00 p.m. on Saturdays and Sundays. Special visitation may be approved by the program director, case manager, or higher authority. Visitation schedules are posted in the front lobby area of the program. The program maintains an approved visitation, telephone, and mail list for each youth. Visitation times are provided to parents/guardians. According to the program's policy, youth are afforded unlimited visitation from attorneys, legal representatives, or family service workers from the Department of Children and Families. Any visitation may be terminated should the visit be determined detrimental to the youth's welfare, or when the security of the program is threatened. All youth are also given opportunities to communicate with family through phone and mail. Searches of incoming and outgoing mail is completed in the presence of the youth by staff. Youth telephone calls are

available daily and are limited to ten minutes. All seven interviewed youth confirmed they were able to communicate with family though mail, visitation, and telephone usage.

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

The program's controlled observation room meets all requirements. The program reported having had a total of four incidents involving placement of a youth in controlled observation for the scope of the annual compliance review. All four were reviewed and determined staff search the room and the youth prior to youth placement. A staff of the same gender performs the search of the youth. The date and time in and out of the youth placements documentation on the controlled observation reports.

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

The program had a total of four incidents involving youth placement in controlled observation for the scope of the annual compliance review. A review of all four controlled observation reports each had documentation of the reasons for placement and were approved by a supervisory staff. Criteria for placement was indicated for each report as required. For each incident, staff advised the reason for placement and expected behavior required for removal. Each incident included documentation of the Health Status Checklist, which was completed for each incident by a staff of the same gender. There were no complaints or injuries noted or observed for any of the incidents. Three of the four incidents included evidence the youth were in controlled observation for over two hours. None of the youth were in controlled observation for four hours or more. For the three incidents which youth were in controlled observation over two hours, there was evidence the program director, or designee granted the extension for placement.

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

Staff designations for controlled observations are included in the program's written policy and procedures. The program had a total of four incidents involving youth placement in controlled observation for the scope of the annual compliance review. A review of all four controlled observation reports each had documentation showing the staff making the placement completed the first page of the controlled observation report and submitted it to the supervisor. Safety checks were documented as required, and on the Controlled Observation Safety Checks form for each incident. For each of the four incidents, the program director or designee gave written authorization prior to the youth release. No internal alerts were warranted for the incidents observed. The Controlled Observation Report, Health Status Checklist, and Controlled Observation Safety Checks forms were maintained in an administrative record. Releases were documented and approved by the program director or designee for all four reports. All controlled observation reports were reviewed and approved by the program director or assistant program director within fourteen days of the youth's release.

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 maintains a safety plan for each youth. The plans are entitled Trauma-Informed Safety Plan. These plans include information gathered concerning the youth's history in programs or detention centers, history of traumatic experiences, and youth triggers and warning signs. A review of seven youth safety plans revealed each was completed within fourteen days of the youth admission. A review of seven youth safety plan documentation found six were reviewed and updated every thirty days as required. One of the seven plans did not have evidence of an update after the youth's first thirty-days; however, the plan was revised every thirty-days thereafter. Documentation of contacts to parents/guardians were captured on the plans. Plans incorporate recommendations from clinical assessments. The designated mental health clinician authority (DMHCA) was interviewed and stated upon admission, the assigned therapist assists the youth with their safety plan development. The therapist completes the Adverse Childhood Experience (ACE) Questionnaire with the youth, which is a trauma assessment instrument utilized at the program. The results of the ACE are incorporated into the plan.

A therapist was also interviewed and stated the plans include information concerning the youth's history in a Department of Juvenile Justice (DJJ) program, post-traumatic experiences, youth's ability to communicate about his safety levels, triggers, and warning signs. The plan also includes what helps the youth feel safe and in control of their behavior, as well as what incentives or positive alternative behaviors the youth can use when they feel unsafe. Seven interviewed youth all reported they were involved in the development of their safety plans. Seven staff were also interviewed. One of the seven stated they were not familiar with the process of reviewing youth safety plans. Six of the seven staff indicated they were familiar with youth safety plans and summarized the process to take when reviewing information within the plans.