STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Palm Beach Youth Academy
Sequel TSI of Florida, LLC
(Contract Provider)
9680 Weisman Way
West Palm Beach, Florida 33411

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

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Paula Friedrich, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, (Standard 1)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 5)
Christine Calvert, Office of Program Accountability, Regional Monitor (Standard 3)
Carol Hickman, TrueCore Behavioral Solutions, Regional Compliance Manager (Standard 2)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Patrick Morse, Office of Program Accountability, Regional Monitor (Standard 4)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Interviews)

Program Name: Palm Beach Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Palm Beach County / Circuit 15
Review Date(s): October 15-18, 2019

MQI Program Code: 1417
Contract Number: 10341
Number of Beds: 82
Lead Reviewer Code: 139

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.09 Performance Plan Development, Goals and Transmittal *	1.10 Delinquency Intervention and Facilitator Training
2.10 Performance Plan Revisions	5.04 Ten Minute Checks *
2.14 Incorporation of Other Plans Into Performance Plan	
2.20 Exit Portfolio	
3.13 Suicide Prevention Training *	

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	Failed
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 *	Limited
2.10	Performance Plan Revisions	Limited
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	Limited
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Limited
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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

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Program Overview

The Palm Beach Youth Academy is an eighty-two-bed program, for fifteen to twenty-one-year old males, located in West Palm Beach, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides safe supervision of youth, the program provides youth with clinical services including mental health overlay services (MHOS) and substance abuse overlay services (SAOS). In addition, the program fosters each youth by providing delinquency programming including Thinking for a Change (T4C), Impact of Crime (IOC), Young Men's Work, Council for Boys and Young Men, Aggression Replacement Therapy (ART), Coping with Stress: a Cognitive Behavioral Therapy (CBT) Guide for Teens with Trauma, Adolescent Coping with Depression (CWD-A), Trauma focused CBT, Seeking Safety, Chestnut Health System Treatment manual, and Health and Sexuality Education. Additional treatment services provided includes individual, group, and family therapy, gender-specific services, pre-vocational and vocational services, job training placement, self-sufficiency planning, recreational and leisure time activities, religious/spiritual opportunities, as well as restorative justice philosophy and programming. According to the program's staff roster, the management staff includes a facility administrator (FA), an assistant facility administrator (AFA) of operations, an AFA of administrative services, a clinical director, an assistant clinical director, a clinical manager supervisor/director of nursing, director of case management, business office manager, a program manager, training manager, and a kitchen manager. Case management services are provided by a director of case management, five case managers, and three transition coordinator/case managers. Mental health staff at the program includes a clinical director/designated mental health clinician authority (DMHCA), an assistant clinical director, one licensed mental health professional and substance abuse counselor, one behavioral analyst, six master's-level therapists, and two recreational specialists. Medical services are offered and are provided by a contracted licensed medical doctor (MD) who serves as the designated health authority (DHA) and three registered nurses (RN), with one serving as the clinical manager supervisor/director of nursing. Educational services are provided by the Fulton-Holland Educational Services Center of the Palm Beach County School District. The program is an eighty-two-bed, high-risk residential treatment program, which is divided into five youth dormitories. At the time of the annual compliance review, one dormitory was not in use due to a planned renovation. The program's staff-to-youth ratio is one-to-eight during day time activities, one-to-twelve during sleeping hours, and one-to-five for transports. The program has a total of 102 operational motion sensitive video cameras capable of recording thirty-days of video footage. At the time of the annual compliance review, the program had seven vacant positions including one licensed therapist position, one case manager position, four youth care worker positions, and one cook. A waiver of the educational requirements has been granted for one of the program's two recreational therapists.

Strengths and Innovative Approaches

- A Fall Feast was held with Halle Place which houses former incarcerated women who are homeless. The young men sang for the women, shared a meal, listened to their stories, and shared similar backgrounds of obstacles and challenges.

- Breast Cancer Awareness activities were conducted in which the youth made cards and gift baskets which were donated to local breast cancer survivors.

- A First Responder Appreciation Day was held in which the youth honored local fire fighters. The youth presented original music, poetry and posters in appreciation of first responders. Guests spoke about their careers and answered questions about life in the firefighting field.

- Suicide Prevention Awareness with National Alliance of Mental Illness (NAMI) was observed as the youth created posters which reflected positive ways to prevent suicide. A representative from the NAMI assisted in judging the posters.

- Program youth filled Halloween candy bags to donate to the Palm Beach Regional Detention Center for their Halloween activities.

- Two youth in the process of transitioning from the program were given permission to leave the program and volunteer at a local thrift shop. Proceeds from the thrift shop goes towards services which assist homeless and reentry populations.

- Youth participating with the Home Builders Institute program built and donated furniture to various community agencies including Aide to Victims of Domestic Violence (AVDA).

Standard 1: Management Accountability

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

The program maintains a written policy and procedures to address required background screenings upon hire, as well as the submission of an Annual Affidavit of Compliance with Level 2 Screening Standards. Since the last annual compliance review, the program hired forty-two new staff, who were all applicable for an initial background screening. A review of documentation for the forty-two newly hired staff found the program received background screening clearances from the Department's Background Screening Unit (BSU)/Clearinghouse for all but one staff prior the date of hire. The one staff without background screening clearance prior to hire was an administrative assistant who the program documented was in training from the May 20, 2019 hire date through the clearance date of June 13, 2019. Twenty-eight of the forty-two newly hired staff records were hired for direct care positions. Twenty four of the forty-two newly hired direct care staff records contained a copy of the pre-employment assessment tool with a passing score. Four records were for staff hired into direct care positions on October 29, 2018, March 4, 2019, April 1, 2019, and May 6, 2019 with documented pre-employment assessment scores lower than the minimum required score of seventy percent. An interview with the program's human resources manager revealed the program hired the four candidates because their scores were less than ten points below the passing score. The four staff with scores below the passing score seventy percent were hired prior to the program's own implementation on June 3, 2019 of corrective action retraining to ensure only prospective candidates with passing scores on the pre-employment assessment are hired. Reviewed documentation and an interview with the program's human resources coordinator confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS). All staff were included on the Department's BSU/Clearinghouse employee roster. An interview with the program's human resources director indicated the program had no volunteers. The program submitted the Annual Affidavit of Compliance with Level 2 Screenings standards to the Department's BSU on December 27, 2018, meeting the annual requirement. However, the Department never received an Annual Affidavit of Compliance with Level 2 Screenings standards for program's teachers who are paid by the Palm Beach County School Board. The program completed an Annual Affidavit of Compliance with Level 2 Screenings standards for the teachers for the current calendar year on October 17, 2019, which was during the week of the annual compliance review.

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

The program maintains a written policy and procedures requiring five-year background re-screenings. A re-screening is required every five years, calculated from the staff's original hire date with the program or five years from the date the staff was screened through the Department's Background Screening Unit (BSU)/Clearinghouse. The program had no staff, contracted providers, or corporate staff eligible for a five-year background rescreening. The program reported having no volunteers.

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 maintains a written policy and procedures for abuse reporting and for providing an abuse-free environment. The policy stipulates youth and staff are to have unhindered access to report alleged abuse to the Florida Abuse Hotline. Observations during the facility tour revealed postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers throughout the program. The program's policy outlines the reporting procedures for all staff to follow when a youth wishes to make an abuse report. Upon hire, all staff signed a form located in the employee handbook acknowledging their understanding of the code of conduct. A resident handbook is provided to each youth upon admission and includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC

telephone numbers. A review of documentation from the previous six months was conducted for allegations of abuse to the Florida Abuse Hotline or CCC and two reports alleging abuse were found. Documentation confirmed a report was made by staff to the Florida Abuse Hotline and CCC within two hours of staff being made aware of each incident. A child protective investigator reported to the program in each instance to follow-up on the allegation and found there were no findings of abuse. Seven interviewed staff, and an interview with the facility administrator (FA) confirmed the program's abuse reporting practice. The program's abuse reporting process includes immediately reporting any knowledge or suspicion regarding abuse to the Florida Abuse Hotline and the CCC for youth eighteen years of age or older, verbally notifying the on-duty supervisor once the call to the Florida Abuse Hotline has been completed, and completion and submission of an incident report form to the assigned supervisor. Any youth who declines to make an abuse call themselves does not relieve any staff from their mandate to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred. Seven interviewed staff were all able to state the program's process for allowing a youth to make a call to the Florida Abuse Hotline and none had ever observed a co-worker telling a youth they could not make such a call. None of the seven staff reported ever hearing another staff use profanity when speaking to a youth. Six of seven interviewed youth indicated all staff are respectful to them. One youth reported only certain staff were respectful but could not identify staff who were not or relate an instance where staff were disrespectful.

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 maintains a written policy and procedures to address allegations of physical, psychological, and emotional abuse. Seven staff training records were reviewed and documented receipt of training on child abuse reporting requirements. An interview with the facility administrator indicated the program has had no substantiated findings of abuse since the last annual compliance review. However, the case related to one allegation remains open and the staff has already been terminated by the program. The program had eleven incidents involving a complaint against staff. A review of five incident reports was completed specific to allegations of abuse. Reviewed documentation indicated program management staff acted immediately in each instance by removing each staff from youth contact while investigations into the allegations were conducted. Reviewed documentation confirmed one staff was terminated by the program prior to the conclusion of the case.

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 maintains a written policy and procedures to address required reporting of incidents occurring at the program to the Department's Central Communications Center (CCC), in accordance with the Florida Administrative Code. Reviewed documentation confirmed the program had thirty-six incidents reported to the CCC over the prior six months and five were reviewed. All five incidents were reported to the CCC within two-hours of the incident or the program becoming aware of the incident. There were no incidents discovered which should

have been reported to the CCC but were not. Reviewed documentation indicated the program experienced a seventeen percent increase in the number of reportable incidents as compared to the previous six months which the program did not attribute to any particular factors. However, the program experienced an eleven percent decrease in the number of reportable incidents in the most recent twelve months, as compared to the previous twelve months.

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

The program maintains a written policy and procedures to address the use of Protective Action Response (PAR) techniques. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 16, 2019. The program had twelve PAR reports in the previous six months, of which five PAR reports were reviewed. All five reports were completed by staff prior to the end of their shift and included statements from all staff members who were engaged with the youth during the incident. All PAR reports were reviewed by the program's management staff, as required, within seventy-two hours and included a post-PAR interview with the youth conducted within thirty minutes of each incident. Documentation indicated medical reviews were not required for any of the reports completed. The program's written PAR procedures require all instances of physical intervention, including touch techniques and escorts, to have a medical follow-up. All reviewed incidents included a medical follow-up as required by the program's policy. An interview with the facility administrator indicated PAR incidents are discussed during daily morning meetings and weekly management team meetings and are also reported monthly to the Department and the Sequel corporate office. The program also tracks PARs on a weekly basis through management reports and the program conducts monthly trend analysis of all PAR related incidents. During the annual compliance review period, the program's PAR rate was 0.74, which is below the statewide residential PAR rate of 1.59.

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

The program maintains a written policy and procedures regarding pre-service training. The program's pre-service orientation training plan was submitted and approved by the Department's Office of Staff Development and Training on February 7, 2019. Seven pre-service training records were reviewed for pre-service certification training within 180 days of hire. All seven staff completed at least 120 hours of pre-service training within the 180-day time frame, as required. All staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), suicide prevention/intervention, child abuse reporting, emergency procedures, and Prison Rape Elimination Act (PREA) training, as well as professionalism and ethics prior to having contact with youth or confidential records. All training was documented in the Department's Learning Management System (SkillPro) and was conducted by qualified trainers. There were no additional training requirements pursuant to the program's contract.

1.08 In-Service Training	Satisfactory Compliance

Residential contracted provider staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed.

Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.

The program maintains a written policy and procedures to address annual in-service training. The program had an in-service annual training plan which was submitted and approved by the Department's Office of Staff Development and Training on February 7, 2019. Reviewed documentation validated the program updates the training plan as changes occur. Seven staff training records, including three supervisory records, were reviewed for completion of in-service training. All seven staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR), as well as completed training in suicide prevention/intervention, professional ethics and standards of conduct, and active shooter training. Each of the seven staff exceeded the twenty-four hours of required in-service training. The program requires management staff to complete a minimum of eight hours of training in areas of management leadership, personal accountability, employee relations, and communication skills in addition to the twenty-four hours of in-service training. The records for all three reviewed supervisors validated each had completed more than eight hours of management topics specified in Florida Administrative Code. Training was documented in the Department's Learning Management system (SkillPro) for all staff with the exception of the on-line supervisory training for one supervisor. The program reported having a problem with SkillPro registration for the one supervisor's course, which the program attempting to rectify. A review of the four licensed nursing staff records found each had a current certification in CPR with AED. There were no additional training requirements pursuant to the program's contract

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 maintains a written policy and procedures to address annual grievance process training, which is included within the program's pre-service training plan. A review of seven staff training records confirmed all seven staff completed training on the program's grievance process and procedures during pre-service training. Additionally, each youth is introduced to the program's grievance process during orientation and the process is also outlined in the youth handbook which each youth receives. The program has a written grievance policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances within the program related to the violation or denial of basic youth rights. The procedures require youth to be treated fairly, respectfully, without discrimination, and have their rights protected. The procedures for the grievance process include specific timeframes to ensure timely feedback to the youth and rectification of situations or conditions should grievances be determined to be valid or justified. The process allows a youth to file an informal or formal complaint and file an appeal, if necessary. Review of the program's policy and procedures and an interview with the facility administrator (FA) indicated the program has an

informal phase for the grievance where youth complete a Request to Talk form and address it with the staff, who help them resolve the complaint, or concern. The FA also indicated the program has a formal phase where the youth complete a grievance form describing their complaint. A written response is provided to the youth by the grievance officer who is a next level and/or shift supervisor. The youth sign to acknowledge their agreement with the findings and action taken, or to disagree with the findings at the supervisor phase and request an appeal to the next level, which is then forwarded to the assistant facility administrator (AFA) for response within twenty-four hours of receipt. The program utilizes a grievance form which delineates the informal, formal, and appeal phases. The locked, wall-mounted grievance box and grievance forms are accessible to all youth. The program maintains a binder and tracking logs, in chronologic order, for all grievances submitted, which was reviewed. A review of the documentation and an interview with the AFA indicated the program had a total of three grievances logged over the previous twelve months. A review of the three submitted grievances indicated all three reached a resolution with which each youth agreed, and no grievances were appealed. Each of the seven interviewed staff and seven interviewed youth were accurately able to explain their understanding of the program's grievance process. All seven interviewed youth indicated they were able to request assistance in completing a grievance form, if needed.

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

The program has a policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract of required services identified Thinking for a Change (T4C) as an evidenced-based intervention curriculum utilized by the program. The program's activity schedule determined youth spend at least sixty-percent of their awake hours in structured, planned programing and/or activities. A review of six months of Thinking for a Change entries in the Department's Evidence Based System (EBS) indicated there were three cohorts of T4C facilitated from April 9, 2019 to July 31, 2019 and three cohorts were in progress during the annual compliance review period. A review of sign-in sheets indicated there were sign-in sheets which were missing. The program provided sign-in sheets for the first group dated May 1, May 13, May 20, May 27 and May 29, 2019. Sign-in sheets from the second group were dated May 15, May 22, June 3, June 6, and June 19, 2019. The sign-in sheets provided for the third group were dated May 13, May 22, May 29, June 3, and June 10, 2019. The clinical director stated the program was entering the T4C cohorts in the EBS system and misplaced the remaining sign-in sheets. A review of the EBS system confirmed this. One cohort in progress during the annual compliance review, started on July 16, 2019 and two cohorts started on September 12, 2019, for which all sign-in sheets were maintained properly. The program's documentation and the Department's Learning Management System (SkillPro) reflected the program had ten staff trained by a certified trainer to facilitate and/or provide internal fidelity monitoring during the annual compliance review period. The case managers facilitating T4C all had bachelor's-level degrees and the clinical director, and the director of case management had master's-level degrees. The trained staff had from two years to seventeen years of experience working with adult and/or juvenile offenders. An interview with the program director indicated education and experience is taken into consideration in determining who delivers or facilitates specific group curriculums. The program director also stated the youth are matched to staff and counselors during the pre-classification meeting. The clinical director identified Aggression

Replacement Therapy (ART), T4C, Impact of Crime (IOC), and Life Skills Training (LST) as interventions provided by the program. A review of seven youth records validated five youth were involved in or had completed delinquency interventions which were evidence-based, promising practice, or a practice with demonstrated effectiveness. Two youth had arrived at the program after the T4C groups began and were on the waiting list for the next T4C group. Six of seven youth performance plans included goals in which youth were to participate in T4C group. One youth had recently arrived at the program and did not yet have a completed performance plan. All seven reviewed records indicated youth are chosen to participate in delinquency interventions based on their priority needs as assessed by the Residential Assessment for Youth (RAY) and Mental Health/Substance Abuse evaluations.

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

The program maintains a written policy and procedures regarding provision of life skills training to the youth. The clinical director identified Aggression Replacement Therapy (ART) and Life Skills Training (LST) as the curriculums used to develop life and social skill competencies in youth. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. The provider's contract does not address required life skill services. However, the contract does identify ART and LST as mental health curriculums with a life skills component. Therapists facilitate one-hour ART groups three times a week. A review of ART group attendance sign-in sheets verified there were two ART groups in progress at the time of the review which were initiated on August 5, 2019 with nine youth participating and on August 26, 2019 with eight youth participating. An ART group was observed during the annual compliance review week. The group had the appropriate number of youth participating and the facilitator was knowledgeable of the material. The program did not facilitate LST groups during the annual compliance review period; however, an LST group was assembled while the review team was on-site. The program's documentation reflected the program had a training protocol and there were four staff who received formal training from a qualified trainer to become a group facilitator in ART, during the annual compliance review period. The program's therapists and clinical director are trained to deliver the curriculum. An interview with the clinical director confirmed youth are able to practice skills during group role-play activities and interactions with staff and youth at the program. Seven youth were interviewed, and all stated they were participating in IOC, ART, T4C, and daily groups. Youth are learning coping skills, anger management and critical thinking skills. All the youth stated they participate in role playing activities during 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 program maintains a written policy and procedures regarding provision of restorative justice awareness to the youth. The program's contract requires provision of the Impact of Crime (IOC) curriculum to the youth. IOC is designed to assist youth to accept responsibility for the harm they have caused by their past criminal actions. The curriculum teaches youth about the impact of crime on their victims, their families, and their community and is designed to expose youth to

victim's perspectives through victim speakers, in person or through digital video disks (DVD). IOC provides opportunities for youth to participate in reparation activities such as community service projects. The program's documentation reflected the program had a training protocol in place and five staff received formal training from a qualified trainer to become group facilitators in IOC during the annual compliance review period. The program's two recreational therapists, director of case management, clinical director, and assistant program director are trained to deliver the curriculum. The sign-in sheets provided by the program validated two cohorts of IOC were completed and two cohorts were in progress during the annual compliance review period. An interview with the clinical director and community liaison validated the program provides opportunities for youth to participate in community service projects and invites guest speakers to increase restorative justice awareness including a mother from Angels on Deck who spoke to the youth about what a mother experiences when they lose a child to violence. A review of seven youth records indicated two youth were participating in an IOC group. Four of seven youth were on the waiting list for the next IOC cohort to begin and one youth had completed IOC at another program in 2018. Observations of an IOC group was unable to be conducted during the annual compliance review.

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 program's contract of required services for gender-specific programming identified Young Men's Work (YMW), Council for Boys and Young Men, Adolescent Coping with Depression, and Trauma Focused Cognitive Behavioral Therapy (CBT). YMW addresses the needs of young men and is designed to provide services on the common characteristics of young men. Council for Boys and Young Men is a curriculum designed to engage, challenge, celebrate, develop, and unite male youth. Adolescent Coping with Depression, and Trauma Focused CBT are gender-specific mental health counseling. The program provided evidence of individual sessions between the youth and therapists of Adolescent Coping with Depression and Trauma Focused CBT. The clinical director stated youth respond better discussing traumatic issues in one-on-one sessions with the therapists. The program also provides an additional curriculum titled Talks My Father Never Had with Me. Council for Boys and Young Men was not offered to the youth during the annual compliance review period. The clinical director stated the program provides adequate gender-specific programing with the youth. In addition to the curriculums, youth participate in gender-specific sports such as football, drum line, and mentoring. The program has a structured intramural sports program which enable youth to participate in leagues and tournaments with other programs and schools. Professional football players come to the program to work with and mentor the youth. The program launched Cuts and Convos sessions with a local barber. The barber came to the program as a guest speaker and provides free professional haircuts and mentoring to the youth. Several youth expressed interest in becoming professional barbers. Guest speakers from the Gatekeepers Mentoring Program participated to mentor youth and discuss topics of interest. The school principal initiated a drum line with the youth. The youth provided a demonstration for the annual compliance review team to demonstrate their drum play of originally written content.

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 maintains a written policy and procedures regarding security, medical, and mental health alerts, the use of an internal alert system, and entering alerts into the Department's Juvenile Justice Information System (JJIS). The program's daily internal alert list reports the assigned dormitory and medical grade for each youth along with any medication allergies, food allergies and dietary restrictions, environmental and other allergies, side effects of medical conditions/medications, any physical restrictions, and whether the youth is on alert for mental health, gang, or security issues. An interview with the facility administrator was conducted and confirmed the JJIS alert reports and internal alerts are reviewed daily during shift briefings with direct care staff. Current alert lists are maintained in master control, sub-control, the medical clinic, and in the kitchen. Alert boards are also maintained in master control and in the medical clinic. A review of seven medical and mental health and substance abuse records found all applicable medical, mental health, and gang alerts were entered in JJIS, as required. A total of twenty-six alerts for seven youth were reviewed and found to have been entered correctly into JJIS, which also matched the program's internal alert system. A review of youth medical records confirmed all youth with medical grades two through five were placed on the program's medical alert system. There were no discrepancies noted between the internal alert system and JJIS. A discussion with review team members reviewing case management, medical, mental health, and safety and security verified youth were placed on the alert system as specified in the program's written procedures. An interview with the program's clinical director confirmed only medical staff can remove or downgrade a medical alert and only licensed mental health staff are able to remove or downgrade a mental health alert. A review of the program's log books verified updates to alerts were entered according to the program's policies. An interview with seven staff confirmed alerts are updated daily and discussed during shift briefings.

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

The program maintains a written policy and procedures to address record management to ensure the management of all records is consistent with legal and contractual requirements. The program's policy echoes the Department's requirements of the organization and maintenance of records. The program maintains an official case record for each youth, which is maintained in three separate records for each youth, including an individual healthcare record (IHCR), an individual case management record, and a clinical mental health and substance

abuse record. A review of seven individual healthcare records for youth active within the program found each record was labeled "confidential" and secured in the medical office behind a locked office door, within locked cabinets which were not accessible to youth and were also marked "confidential." Each mental health and substance abuse record was secured in the therapist's office and was organized with tabs dividing information into specific sections for legal information, correspondence, and documentation of case management and treatment activities. Each individual case management record was divided into the required sections as set forth in Florida Administrative Rule and maintained in the case management office behind a locked door within a locked cabinet. A review of the youth program's case management records confirmed the program's practice is following the tab requirements, records, and confidential information provisions pursuant to Florida Statute. Observations of the filing cabinet storing mental health records showed the cabinet was also marked "confidential."

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

A review of documentation, observations made during the annual compliance review, and seven youth interviews validated the program has a formal process to improve communication between administration and youth at the program which allows youth opportunities to provide input into the program's operations and living environment. The program utilizes grievance forms, as well as the Request to Talk forms which provide individual youth the opportunity to address issues, problems, or concerns they may have which are not necessarily grievances. Monthly town hall meetings and weekly dormitory meetings take place during which youth may identify issues they are concerned with. The program also maintains a Youth Advisory Board consisting of youth leader representatives from each dormitory who meet with upper level facility management. The youth leaders are selected by their respective treatment teams and solicit recommendations, issues or concerns from the youth on their assigned living unit to be presented during advisory board meetings. An interview with the facility administrator (FA) indicated the youth advisory board meetings occur each month. A review of the board binder confirmed youth meetings were conducted at least once a month. Interviews completed with seven randomly selected youth confirmed the program has a process allowing them to provide input about what happens at the program. Additionally, the program conducted monthly surveys which queried about a variety of program related areas including whether educational and medical needs were met and seeking suggestions for improving the program. The program also has a speak out form which enables all youth to share their thoughts and feelings about any topic they wish to address.

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 provided a contact list for their forty-five member community advisory board consisting of representatives of law enforcement agencies including a police chief, the judiciary community including a judge, the Florida Senate, the business community, the local school district and school board, faith community, and a local victim advocacy agency, as well as a former program resident and parents/guardians of youth formerly involved in the juvenile justice system. Additional members include a representative of the National Football League's players association, a retired firefighter, a recording artist, and a motivational speaker. The program provided copies of recruitment letters and letters of invitation to different individuals. An

interview with the community liaison indicated the program has been working to engage a representative of the lesbian, gay, bi-sexual, transgender, questioning, and intersex (LGBTQI) community. A review of the community advisory board agendas and sign-in-sheets validated the program hosted quarterly advisory board meetings since the last annual compliance review on January 24, April 25, and July 25, 2019, with the last 2019 board meeting taking place on October 28, 2019. The program maintains a community advisory board binder, which was reviewed. An interview conducted with a current board member confirmed their involvement with the board. An interview with the facility administrator (FA) clarified the invitations to the program's quarterly community advisory board meetings are sent by mail or email. The program responded to a recommendation of the advisory board by planning an open forum between the program youth and local law enforcement officers to help dispel myths and develop relationships between the youth and law enforcement.

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

The program maintains a written policy and procedures to provide a system of staff communication, opportunities for providing input, and feedback on the program's operations. The program holds a weekly management meeting, monthly all staff meetings and specific departmental meetings, as well as shift briefings at the start of each shift. The program uses youth and staff surveys, weekly and monthly reports, and contractual program performance measures as a means of evaluating the program's outcome data. Administration shares the results of comprehensive accountability report with staff on a monthly basis during monthly all staff meetings. Five of seven interviewed staff confirmed receiving information on annual reports and parent/guardian/youth surveys. Staff surveys are conducted twice a year and are optionally anonymous, which allows staff to candidly respond to the survey questions. Parent/guardian surveys are also conducted with specific questions to address the program's medical, educational, mental health and case management services, as well as seeking general opinions about the program overall. Interviews completed with seven staff indicated they can communicate with management to provide input and feedback with five staff stating communication was very good, one staff rating communication as good and one staff rating it as fair. An interview with the facility administrator revealed the program has good staff retention rates and has not experienced any challenges regarding high staff turnover or low morale.

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

The program maintains a written policy and procedures to address staff performance to ensure the evaluations of staff are conducted based on established performance standards. A review of seven pre-service and in-service staff records revealed newly hired staff received ninety-day performance evaluations and each staff received an annual evaluation from their direct supervisor on the anniversary of their hire date. The review of staff records validated the program maintains position descriptions for each position title which outline the position expectations and essential functions, requirements, qualifications, skills and abilities, physical requirements, and physical demands of each position. Seven staff were interviewed and three responded to indicate staff receive formal evaluations of their performance based on performance standards every year, three indicated the evaluations were conducted monthly, and one staff indicated receipt of a couple of evaluations but did not remember the time frames.

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

The program is to provide daily recreational and leisure time activities in ways which are physically challenging, educational, and constructive which teach youth healthy ways to maintain their own physical wellbeing in additional to providing alternative ways of spending leisure time. A review of the program's logbooks and observations during the annual compliance review week revealed the program conducts outdoor recreation and indoor leisure activities in accordance with the program's daily schedule. Interviews completed with seven randomly selected youth revealed the youth play football or basketball outdoors unless it is raining, and during indoor recreation the youth play cards, chess, board games, and video games, as well as watching television under the supervision of direct care staff. The program has two full-time recreational therapists who work with the youth and complete recreation therapy assessments and develop wellness plans. The education and qualifications of each recreational specialist were reviewed. One of the therapists is a bachelor's-level recreational specialist who holds a degree in therapeutic recreation. The second recreational specialist possess a high school diploma, with an approved waiver from the Department in place, and eighteen years of experience in the areas of recreation coordination and treatment of youth mental health issues through the use of recreation activities. The recreational therapists work under the supervision of the designated mental health clinician authority (DMHCA). In turn, the wellness plans are discussed with the assigned therapist and a wellness goal is developed and placed on the youth's individualized treatment plan. A review of seven youth case management records revealed the program included clinical goals related to overall mental, physical, and emotional health within the treatment plan for each of the reviewed youth records. All seven interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Interviews with the youth and seven staff indicated youth are provided at least one hour of large muscle activity each day.

Standard 2: Assessment and Performance Plan

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

The program maintains a written policy and procedures requiring each youth's parent/guardian to be notified by telephone within twenty-four hours of admission and maintain written correspondence within forty-hours of admission. A review of seven youth case management records found each documented the parent/guardian was contacted within twenty-four hours of admission. In addition, the parents/guardians were notified in writing within forty-eight hours, as outlined in the program's facility operating procedures. A review of the records also revealed the program was timely in notification to the committing court, assigned juvenile probation officer (JPO), and post-residential services when applicable.

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

The program maintains a written policy and procedures ensuring all youth successfully complete program orientation, including all required elements required by Florida Administrative Rule within twenty-four hours of admission. Seven reviewed youth case management records included youth acknowledgment forms confirming receipt of orientation. All documentation was in accordance to the policy time frames. During the annual compliance review, there were no new admissions to the program. Seven youth were interviewed and each verbalized receipt of orientation within twenty-four hours of admission.

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

The program maintains a written policy and procedures to obtain consent from any youth eighteen years of age or older prior to discussing or providing the youth's parent/guardian any information related to the youth's physical or mental health screenings or assessments. Seven youth case management records were reviewed, and three youth were applicable. All three records contained a consent form signed by each youth prior to any release of information.

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 maintains a written policy and procedures regarding the classification system. A review of seven youth case management records indicated youth were classified in such a way which promoted safety and security, as well as the effective delivery of treatment services in accordance with Florida Administrative Code. The program's classification form included maturity level, age, history of violence, security alerts, mental health and substance abuse history, medical records, and vulnerability to victimization. Forms revealed all pertinent key staff were present during the classification meeting at admission. The program has an internal alert roster which is maintained in the conference room area for accessibility. A review of the Risk Assessment/Leisure Activity binder documented youth were reviewed to assess the level of privileges or participation in activities and use of tools. An interview with the director of case management (DCM) reflected youth are reviewed monthly, and the information is maintained in the binder, accessible to all direct care, medical, administration, kitchen and pertinent staff. In addition, a review of the Vulnerability to Sexual Aggressive Behavior (VSAB) assessment was completed prior to the classification of each youth, with the exception of one youth whose VSAB was completed the day after he was classified. The assessments are maintained in the Department's Juvenile Justice Information System (JJIS). There was one youth who was admitted with an open medical alert; however, this was not included on the classification. Reclassifications were not completed on two of seven youth who were moved from the Alpha dorm, as it was closed earlier in the month to either of the other two dorms. The third youth in the sample of seven had a reclassification completed; however, the youth was not assigned a dormitory based on a VSAB completed in JJIS, but rather a VSAB completed by hand.

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

The program maintains a written policy and procedures to ensure youth who are identified as or are suspected gang members are provided gang prevention and intervention services/activities. Seven youth case management records were reviewed and six were applicable for gang involvement. Each of the six applicable youth records confirmed the notification to the law enforcement was made to the identified local law enforcement agency. In addition, documentation supported the educational staff and the youth's assigned juvenile probation officer (JPO) were also notified. Local law enforcement is notified in writing by the program's director of case management. The program identifies youth who are suspected gang members at intake and enter any applicable alert in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation reflected all gang alerts were maintained in JJIS.

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 maintains a written policy and procedures to ensure youth who are identified as or are suspected gang members are provided intervention services and activities. However, the policy did not contain a process if a youth wanted to disaffiliate with a criminal street gang. Five of the six applicable youth were eligible to have gang interventions included in their Individual Performance Plan (IPP). The remaining youth's IPP was not due at the time of the annual compliance review. One youth did not have interventions included on his IPP; however, the youth was enrolled in the gang intervention program. Each of the six youth were enrolled in and receiving interventions. The program utilizes both Gang Resistance and Drug Education (GRADE) curriculum, as well as Impact of Crime (IOC) as their gang interventions. Reviewed sign-in sheets for the past six months confirmed youth participation.

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

The program maintains a written policy and procedures which outlines all initial Residential Assessments for Youth (RAY) be completed within thirty days of a youth's admission. Seven reviewed youth case management records indicated the RAY was completed within thirty days of each youth's admission to the program. One youth was not in the program for thirty-days; however, the RAY was completed within the first fourteen days of admission. The initial RAY was maintained in each youth's case record and located in the Department's Juvenile Justice Information System (JJIS). Four of the seven records reviewed were applicable for a RAY Reassessment. The four applicable reassessments were completed within ninety days of the initial assessment.

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

The program maintains a written policy and procedures to ensure each youth has a completed a Youth Needs Assessment Summary (YNAS) within the initial thirty-days after admission. Seven youth case management records were reviewed and six were applicable for completion of a YNAS. One youth was not in the program for thirty-days. Six of the applicable youth case management records contained a copy of the YNAS which was generated within thirty days of admission; however, three of the six were not marked completed in the Department's Juvenile Justice Information System (JJIS) within the thirty

days. All the applicable documentation and the original YNASs were maintained in JJIS for each youth; however, are considered incomplete until they are electronically marked complete.

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

The program maintains a written policy and procedures to ensure the intervention and treatment team and youth develop an Individual Performance Plan (IPP) within the initial thirty days of admission. Seven youth case management records were reviewed and six were applicable for completion of an IPP. One youth was not in the program for thirty-days at the time of the annual compliance review. Each applicable youth case management record contained an IPP created within thirty days of the youth's admission. All IPPs included acknowledgement indicating the youth, treatment team leader, medical staff, therapist, administrator, education staff, and parent/guardian participated in the development of the IPP. In addition, reviewed documentation supported an IPP questionnaire was mailed to each parent/guardian with the admission package. Each of the six IPPs included delinquency interventions and measurable goals. Community service hours were required in five of the six applicable records and, none of the IPPs contained an intervention specific to what the youth needed to complete nor a general intervention. Each reviewed IPP outlined staff and youth responsibilities to accomplish the goals. While all six records had staff and youth interventions, two had staff interventions in pending status, and one youth did not have targeted transition interventions. Each record also contained documentation indicating a copy of the IPP was sent to the committing court, assigned juvenile probation officer (JPO), and parent/guardian. Seven youth were interviewed, and each confirmed receiving a copy of the IPP, and participation in the creation.

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

The program maintains a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY). Seven youth case management records were reviewed and six were applicable for completion of a performance plan revision. One youth was not in the program for thirty-days at the time of the annual compliance review. A review of six applicable youth case management records included performance plan revisions in three of six records. Three youth based upon RAY Reassessments had new criminogenic needs identified; however, the domains were neither

added or addressed within the Department's Juvenile Justice Information System (JJIS). One youth had an Individual Behavior Plan (IBP) written based on behavior but the program did not incorporate and make the applicable revisions. There were three youth who had Individual Performance Plans (IPP) revised; however, the completion dates were not updated to show either completed or extend the date range to continue to work on as they were outdated. The program revisions were made to two of the youth's IPP due to failure to progress within goals. A review of three close records indicated, based on the transition conference, the intervention and treatment team revised the youth's IPP and transition plan.

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

The program maintains a written policy and procedures to address the transmittal of performance summaries. A review of seven active youth case management records found four were applicable for completion of a performance summary. In addition, three closed youth case management records were reviewed. Each of the reviewed records revealed each youth's performance summary was completed every ninety days or less, with the exception of two. One was late due to the hurricane evacuation and one was one day late. Summaries included reports on education, mental health, performance plan goals progress, staff and peer interactions, the youth's level of motivation to change, significant events, and anti and pro-social behaviors.

A review of three closed records contained a release summary which was sent to the committing court within the required time frame as well included a justification for discharge for the program. All of the performance summaries and release summaries in the seven total youth records found each youth was able to provide a comment. Each of the records reflected the required signatures of the youth, treatment team leader, the staff whom prepared the summary, and the program director or designee. All records contained supporting documentation indicating the performance summaries were sent to the committing courts, assigned juvenile probation officer (JPO), and parent/guardian. A review of three youth close case management records reflected Pre-Release Notifications and release summaries were sent to the committing courts and assigned JPO at least forty-five days prior to each youth's scheduled discharge date.

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.	

Seven youth case management records were reviewed, and each contained documentation the parent/guardian participated in the creation of the Individual Performance Plan, treatment team meetings, and monitoring events. Each record indicated multiple attempts of notification

to the parent/guardian to participate in treatment services, and participate in treatment team meetings, including mailing a schedule of youth events, encouragement to participate in activities, and telephone meetings, as well as being mailed copies of youth documentation. An interview with the director of case management (DCM) indicated parents/guardians are notified of and invited to all scheduled meetings involving their youth from the date of entry until the time of discharge. All seven interviewed youth indicated their parents/guardians are involved in their case management activities.

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

The program assigns a representative from each program area to participate in biweekly informal progress reviews and formal reviews for each youth at least once every thirty days. A review seven youth case management records found six were applicable for treatment team meetings. One youth was not in the program for thirty-days; however, had a treatment team review meeting date scheduled for the future. Documentation indicated a formal review was conducted once a month in all six records. Names and signatures of treatment team members were documented on the treatment team form, which included the youth, case manager, medical staff, and therapist. Education staff provided written input in all records. Parent/guardian participation was noted by telephone in some instances. Two applicable youth case management records documented invitations to the Florida Department of Children and Families (DCF) representatives to participate in the meetings. Observations of two treatment team meetings during the annual compliance review revealed active participation by all required staff and parties, as outlined in the program's facility operation procedures and Florida Administrative Code. The assigned juvenile probation officers participated by telephone in both meetings.

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

The program maintains a written policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's performance plan. A review of seven youth case management records found six applicable for the incorporation of other plans into each youth's performance plan. One youth was not in the program for thirty-days. Four of the six applicable plans did not include specific interventions to address education plans. Five of the six applicable records contained interventions which addressed their Individualized Mental Health and Substance Abuse Treatment Plan. Two applicable reviewed records confirmed the incorporation of plans with the Florida Department of Children and Families (DCF). The program had no applicable youth for involvement with the Agency for Persons with Disabilities.

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

The program maintains a written policy and procedures to address formal and informal treatment team meetings, ensuring the case manager meets informally with each youth at least biweekly and formal treatment team meetings occur at least once every thirty days. Seven youth case management records were reviewed and six were applicable for treatment team meetings. One youth was not in the program for thirty-days. A review of the six youth case management records confirmed each youth received formal treatment team reviews every thirty days. Documentation supported the case manager, therapist, medical staff, direct care staff, and assistant program director (AFA) physically participated in formal reviews. It was also evidenced the parent/guardian and assigned juvenile probation officer (JPO) participated in the treatment team meetings by telephone. The Residential Assessment for Youth (RAY) is reviewed and, when necessary, revisions to the individual treatment and or performance plans are discussed at the formal review. Observations of three formal treatment team meetings during the annual compliance review evidenced the program practices the review of performance goals, and written reports from education, and medical with the youth's progress notes and follow-up goal(s) were completed. Each of the applicable youth case management records documented informal treatment team review meetings were conducted at least once a month. Information included in each reviewed record supported the youth's progress in mental health, education, behavior, and performance plan goals were discussed. Documentation in each of the youth's records reflected the youth's name, date of review, meeting participants, and an overview of the youth's progression over the last month. Interviews completed with seven youth revealed the youth are provided with the opportunity to present and demonstrate certain skills they are learning and working towards in the program during treatment team meetings.

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

The program offers Type 2 career education services provided by the Palm Beach County School Board, which teaches personal accountability skills and behaviors, such as interpersonal and decision-making skills appropriate for youth in all age groups and ability levels and are geared to help youth maintain employment. The vocational programming provides an orientation to various occupations which are directly related to each youth's individual abilities, aptitudes, and skill levels. An interview with the lead teacher indicated the career education assessments and services at the program include the My Career Sines (Career Exploration), Microsoft Office Certification, and Digital Technology Syllabus and Lesson Plans. An interview with the facility administrator revealed the program has a vocational program through the Home Builders Institute through which the youth can earn certification in Building Construction Technology, as well as first aid, cardiopulmonary resuscitation (CPR), and Occupational Safety and Health Administration (OSHA) 10 certifications. Additionally, the youth can earn industry certification in both Microsoft Office Suite and the Adobe Cloud.

Three closed youth case management records were reviewed for youth with employability skills and each individual performance plan included an employability skills goal. All three closed records contained a sample application and completed resume. None of the three closed contained a copy of a Social Security card which is essential to obtaining employment upon leaving the program; however, one record included a copy of an application for a Social Security card. One of the three closed records contained a copy of a valid Florida identification card and two did not. One of the three was missing information pertaining to the Career Source Center located near the area in which the youth would be seeking employment. All three records indicated the parent/guardian and juvenile probation officer (JPO) had knowledge of the youth's vocational plan.

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

Educational services are provided by the Fulton-Holland Educational Services Center of the Palm Beach County School District. The youth are required to participate in educational and vocational career-related instruction for, a minimum of 250 days during the calendar year, with a minimum of twenty-five hours of instruction weekly. Ten days are set aside for teacher planning and professional development. Seven youth were interviewed, and none reported educational classes being interrupted. The program's daily schedule and logbooks were reviewed and reflected youth attended educational classes as required.

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

Three closed case management records were reviewed, and each contained an education transition plan completed prior to the youth's release from the program. Each plan was based upon the youth's specific post-release goals beginning at the youth's admission to the program, as required. Documentation indicated all required participants, including the youth, parent/guardian, educational staff with access to the district's management information system, certified school counselor, and post-release/re-entry staff provided input regarding each youth's education transition plan. A review of the transition plans indicated the services, interventions, and placements were based upon the assessed educational needs, performance, and post-release educational plans for each youth. Each plan identified the individuals specifically responsible for monitoring the reintegration and coordination of support services. All three records were for youth with employability as a transition goal and each plan included provisions for continuation of education or employment, a completed employment application, a résumé summarizing the youth's education, work experience, and completed career training. Documentation indicated each youth's case manager and parent/guardian was aware of the post-release discharge plan.

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

A review of three closed case management records confirmed the program held a transition conference at least sixty-days prior to each youth's anticipated release date for each reviewed record. The program sent written notification to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. Reviewed documentation reflected the program's treatment team leader, program director/designee, and other treatment team members participated in each transition conference. The parent/guardian and JPO participated in the transition conference by telephone. Documentation indicated transition activities were reviewed during the transition conference, including target dates for goal completion, along with any additional goals needed upon release. There was documentation to support goals for completion of transition activities were identified during the transition conference. Reviewed documentation confirmed each youth participated in a Community Re-Entry Team (CRT) meeting prior to their release from the program.

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

The program maintains a written policy and procedures to address the development and contents of a comprehensive exit portfolio for each youth. A review of three closed case management records confirmed an exit portfolio was completed by the program and was provided to each youth to assist with a successful transition back into the community. One of the three records reviewed had a state identification card, birth certificate and application for a Social Security card. Two records did not contain this documentation. Each record contained a résumé, sample job applications, education records, and a calendar with dates, times, and locations of follow-up appointments within the community. Reviewed documentation confirmed a copy of the exit portfolio was sent to each youth's juvenile probation officer (JPO).

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

The program maintains a policy and procedures to address the requirements for each youth's exit conference. A review of three closed case management records reflected the youth's juvenile probation officer (JPO) was notified of each youth's release prior to the program conducting an exit conference. Each exit conference was held within fourteen days prior to the youth's release. Reviewed documentation confirmed each exit conference was documented in the case record inclusive of dated signatures of all applicable participants. When applicable, program staff noted the participants attending the conference telephonically on the signature line. Reviewed documentation confirmed the participation of the case manager, parent/guardian, education staff, JPO, youth, and other applicable parties in the exit conference. Each date of admission and release corroborated the dates entered into the Department's Juvenile Justice Information System.

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 maintains a written policy and procedures regarding the designated mental health clinician authority (DMHCA). The policy documented review and signature of the facility administrator and the DMHCA on July 1, 2019. The program's DMHCA is responsible for the coordination and implementation of mental health and substance abuse service delivery. A review of the DHMCA's job description verified the coordination and implementation responsibilities in addition to the delivery of direct clinical supervision, staff education, clinical consultations, conducting psychometric testing with evaluation and clinical interviews, and providing on-call emergency consultation services. The program's DMHCA is a licensed clinical social worker (LCSW). A review of the license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021. The program's DMHCA is scheduled to be on-site Monday through Friday from 8:30 a.m. to 5:30 p.m. and on call twenty-four hours a day, seven days a week for consultation and emergency services. During an interview, the program's DMHCA reported responsibilities to include administrative oversight and management of the mental health and substance abuse services in the program. Additional responsibilities also included oversight of Assessments of Suicide Risk, crisis intervention, diagnostic assessments, interview and examinations, and administration and interpretation of psychological and psychiatric testing.

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

The program maintains a written policy and procedures regarding licensed mental health and substance abuse clinical staff. The policy documented review and signature of facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. The program's clinical treatment staff includes a licensed DMHCA, an assistant clinical director, one full time licensed therapist, and seven master's-level therapists. The program's assistant clinical director is a licensed mental health counselor (LMHC). A review of the assistant clinical director's license showed it was free and clear in the State of Florida with an expiration date of March 31, 2021. The program's licensed therapist position has been vacant since September 22, 2019. A review of the former licensed therapist's credentials showed a free and clear LMHC license with an expiration date of March 31, 2021. The program's mental health team also consists of a licensed psychologist who offers services as needed. A review of the

psychologist's license showed it was free and clear in the State of Florida with an expiration date of May 31, 2020. Additionally, the program maintains an agreement for professional services with a State of Florida American Board of Psychiatry and Neurology certified licensed psychiatrist who is scheduled to be on-site weekly. A review of the license reflected the medical doctor license was free and clear in the State of Florida with an expiration date of January 31, 2020. Reviewed training records reflected each staff was working within the scope of their licensure, experience, and training. The program is licensed through the Florida Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires October 26, 2019. The program's renewal substance abuse audit was completed on July 9, 2019 with a preliminary score of one hundred percent, and the program is currently awaiting the issuance of the new Chapter 397 license. An interview with the program's DMHCA verified both the DMHCA and psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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

The program maintains a written policy and procedures regarding non-licensed mental health and substance abuse clinical staff to ensure all non-licensed staff are performing qualified services based on education, training, and experience. The policy documented review and signature of the executive director and the designated mental health clinician authority (DMHCA) on July 1, 2019. The policy states all non-licensed mental health staff shall possess a master's degree, receive at least one hour a week of face-to-face supervision by a licensed professional, and participate in on-going peer and supervisory record reviews. The program has seven non-licensed, master's-level therapists currently providing services to youth at the program. A review of clinical supervision documentation for the past six months showed each of the program's non-licensed master's-level therapists received weekly face-to-face supervision by the licensed DMHCA for each week services were provided. Each reviewed direct supervision log was documented on the program's form and included all elements outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. A review of the training records for each non-licensed staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation also included the administration of five Assessments of Suicide Risk or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. A review of each therapist's caseload assignment showed each therapist was assigned ten or fewer youth. The program is licensed through the Florida Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires October 26, 2019. The program's renewal substance abuse audit was completed on July 9, 2019 with a preliminary score of one hundred percent, and the program is currently awaiting the issuance of the new Chapter 397 license. The interviewed DMHCA reported communication between

clinical staff at the program includes informal daily communication, and formal weekly clinical supervision.

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

The program maintains a written policy and procedures regarding mental health and substance abuse admission screenings. The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. The program's policy is to screen all new youth upon admission, in a private and confidential manner, through administration of the Department's Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). A review of seven individualized mental health and substance abuse records showed the program administered a MAYSI-2 screening on the day of admission. Each reviewed record documented a review of available information to include the commitment packet, and records of existing documentation of mental health or substance abuse problems by way of the completed mental health and substance abuse screening checklist. A review of training records confirmed each record contained screenings administered by a trained case management staff. Each of the seven reviewed MAYSI-2 screenings was initially completed using a paper questionnaire and then immediately entered and scored in the Department's Juvenile Justice Information System (JJIS). Five of the seven reviewed records indicated the need for further assessment based on screening results and the need for further assessment was clearly checked on each form. Three youth were applicable for a referral for a comprehensive assessment and two were applicable for a referral for the completion of an Assessment of Suicide Risk (ASR). Each record contained a MAYSI-2 referral form completed and submitted to the program's mental health staff. The program's practice is to refer all newly admitted youth for a comprehensive evaluation and an ASR regardless of MAYSI-2 screening results. Each reviewed referral form documented the MAYSI-2 screening results and signature of a case manager, mental health staff, and the facility administrator. None of the seven reviewed records were applicable for requiring immediate attention due to an identified crisis or emergency based on the MAYSI-2 screening results. An interview with the program director reported newly admitted youth are screened using the MAYSI-2 by the case management staff. The case management staff then submit the MAYSI-2 results, a referral form, the youth's pre-disposition report, face sheet, and previous psychological evaluations to the program's mental health staff.

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

The program maintains a written policy and procedures regarding mental health and substance abuse treatment, ensuring all youth identified with a mental health and/or substance abuse needs at admission receive an in-depth comprehensive bio-psychosocial evaluation completed within thirty days. The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. The program's policy is to refer all youth for a comprehensive bio-psychosocial evaluation regardless of the

Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) screening results. The program documents all bio-psychosocial evaluations on the program's form identified as the Mental Health and Substance Abuse Comprehensive Evaluation In-Depth Assessment. A review of seven individualized mental health and substance abuse records showed six were applicable for the completion of a bio-psychosocial evaluation. One youth record reflected the youth had not yet been in attendance for thirty days at the program. Each of the six applicable youth records contained a new evaluation completed within thirty days of admission by a master's-level clinician working under the direct supervision of the licensed DMHCA. Each of the six evaluations completed by a non-licensed clinician were reviewed and signed by the licensed staff within ten calendar days, as required. Each new evaluation contained identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. Each of the six reviewed bio-psychosocial evaluations were applicable for a substance abuse diagnosis and contained applicable substance abuse assessment information. Each record documented a consent for substance abuse services and authorization for urinalysis testing dated the day of admission. Each of the six applicable substance abuse evaluations documented the reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drug abuse on major life areas, risk factors of continued alcohol and drug abuse, clinical impressions, recommendations, and the original referral reason. An interview with the program's DMHCA and program administrator confirmed the program's bio-psychosocial evaluation process.

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

The program maintains a written policy and procedures regarding mental health and substance abuse treatment ensuring all youth determined in need of treatment receive individual, group, and family counseling in accordance with the youth's treatment plan. The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. The program's services are designed and implemented to support recovery, ensure safety, enhance quality of life, reduce symptoms, build resilience, improve functioning, and support community integration. Each youth is assigned to a multidisciplinary treatment team upon arrival to the program. The team is comprised of the youth, program administration, a residential living unit representative, the youth's parent/guardian, and others responsible for delinquency intervention and treatment services. Each reviewed record contained a Treatment Team Designation List form sent to the parent/guardian on the day of admission. The form clearly identified treatment team members and pre-determined treatment team development and review dates. A review of seven individualized mental health and substance abuse records documented each youth was assigned to a treatment team on the day of admission. Each of the reviewed records contained an active Authority for Evaluation and Treatment (AET), program-specific consent for treatment form, and a substance abuse treatment consent form. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. Each of the seven reviewed mental

health and substance abuse treatment records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Daily progress notes are maintained by the assigned counselor for each youth on the program's Mental Health/Substance Abuse Daily Service Progress Note form. Reviewed progress notes documented the youth's identifying information, date, time, type of service, intervention details, observations, session goals addressed, overall progress, youth response to interventions, and signature of the therapist providing the service. A review of seven individualized mental health and substance abuse records showed youth received mental health and substance abuse treatment, as prescribed, with no exceptions. An interview with the program's DMHCA reflected the program's assistant clinical director maintains an electronic tracking log of individual and family counseling sessions, in addition to reviewing the daily sign-in sheets and progress notes to ensure services are provided as indicated.

Daily service notes supported youth received group services seven days a week, as required; however, the notes did not always clearly define the group curriculum utilized. The program's contract outlines three mental health groups, and four substance abuse groups to be provided to youth at the program. Mental health group offerings include Aggression Replacement Training (ART), Coping with Stress, and Adolescents Coping with Depression. A review of the program schedule, youth case notes, and an interview with the DMHCA revealed the program was only providing two of the four contractually outlined substance abuse groups. The contract outlines substance abuse groups to include Chestnut Health Systems, Seeking Safety, LifeSkills Training (LST), and Cannabis Youth Treatment (CYT); however, the program was not providing LST or CYT groups during the annual compliance review period. The program initiated an LST group and CYT individual sessions during the annual compliance review week and provided sign-in sheets to support the correction. Seven youth were interviewed regarding participation in groups at the program. Each youth reported participating in group counseling at the program. Seven staff were interviewed regarding which staff facilitate mental health and substance abuse groups at the program. Each of the five staff reported direct care staff do not facilitate groups and therapists facilitate groups. Observations of mental health and substance abuse groups during the annual compliance review week and reviewed sign-in sheets reflected mental health groups had no more than ten youth and substance abuse groups had no more than fifteen youth as required.

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

The program maintains a written policy and procedures regarding treatment and discharge planning. The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. Treatment planning at the program includes an initial treatment plan, an individualized treatment plan, monthly treatment plan reviews, and discharge planning. A review of seven individualized mental health

and substance abuse records showed an Initial Mental Health/Substance Abuse (MHSA) Treatment Plan was developed on the day of admission. Each initial treatment plan was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed initial treatment plan was completed by a master's-level therapist working under the direct supervision of the licensed DMHCA. The licensed staff signed each plan within ten calendar days, as required. Each reviewed Initial MHSA Treatment Plan was also signed by all team members participating in the development of the plan and documented the youth's psychiatric needs, to include, prescribed medication and medication monitoring frequency, when applicable.

A review of seven records showed five were applicable for the completion of an Individualized Treatment Plan and two youth were attending the program for less than thirty days. Each reviewed Individualized Treatment Plan was documented on the program's form containing all elements in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Each Individualized Treatment Plan form included youth identification information, youth Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in the program, medication details, and all treatment team member signatures. Each of the five applicable reviewed plans were developed within thirty days of admission, as required. Each reviewed Individualized Treatment Plan was completed by a non-licensed mental health staff and documented review and signature of the licensed DMHCA within ten days, as required.

Seven records were reviewed and four were applicable for Individualized Treatment Plan Reviews. Three records reflected the youth's length of stay did not yet warrant the completion of an Individualized Treatment Plan Review. Each of the four reviewed Individualized Treatment Plan Reviews were documented on the program's form containing all the information on the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. Each plan clearly documented identifying youth information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and services to be provided. A total of twenty-one Treatment Plan Reviews were applicable in the reviewed four youth records. Each review contained signatures of all treatment team members participating in the review, as required.

Three closed individualized mental health and substance abuse records were reviewed for the completion of a Mental Health/Substance Abuse Treatment Discharge Plan. Each record contained a discharge plan documented on the program's form and included all elements outlined on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. Each of the three reviewed discharge plans documented completion prior to each youth's exit staffing. Each youth's discharge summary documented services needed, and documented youth and parent/guardian participation. None of the records were applicable for notification of suicide risk upon discharge. The program practice is to obtain the parent/guardian signature on the discharge plan upon the youth's release from the program. The parent/guardian is then provided with a copy of the plan. The program also sends all Mental Health/Substance Abuse Treatment Discharge Plans to the youth's juvenile probation officer (JPO) by mail and email upon release. An interview with the program's DMHCA explained the formal treatment team includes the youth, their case manager, a representative from education, medical, mental

health, direct care, and an administrator. Additionally, it was explained during the treatment team meetings, youth's progress on treatment goals and performance goals is discussed by all team members and documented. The program practice is to make complete, update, revised, and/or add to youth goals during the treatment team review meetings at least every thirty days. Observations of treatment team meetings during the annual compliance review verified the program's practice.

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 maintains a written policy and procedures for specialized treatment services which includes the provisions for substance abuse treatment overlay services (SAOS) and mental health overlay services (MHOS). The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. Youth receiving SAOS services receive a minimum of five substance abuse specific groups each week, and youth receiving MHOS services receive a minimum of five mental health specific groups each week. Seven youth were interviewed regarding participation in groups at the program and each youth reported participating in group counseling at the program. All program youth are offered therapeutic activities seven days a week by the mental health clinical staff. The program's mental health team also consists of a licensed psychologist who offers services up to four hours a week, as needed.

A review of seven individualized mental health and substance abuse records showed each contained an initial urine drug screen, and random urine drug screens are completed monthly. An interview with the program's DMHCA explained the program's efforts to obtain on-site Alcoholic Anonymous (AA) and/or Narcotics Anonymous (NA) services to youth. The AA/NA provider declined to offer on-site services. However, the program is currently coordinating the offerings of a twelve-step recovery program entitled Celebrate Recovery, to be provided on-site. The program is licensed through the Florida Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment.

The program's recreation therapist leads the program's concept art gallery. The gallery is a community based "art collective" consisting of aspiring artists from inner cities located throughout South Florida. The gallery concept is to provide at-risk youth knowledge in the areas of creative arts, self-awareness, and community outreach. Within the program's art gallery, the program has established a library. Working in partnership with the Palm Beach County Library System, the program's library features a variety of literature and reading materials for youth including books and magazine subscriptions. Additionally, the program's clinical staff have partnered with the Pixel Fund in an animal fostering program. The program youth foster shelter puppies and provide basic training, human socialization, and even service aid pet training prior to adoption. An interview with the program's DMHCA reported additional specialized assessments completed upon admission and throughout treatment include the Beck Depression Inventory-II (BDI-II), the Suicide Probability Scale (SPS), the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), the Adolescent Anger Rating Scale (AARS), the Conner's Rating Scales (CRS), and the Trauma Symptom Checklist for Children (TSCC). The assessment results are used to prescribe individualized treatment for youth. The interviewed DMHCA also explained specialized services provided are based on the youth's symptoms,

Diagnostics and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) diagnosis and prescribed Individualized Treatment Plan.

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

The program maintains a written policy and procedures for psychiatric services to ensure psychiatric services are provided to youth exhibiting symptoms of a mental health or substance abuse related disorders, and/or youth prescribed psychotropic medications. The policy documented review and signature of the facility administrator and the designated mental health clinician authority (DMHCA) on July 1, 2019. The program's psychiatrist responsibilities include on-site weekly consultation, medication management, and treatment planning participation, in addition to seven-day a week, twenty-four hour a day on-call availability. The program maintains an automatically renewing independent contractor agreement with a State of Florida, board-certified, licensed psychiatrist executed on March 12, 2016. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the psychiatrist's license showed it was clear and active in the State of Florida with an expiration date of January 31, 2020. The psychiatrist is a licensed medical doctor with a specialty in child and adolescent psychiatry. A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly and participates in weekly treatment team meetings with the program's mental health staff.

A review of seven individualized mental health and substance abuse records showed each contained a new psychiatric initial diagnostic interview completed within fourteen days of admission. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, frequency of medication monitoring, and treatment recommendations. All reviewed records documented the initial diagnostic psychiatric interview on the department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN. A review of seven individualized mental health and substance abuse records showed five youth records were applicable for the prescription of psychotropic medications prior to admission, and two had no medications prescribed. Each of the five youth were continued on prescribed medications and the explanation of the need for psychotropic medication related to the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, and risks and benefits of taking the medication was clearly documented. The five reviewed records applicable for the prescription of psychotropic medications required a total of eighteen monthly medication management reviews. Each medication management review was completed within thirty days as required. The program's practice is to complete page three of the CPPN regardless of changes to, or a new prescription of psychotropic medications; however, two youth records were applicable for three separate instances where significant changes to medications required parent/guardian consent. Documentation of a witnessed telephone consent was clearly documented on page three of the CPPN in all three applicable instances. An interview with the program's psychiatrist confirmed the psychiatrist's responsibilities, weekly site visits, and twenty-four hour on-call emergency consultation status. The program's DMHCA reported the program's licensed assistant clinical director meets weekly

with the psychiatrist on-site to discuss all new youth, medication management needs, and all psychiatric referrals.

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 maintains a written policy and procedures ensuring a method in which suicide prevention services shall be provided to all youth in accordance with Florida Administrative Code. The program also maintains a Suicide Prevention Plan. The program's suicide prevention plan documented review and signature by the designated mental clinician authority (DMHCA) and the facility administrator on July 1, 2019. The program's suicide prevention plan is inclusive of requirements for admission screening, alerts, staff observation, levels of supervision, suicide precautions, referrals, proper notifications and communications, assessment and follow up of suicide risk, immediate staff responses, suicide attempt or serious self-inflicted injury review process, and training. An interview with the facility administrator (FA) confirmed the program conducts emergency mental health drills, to include emergency response to suicide attempts, at least quarterly on each shift.

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

The program maintains a written policy and procedures ensuring mental health and substance abuse services are established for all youth. The program's mental health and substance abuse procedures outlines the requirements for all youth placed on suicide precautions. The program's practice is to complete an Assessment of Suicide Risk (ASR) on the day of admission, regardless of admission/intake screening results. All direct care and non-direct care staff receive pre-service and annual training regarding suicide prevention, crisis intervention, and emergency care. Seven youth individualized mental health and substance abuse records were reviewed for suicide prevention services. Four youth were applicable for exhibiting risk factors requiring a suicide assessment in which three ASR were completed, as required. The program completed a crisis assessment on the fourth youth instead of an ASR. The youth reported feelings of grief and expressed he did not want to live anymore. The program placed the youth on mental health observation instead of suicide precautions; and subsequently, did not complete a Follow-Up ASR, as well. Additionally, one youth was found to be at risk during the intake screening process and subsequently stepped down to standard observation. The second youth self-reported suicidal thoughts and was observed by staff to be making suicidal comments, and the third was also observed by staff to be making suicidal comments. Reviewed documentation showed the other two youth were placed on precautionary observation, as required.

Each of the three records documented an ASR was completed on the Department's ASR form within the required twenty-four-hour timeframe. Each of three reviewed records found documentation to support the parent/guardian and juvenile probation officer (JPO) was notified, and mental health staff provided supportive services. Two youth were applicable for a Follow-Up ASR. Each reviewed record documented the completion of a Follow-Up ASR completed on the Department's form. Each reviewed ASR and Follow-Up ASR was completed on-site by a licensed mental health professional or a clinical staff under the supervision of a licensed mental health professional. Each of the two applicable records also documented the completion of a mental health status exam prior to placing back on standard supervision. Each reviewed record confirmed a conference with the facility administrator (FA) was held prior to stepping a youth to close supervision. Precautionary observation allowed for each youth to participate in select activities with other youth in designated safe housing areas of the program.

A review of the Department's Juvenile Justice Information System (JJIS) and program logbooks confirmed the program documented the beginning and end times of the three-youth placed on suicide precautions. The program does not utilize secure observation. The program maintains two complete suicide response kits located in phase one master control one and phase two master control. Seven staff were interviewed regarding responsibilities if a youth expresses suicidal thoughts. Each interviewed staff reported they would notify the shift supervisor and notify mental health. Six staff also stated they would document supervision and maintain constant sight and sound. Four staff reported they would also search the youth's room for sharp objects. Five staff reported the program's suicide kits were in master control. One staff did not know where the suicide kits were located. One staff reported suicide kits are located in phase one and phase two master control areas. Additionally, three staff reported suicide kits are also located in medical and sub control. An interview with the program's designated mental health clinician authority (DMHCA) confirmed each youth receives an ASR at admission into the program. Any time a staff observes a youth to have suicide risk factors or overt behaviors, the shift supervisor is notified immediately. Staff utilize a referral form indicating a youth is suicidal, the clinical director is notified and will assess the youth within two hours. The youth is placed on one-to-one observation until the youth can be seen by the clinical director.

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

The program maintains a written policy and procedures ensuring a method in which suicide prevention services shall be provided to each youth. The program maintains an attached suicide prevention plan. The suicide prevention plan outlines the requirements for all youth maintained on precautionary observation. A review of seven youth individualized mental health and substance abuse records for suicide prevention services found three were applicable for completion of a precautionary observation log. Each reviewed log was maintained for the duration each youth was on suicide precautions and documented on the Department's Suicide Precaution Observation Log. Each reviewed log was documented in real time not exceeding thirty-minute intervals. Two reviewed logs had warning signs documented and showed the proper notifications to the facility administrator (FA) and/or mental health clinical staff. One reviewed log was not applicable for documenting warnings signs or the need for immediate consultation with mental health staff. Each of the three reviewed logs showed documentation of

a review and signature of the shift supervisor and mental health staff. Each reviewed log documented safe housing requirements. There were no documented lapses in supervision on each reviewed log. There were no documented lapses in supervisory reviews. Three youth previously placed on suicide precautions were interviewed. Each of the three interviewed youth reported never being left alone while on precautionary observation.

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

The program maintains a written policy and procedures ensuring a method in which suicide prevention services shall be provided to each youth. The program also maintains an attached suicide prevention plan which outlines staff training provisions. The program maintains a written training plan training plan inclusive of suicide training requirements for all staff. Ongoing on-site annual training is required for all direct and non-direct care staff. Additionally, mock suicide drills are conducted quarterly on each shift. A review of all drills is conducted monthly with all staff at each staff meeting. A review of seven direct care staff training records validated each staff received six hours of annual suicide training, as required. The program completed a total of eight mock suicide drills in the last twelve months. The program has two shifts and documentation of drill logs found mock quarterly suicide drills were completed on each shift, as required. All the completed drills included the use of life saving measure inclusive of the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED). Each reviewed drill documented a description of the incident, synopsis of the response, identified deficiencies, when applicable, corrective action, when applicable, and staff members involved. A review of the program's staff roster showed twenty-nine staff were applicable for participating in mock drills semi-annually. A review of the completed drills and staff meeting attendance logs thirteen of twenty-nine applicable staff participated in mock drills semi-annually; however, drills are reviewed during monthly all-staff meetings. An interview with the program's program director confirmed the program conducts quarterly mental health/suicide drills on each shift.

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 maintains a written policy and procedures ensuring crisis intervention services are provided to all youth. The program also maintains an attached crisis intervention plan. The program's crisis intervention plan facility operating procedures documented review and signature by the designated mental health clinician authority (DMHCA) on July 1, 2019. On October 16, 2019, during the week of the annual compliance review, the facility administrator reviewed and signed the program's crisis intervention plan facility operating procedures. A review of the program's crisis intervention plan found it included a plan for ensuring safety and security, notification and alert system, referral methods, communication, supervision, documentation, and review, as required.

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 maintains a written policy and procedures for ensuring mental health and substance abuse services are established for all youth. The program maintains a crisis intervention plan. The plan requires crisis intervention to be provided as needed in a one-to-one setting for youth who are suffering from psychologic distress which is not associated with suicide risk factors or behaviors. Any direct care staff which observe youth exhibiting out of control behaviors must place the youth on a mental health alert and refer the youth to a mental health professional for a crisis assessment. A review of seven youth individualized mental health and substance records showed three applicable crisis assessment and crisis interventions were provided. Each of the reviewed crisis assessments included the reason for the assessment, mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up, and parent/guardian notification. Each reviewed crisis assessment was completed on-site by a master's-level therapist and documented reviewed and signature by the licensed mental health professional within twenty-four hours, as required. None of the reviewed crisis assessments required an increased supervision level and/or mental health alert entered in the Department's Juvenile Justice Information System (JJIS). Each youth was placed on standard supervision. There were no Prison Rape Elimination Act (PREA) allegations requiring a crisis assessment since the last annual compliance review.

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 maintains a written policy and procedures for ensuring emergency mental health and substance abuse services are provided to all youth. The program also maintains an attached emergency care plan. The program's emergency care plan facilitating operating procedures documented review and signature by the designated mental health clinician authority (DMHCA) and facility administrator on July 1, 2019. A review of the program's emergency care plan confirmed it included a procedure for emergency identification and immediate staff response, notifications, communication, supervision, authorization of transport for emergency services and transportation for mental health and substance abuse services, documentation, staff training, and mortality review. The program uses JFK Medical Center North Campus, located in West Palm Beach for youth under eighteen and over eighteen years old for mental health/baker act emergencies which require involuntary placement and/or assessments.

The program also utilizes JFK Medical Center North Campus for youth admitted under Marchman Act proceedings.

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

The program maintains a written policy and procedures for ensuring emergency mental health and substance abuse services are provided to all youth. The program also maintains an attached emergency care plan. The program's emergency care plan outlines the process for Marchman Act and Baker Act proceedings. The program had two Baker Acts and no Marchman Act proceedings since the last annual compliance review. A review of two Baker Act records found the licensed mental health counselor completed the required Certificate of Professional Initiating Involuntary Examination of Baker Act proceedings for one youth and the psychiatrist completed Certificate of Professional Initiating Involuntary Examination of Baker Act proceedings for the other youth. A review of the two Baker Act records showed one out of two youth were placed on one-to-one supervision at the time of discovery and prior to hospital admission. Documentation showed mental health staff were involved and the program transported both youth to JFK Medical Center North Campus. A review of the Baker Act records and the program's logbooks confirmed both youth were placed on constant supervision, as required, upon return to the program. Each youth record revealed an Assessment of Suicide Risk (ASR) and mental health status examination was completed, prior to lowering the youth's supervision level, as required.

Standard 4: Health Services

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

The program maintains a contract with a State of Florida board-certified licensed medical doctor to serve as the designated health authority (DHA). The DHA holds a clear and unrestricted license to practice medicine with a specialization in pediatrics and surgery. The current license expires on January 31, 2020. The DHA is on-site weekly for up to four hours each visit and has the responsibility for arranging all levels of healthcare and for providing quality and accessibility of all health services provided to youth. The DHA has the clinical responsibility for all program physical health and medical services. The director of nursing has the responsibility for the delivery of health services, supervision of personnel, and serves as the liaison within the program. Final clinical judgment rests with the DHA. Reviewed attendance logs for the last six months validated the DHA was on-site weekly, as required, with no exceptions. The program also maintains a contract with a State of Florida board-certified licensed medical doctor to serve as the back-up DHA for scheduled absences, emergency services, and vacations. The back-up DHA has specialized training in internal medicine and the current license expires on January 31, 2020. The DHA does not utilize the clinical services of an advanced practice registered nurse (APRN) or physician assistant (PA). The DHA is responsible for communication with program staff regarding youth medical needs and is available for consultation by electronic means twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. During an interview, the DHA described their duties as being on-site weekly, evaluate youth and conduct Comprehensive Physical Assessments within seven days of each youth's admission. In addition, evaluated youth identified with a chronic condition at least every three months, conduct sick call and episodic care, review all off-site care, and review and update all applicable healthcare protocols, policies, and procedures. The program utilizes the Palm Beach County Health Department for dental services and maintains an agreement for services with a State of Florida licensed optometrist to provide comprehensive visual examinations, single vision eyeglasses, and additional eyecare services as deemed appropriate. The optometrist license expires on February 28, 2021.

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 maintains written healthcare protocols, policies, and procedures. Reviewed protocols, policies, and procedures validated they were reviewed, updated, and approved by the designated health authority (DHA) and the facility administrator on August 1, 2019. The psychiatrist documented their review on August 25, 2019. The program hired two new registered nurses (RN) in June 2019 and each received a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by the program's director of nursing who is a RN. A review of on-the-job training documentation for each nurse validated the practice. Nursing staff documented their review of the protocols, policies, and procedures on October 1, 2019.

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 maintains a written policy and procedures ensuring the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the program. At the time of the annual compliance review the program had four youth in the shared custody of the Department of Children and Families (DCF). A review of seven youth healthcare records indicated two youth were in the custody of the DCF and both youth had a court order authorizing the routine medical and mental health screenings, physical examinations, ordinary medical care for minor illnesses or injury, administration of all current medications prescribed to the youth upon admission, and any and all psychiatric treatment. The other five reviewed healthcare records supported no youth had an original AET; however, the word "Copy" was legibly stamped in red on the AET copy. Each AET was valid until the youth's eighteenth birthdate. One of the seven reviewed healthcare records indicated the youth turned eighteen while in the program. Youth eighteen years of age or older sign a release of information form giving their permission to contact their legal guardian to discuss all healthcare related issues. The form is signed by the youth, witness, and facility administrator and then filed in the healthcare record. At the time of the annual compliance review the program had eighteen youth eighteen years of age or older. Copies of completed parental notifications were maintained behind the AET and/or court order in the youth's healthcare record. Interview with registered nursing staff indicated the current AET is downloaded from the Department's Juvenile Justice Information System (JJIS) upon the youth's arrival to the program. When an AET is needed the assigned juvenile probation officer (JPO) is notified with a time frame to obtain a new AET. When a youth is eighteen years of age or older, each applicable youth consents to whom their healthcare information is shared.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and obtain consent for new medications are prescribed, medication changes, changes in medical status, and any identified chronic illness. A review of seven youth healthcare records found three were applicable with significant changes to existing medication and/or chronic conditions, and two youth required vaccinations/immunizations not consented for on the current Authority for Evaluation and Treatment (AET) form. Three youth required off-site emergency care and parent/guardian notification was made by telephone and, subsequently, in writing. A review of documented practice supported written notification was sent to the parent/guardian regardless of telephone notifications. There were two reviewed youth records whereby there was shared custody with the Florida Department of Children and Families (DCF); however, there was no applicable medical events requiring the notification of the DCF case worker. One youth was prescribed psychotropic medications and the parent/guardian was notified, as required. A review of seven youth records validated each contained a printed Florida Certification of Immunization record pulled from the Florida Shots website. Reviewed documentation supported the registered nursing staff and the designated health authority reviewed the certificate of immunization within the first seven days of admission into the program. Two youth required vaccinations and both reviewed records documented consent was obtained prior to administration. Interviews with the registered nursing staff indicated if a parent/guardian exempts from immunization for religious

reasons, a Religious Exemption from Immunization form must be signed and submitted to the program. There were no applicable youth whereby a parent/guardian did not consent to a vaccination for medical reasons or submitted a Religious Exemption from Immunization form.

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 maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission. A healthcare readmission rescreening will be completed each time the physical custody of the youth changes with subsequent return or readmission to the program. Each youth is screened upon admission to determine if there is an acute injury, illness, chronic medical condition, physical impairment, mental disability, or developmental disability requiring medical or mental health evaluation and treatment and/or medication needs to be met. Interviews with registered nursing staff validated the program practice is for the nursing staff to conduct a screening during the admission screening process utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. The youth shall not be placed into the general population until their healthcare needs identified are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. A review of seven youth healthcare records validated the FEPHS form was completed on the date of admission. Interviews with nursing staff and documented program practice is to notify the designated health authority (DHA) and/or psychiatrist of all admissions and to document the notification on the DHA and Psychiatrist Notification of Admission form, as well as on the Admission Chronological Progress Note form. One of the seven reviewed youth records supported there was a change in custody on two separate occasions and a new FEPHS form was completed by nursing staff on the day the youth returned to the program. Two additional records were reviewed to meet the minimum sample size and both youth records documented a change in custody and new FEPHS forms were completed the day the youth returned 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 facility.	

The program maintains a written policy and procedures ensuring all youth admitted to the program are provided with an orientation to healthcare services commencing within twenty-four hours of admission. A review of seven youth healthcare records validated each youth received a general orientation to the program's healthcare services upon admission conducted by a registered nurse. Reviewed documentation supported each youth signed and dated a Youth Health Education Summary form identifying twenty-seven separate healthcare topics and reviewing previous healthcare contacts. In addition, the Department's Health Education Record was updated as each topic was addressed.

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 maintains a written policy and procedures ensuring the designated health authority (DHA) or designee shall be notified immediately when a youth is admitted and requires emergency care or routine notification of a youth's arrival by telephone or verbally. A review of seven youth healthcare records supported the DHA, and when applicable, the psychiatrist was notified of a youth's admission into the program. Each contact was made by telephone and was documented on the program's DHA and Psychiatrist Notification of Admission form, as well as on the Admission Chronological Progress Note. Each form was signed and dated identifying the mode of notification, date, and time to include the name of the DHA and psychiatrist.

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

The program maintains a written policy and procedures ensuring all youth receive routine healthcare related history and evaluations upon admission. Interviews with registered nursing staff validated the program's nursing staff complete a new Department Health Related History (HRH) form during the admission healthcare screening process. Program practice is to not place the youth into the general population until their healthcare needs have been identified and deemed not to require immediate medical attention and/or a referral for further assessment by the designated health authority (DHA). A review of seven youth healthcare records supported each youth was screened upon admission by the nursing staff utilizing the HRH form and was reviewed by the DHA. The completed form was filed in each youth healthcare record.

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 maintains a written policy and procedures ensuring effective planning is demonstrated for the well care, routine, acute, and chronic healthcare needs of the youth. All youth admitted to the program receive and /or have a current Comprehensive Physical Assessment (CPA). The program does not allow the youth to engage in any strenuous exercise prior to the assessment conducted by the designated health authority (DHA). Interviews with the registered nursing staff indicated nursing staff complete a new Health Related History (HRH) form upon admission and schedules each youth for evaluation by the DHA within seven calendar days of admission. A review of seven youth healthcare records supported each youth received a new CPA conducted by the DHA within the required time frame. At the time of the CPA evaluation, each youth completed a Pre-Participation Physical Evaluation form identifying specific health-related questions and sign each form affirming their answers were complete and correct. The DHA reviews and completes their section prior to dating and signing the form. Each reviewed CPA was completed in full, with all sections marked with an "O" or an "X" which documented a comment to elaborate the reason. Each CPA documented the youth's medical grade, tuberculin skin test (TST), and visual acuity test results. Youth who refused any portion of the examination documented their signature on the CPA indicating the refusal sections of the examination. Each completed evaluation included an assessment diagnosis and any physical

activity restrictions. During the CPA evaluation, each youth's height and weight is documented on a chart, which is maintained and updated monthly by the registered nursing staff. In addition, during the CPA evaluation youth are assessed for further ophthalmology and/or optometry evaluations. Documented practice supported the Department's Problem List was updated for each youth.

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 maintains a written policy and procedures ensuring all sexually active youth are clinically screened and evaluated for sexually transmitted infections by both cause and/or symptoms during the admission screening process. Youth are referred to the designated health authority (DHA) for evaluation and screening with testing. The DHA then decides, based on the evaluation, which test to perform to prevent the advancement of the infections and to decrease the risk of future transmission. A review of seven youth healthcare records indicated each youth was identified as sexually active and was referred to the DHA. Each youth received further evaluation to include testing for gonorrhea and chlamydia. All test results were reviewed by the DHA and then filed in the lab section of the youth's healthcare record. In addition, the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form.

During the admission healthcare screening process, each youth is provided the opportunity to consent to testing for human immunodeficiency virus (HIV) and the consent form is filed in the youth's healthcare record. The program's director of nursing (DON) maintains a current 501 HIV/AIDS certificate for HIV prevention counseling and testing with an expiration date of December 31, 2020. An interview with the DON indicated pre-counseling is conducted prior to testing and upon receiving the test results, post-test counseling is provided. The lab results are reviewed by the DHA and then sealed and filed in the youth's healthcare record. A review of seven youth healthcare records indicated all seven were offered HIV testing and three youth consented, and the HIV results were filed confidentially in a sealed envelope marked "Confidential." A review of the program's internal alert system validated none of the youth's HIV status were documented. The three youth consenting to HIV testing documented the pre-test counseling, post-test counseling, and education on the Department's Health Education Record form. Seven youth were interviewed and indicated they can request a HIV test while in the program.

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

The program maintains a written policy and procedures ensuring each youth has the right to request the services of a health trained professional at any time. Non-emergency healthcare needs will be addressed through the process of nurse's sick call. The youth are provided unimpeded access to the designated health authority (DHA), which also includes timely referrals to specialist when needed. During a tour of the program, the annual compliance review team

observed Sick Call Request forms in each dorm. A review of seven youth healthcare records validated each youth submitted at least one Sick Call Request form since their admission into the program. Reviewed documentation supported each youth received an orientation to healthcare services which included sick call. A review of documented practice indicated there were two youth presenting with similar sick call complaints for dental concerns three or more times within a two-week period. Both youth were referred to the DHA for evaluation and were also referred to the Palm Beach County Health Department for dental services. All seven youth Sick Call Request forms documented follow-up conducted by the registered nursing staff and filed with the progress notes in each youth's healthcare record. The program did not have any applicable youth in restricted housing of any kind since the last annual compliance review. Sick call is conducted three times daily at 7:30 a.m., 1:30 p.m., and 4:00 p.m. seven days a week. The DHA addresses youth complaints regarding services they received or didn't receive at least one time each week. The DHA has developed and approved Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site. The DHA is on-call seven days a week, twenty-four hours a day for consultation. All staff have access to call 9-1-1 if they feel a youth requires emergency care. Program policy indicates when healthcare nursing staff are not on-site, the Sick Call Request form is turned into the shift supervisor who may address complaints such as constipation, mild headaches, unless there has been a blow to the head and/or the youth is experiencing severe pain, or the servility of the headache cannot be determined by the shift supervisor. In addition, the shift supervisor may address indigestion or acid reflux, initial splinting of injured toes, asthma, human/insect bites, cuts/abrasions, syncope, seizures, skin irritations, and rashes. The shift supervisor completes the Report of On-Site Healthcare by Non-Healthcare Staff form. The completed form is reviewed by the registered nursing staff and then filed in the applicable youth healthcare record. All seven youth healthcare documented the Sick Call Index and Sick Call Referral Log was updated for each submitted Sick Call Request form.

During the annual compliance review week, a sick call was observed by the review team. The youth provided permission prior to the sick call encounter commencing from both the direct care staff member and the review team member. The youth's privacy was maintained as the sick call was conducted behind a pulled curtain. The youth was weighed in prior to the sick call and the vital signs were taken. The youth was placed on the examination table and the registered nurse performed the sick call utilizing the DHA approved nursing protocols. Upon completion, the youth was provided with a healthcare education form applicable to the sick call encounter. Seven interviewed youth indicated when they submit a Sick Call Request form five indicated they can be evaluated within one day, one within three days, and one youth indicated they never submitted a Sick Call Request. Seven interviewed staff indicated the nursing staff conduct sick. One staff indicated the shift supervisors check the sick call box during the evening hours when nursing staff are not on-site.

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

The program maintains a written policy and procedures ensuring twenty-four-hour emergency medical, mental health, and dental care shall be available to all youth. A review of seven staff training records supported each maintained a current certification in first aid and cardiopulmonary resuscitation (CPR). In addition, all nursing staff maintained current certifications in CPR. Program policy outlines all staff with direct contact with or provide supervision to youth, including transporters, shall be trained in sick call complaints to include emergency complaints and proper on-site emergency notification procedures and care to

include transfer procedures in order to facilitate the immediate transfer of youth who require emergency medical, mental health, and dental care services. The program conducts monthly medical emergency drills on both shifts and the results of the drills are also discussed by the registered nursing staff at the monthly all-staff meetings to ensure all staff are made aware of the drill outcomes and critiques. The emergency drills included CPR and automated external defibrillator (AED) demonstration at least three times during the last twelve months.

A review of seven youth healthcare records supported three youth received episodic care, all completed by the registered nursing staff. Each episodic encounter was documented in the youth healthcare record in the nursing chronological progress notes. Documentation included the subjective, objective, assessment, and plan (SOAP) format, as well as documentation of the date and time of the episodic care, nature of the compliant, findings of the person rendering the care, treatment rendered, applicable off-site referral, and plans for applicable follow-up care. Each episodic event was documented on the Department's Episodic Care Log. There were no youth currently prescribed an epinephrine auto-injector (EAI) at the time of the annual compliance review; however, reviewed training records supported supervisory staff were trained in assisting youth in self-administration of the EAI. The program maintains one AED maintained in the medical clinic. During the annual compliance review week, the nursing staff demonstrated the AED and found it to provide audio instructions. Nursing staff complete weekly checks and document the checks on the weekly log. Reviewed logs supported the AED battery expires on October 10, 2022, and the AED pads expire on October 20, 2022. The program maintains eleven designated health authority (DHA) approved first aid kits. There were three kits located in phase one master control, three in phase two master control, one in sub-control, and one in the kitchen. Three first aid kits were opened by nursing staff and each was fully stocked with the DHA approved contents as outlined on the lid of each kit. Reviewed documentation supported nursing staff conducts weekly checks on each first aid kit and documents the review on the weekly log. Seven interviewed youth indicated they can see a doctor and/or dentist if needed. Seven interviewed staff indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency; however, in practice, the shift supervisor is notified, and they call 9-1-1 since direct care staff do not have telephones.

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

The program maintains a written policy and procedures ensuring time referrals and coordination of medical service to an off-site healthcare provider. Youth requiring off-site medical or emergency care, the Summary of Off-Site Care form is utilized, and the completed form is filed in the youth's healthcare record. Once the youth returns to the program the registered nursing staff reviews all notes and orders and notifies the designated health authority (DHA). The DHA then signs and dates all off-site care documentation during the next on-site visit. A review of seven youth healthcare records indicated six youth required off-site first aid and/or emergency care. For each instance, the youth's parent/guardian was notified. Reviewed practice supported the Summary of Off-Site Care form was utilized and filed in the healthcare record. Five of the six youth required follow-up care and there was evidence the referrals were tracked and the youth received the appropriate care as needed. The DHA documented their review of the off-site care finds and discharge instructions. Interview with the DHA indicated all off-site documentations are reviewed during the visit with the youth. The reviewed off-site care document is initialed and dated.

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

The program maintains a written policy and procedures ensuring a uniform process to identify staff the necessary information in reference to youth and other mental health information as needed. Youth identified with chronic illnesses receive regularly scheduled and as-needed follow-up care. During the admission healthcare screening process, registered nursing staff complete the Facility Entry Physical Health Screening (FEPHS) form and the Health-Related History (HRH) form to identify youth allergies, disabilities of any kind, or chronic medical conditions. A review of seven youth healthcare records indicated two youth were identified upon admission and completion of the FEPHS form with a chronic condition. One additional applicable youth healthcare record was reviewed to meet the minimum sample size. All three youth were classified with a medical grade two to five. There were two youth undergoing treatment for a physical health condition which included a body mass index greater than thirty. Each applicable youth had a treatment plan with a specialized 1800 calorie diet. One youth was identified with a head abrasion injury within two weeks prior to admission and the youth was sent to the Palm West Hospital emergency room for clearance. There were no youth in the program prescribed anti-tuberculosis medication. The program utilized a Chronic Physical Health Conditions and Physical Disabilities Roster to keep track of the youth in need of periodic evaluations. An interview with the DHA indicated they maintain a personal calendar in addition to the roster maintained by nursing staff. Periodic evaluations were scheduled and documented as completed prior to renewal of a prescription medication. Treatment orders were written so they were clearly distinguishable for clinical staff. Reviewed documentation supported there were no lapses in care or any missed periodic evaluations. Each applicable youth's Department Problem List form was updated, as required. The facility administrator (FA) indicated the management team meets daily to discuss medical issues and the director of nursing (DON) attends these meetings. The designated health authority (DHA) meets weekly with the FA and DON to discuss youth medical conditions and concerns.

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 maintains a written policy and procedures ensuring there is a comprehensive system in place for medication management for the accurate and safe administration of medication. This shall include all aspects of ordering medications, receipt and storage, inventories, administration, documentation, and disposal. It is the responsibility of the registered nursing staff to ensure all orders are carried out professionally and in compliance with state and federal guidelines. Medications are administered only by the order of the consulting licensed physician, designated health authority, and/or psychiatrist. The program's contract with the Department outlines nursing services shall be provided at least 100 hours each week, which includes forty hours for the director of nursing and sixty hours for the other registered nursing staff. A review of the 2019 Nursing Schedule validated nursing staff are scheduled seven days a week for approximately 124 hours of on-site services. In addition, the DON is on-call twenty-four hours a day for consultation. A review of seven youth healthcare records indicated three youth were prescribed medications prior to admission. Reviewed documentation supported the

nursing staff verified the medication during the admission healthcare screening and a new order to continue the medication was obtained by either the designated health authority (DHA) or psychiatrist. The contact was documented on the DHA and Psychiatrist Notification of Admission form, as well as on the Admission Chronological Progress Note form. Reviewed documentation supported each applicable youth had a current, valid order for the prescribed medication. Any time current medications were continued, discontinued, changed, or a new prescription was ordered, the DHA and/or psychiatrist placed an order on the Physician's Order form which was signed and dated by the physician. The program procures all medications from a pharmacy in Fort Lauderdale, Florida and utilizes a standard pre-printed Medication Administration Record (MAR) which includes all required information, as outlined on the standard Department MAR. The medication is delivered in blister packs identifying the name of the youth, name of the medication, dosage, and number of tabs in each pack. The program's nursing staff ensures there is licensed healthcare staff coverage seven days a week from 6:00 a.m. to 6:00 p.m. All prescribed morning, noon, and evening medications are administered during these hours to ensure nursing staff administer the medications. The program has trained six shift supervisors and two youth care worker II staff members to assist with the delivery of over-the-counter medications to youth when nursing staff are not on-site. Reviewed MARs indicated there were no lapses or errors in medication administration during this annual compliance review period and side effect monitoring was documented on the MAR. There were no applicable refusals of medications; however, interviews with nursing staff indicated the nurse and youth sign a Refusal of Care form indicating when a youth refuses treatment and the refusal would also be documented on the applicable MAR. Observations of medication administration made by the annual compliance review team supported the nursing staff maintained the Six Rights of Medication Delivery/Administration. The youth approached the nurse and the nurse then prepared the medication by removing it from a blister pack and placing in a small medication cup and handed the medication to the youth with a small cup of water to self-administer. The nurse and the direct care staff both swabbed the youth's mouth and had the youth cough to ensure the medication was swallowed. A review of the medication storage and inventory was conducted and found all medications were in a separate, secured medication cart and/or locked cabinet inaccessible to youth. At the time of the annual compliance review, the program had two youth prescribed narcotic medications and the observations found the medications were stored in a locked box within the secured medication cart. Oral medications were not stored with injectable or topical medications. The medication cart was observed to be clean and well organized with youth-specific medications. The program maintains a medication refrigerator and a specimen refrigerator in a locked closet within the medical clinic. At the time of the annual compliance review, the program had no applicable medications requiring refrigeration. Seven interviewed youth found four indicated the nurse administers medication and three youth indicated they do not take medication. Seven interviewed staff indicated nursing staff administer medication, three staff indicated the shift supervisor also administer medication, and one indicated only trained shift supervisors can administer over-the-counter (OTC) medications.

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

The program maintains a written policy and procedures ensuring all medications are stored in secure areas and in a manner, which facilitates inventories and safety. Bulk supplies of over-the-counter (OTC) must have formulary and are to be inventoried in accordance with the

Department's Rule. Controlled medications are stored behind two locks with two separate key access. A working supply of syringes and/or sharps is counted at least daily. Stock supply of syringes and needles will have perpetual inventories conducted at least weekly. The program maintains a Modified Institution Class II Type B Pharmacy license through the Department of Health, Division of Medical Quality Assurance with an expiration date of February 28, 2021. The program maintains a contract with Senior Care Consultant Group, LLC to provide for a State of Florida licensed consultant pharmacist, expiration date of December 31, 2020. The consultant pharmacist provides monthly on-site services to include observations and review of the medication room and medication carts, controlled medications, and quarterly continuous quality improvement summary reports. Observations made during the annual compliance review week supported the program maintained a secure medication cart with medications and sharps stored separately. Within the medication cart was a locked box with a separate key entry to store controlled medications. At the time of the annual compliance review, there were two youth prescription medications stored in the secured medication box. Reviewed inventories supported the program maintained daily, weekly, and monthly inventories of medications and sharps. Perpetual weekly inventories of all sharps and stock OTC medications were maintained. Shift-to-shift inventories of controlled medications were conducted and documented on the youth's individualized Controlled Mediation Inventory Record. The annual compliance review team observed the registered nursing staff conduct inventory of three youth prescribed medications, three OTC medications, three sharps, and two controlled medications. Each was found to accurate as documented in the inventory record. There were no applicable medications requiring refrigeration at the time of the annual compliance review. The nursing staff indicated the method of detecting an inventory discrepancy is to double-check by having another nurse conduct a count. If the discrepancy remains, the program director is contacted, the Department's Central Communications Center (CCC) is contacted, and an incident report is generated. Nursing interviews and reviewed documentation supported the program utilized Drug Buster for the disposal and destruction of expired and/or discontinued medications. For non-controlled medications, two nurses will dispose of the medications and document it on the Medication Disposition Sheet. For controlled medications, the consultant pharmacist and two nurses dispose of the medications and document the disposal on the Controlled Medication Inventory Record. For discontinued Polaris Pharmacy medications which have not expired are returned to the pharmacy for credit. The program maintains a biomedical waste – storage operating permit through the Department of Health with an expiration date of September 30, 2020.

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 maintains a written policy and procedures ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The exposure and infection control program follow the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA), and state and federal standards related to infection control. The program maintains a combined infection control/exposure control plan outlining procedures to include prevention, containment,

treatment, and reporting requirements related to the infectious diseases. The plan was reviewed, updated, and approved by the designated health authority, program director, and director of nursing on October 7, 2019. The plan was written in accordance with the CDC and OSHA standards and guidelines and included standard universal precautions, risk assessment, methods of compliance, and a comprehensive process in place for needle stick post-exposure evaluation. The program had no instances in which the local county health department, CDC, and/or CCC should have been notified of an infectious disease. There were no documented instances of quarantining and/or hospitalization of ten percent of the program's population of youth or staff since the last annual compliance review. Interview with nursing staff indicated the infection control / exposure control plan is available to all staff and located in the program director's office, medical clinic, in phase one master control, and phase two master control.

4.18 Prenatal Care/Education	**Satisfactory Compliance**
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 to promotes safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observe behavior of youth and change inappropriate behavior, and consistently apply the program's positive performance system. The program conducts formal and informal head counts throughout the day. A review of the program logbooks for the past six months verified head counts and movements are conducted and documented, as required. Observations of staff supervision for four days during the annual compliance review included movement from classroom to dorm, from dormitory to recreation, from dormitory to group, and from classroom to cafeteria. During the observations, staff were actively supervising youth and strategically situated to visibly see youth and respond to any emergency situation. The program's contract requires a staff-to-youth ratio of one-to-eight during awake hours which was observed to be in compliance. Prior to any movement, staff are informed, by way of two-way radio, of the count. Once the count is confirmed, youth are moved to the designated area. Random interviews with three direct care staff indicated they knew what the count was without counting and indicated when the count is not correct, all movement in the facility stopped and an emergency count is conduct.

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

The program has a written policy and procedures addressing the implementation and training of the program's behavioral management system (BMS) which was approved by the facility administrator (FA) and has not changed since the last annual compliance review. The program has a clearly written BMS which is a multi-level point system designed to maintain order and security, promote safety, respect, fairness, protection of rights within the program, foster compliance with program rule, and teach youth alternative pro-social methods of dealing with issues. Youth earn points daily for complying with the program rules. At the end of the week, the points are totaled, and the youth are rewarded based on the number of points earned. A review of seven youth records which contained prior point cards verified this practice. A review of seven staff training records for pre-service training and seven training records for in-service training indicated staff were trained on the BMS. The program does have an agreement with the Palm Beach County School District related to the BMS; however, the program was unable to verify teachers were trained in the implementation of the BMS. During the annual compliance

review week, a training session was held on October 18, 2019 to have each teacher trained in the implementation of the BMS. A review of the training sign-in sheets verified the training was conducted. Youth are made aware of the BMS during orientation. Each youth is provided a program handbook which describes the BMS. A review of the youth handbook indicated the BMS is included. A review of seven youth case management records indicated each youth received an orientation informing them of the BMS. Observations of the facility found the BMS is posted. Observations during school hours of staff and youth interactions found staff adhering to the BMS by utilizing a ratio of four-to-one positive to negative consequences when redirecting the youth as indicated in the program's policy. Seven youth were interviewed, and each stated the consequences used in the program is level restriction or behavioral plan. Seven youth were interviewed about the rewards used in the program. Each youth state later bedtime, longer phone calls, canteen, and the good citizen raffle. An interview with the FA indicated the program utilizes a system which consists of five levels. All youth enter the program on the orientation level for seven days. This level is designed to give the youth an opportunity to learn the program rules, expectation, and daily living norms. A youth on level one spends six weeks and must obtain a minimum of eighty percent of the allotted points. A level two youth spends ten weeks and must obtain eight-five percent of the allotted points. A youth on level three spends ten weeks and must obtain ninety percent of the allotted points. A level four youth spends nine weeks and must obtain ninety-five percent of the allotted points. Rewards are monitored when a youth earns the privilege to obtain items such as snacks and hygiene items. Youth who do so, completes a request form indicating what they want. All youth are given the opportunity to obtain items weekly regardless of their negative choices. The youth are only allowed to obtain items based on the number of points earned. The program director indicated youth consequences are monitored when youth receive a consequence based on the program rule violation. Consequences are given based on a three-strike rule. Major and minor incidents may receive level one restrictions, a refocus intensive behavioral plan, or an intensive behavioral plan.

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 to ensure staff are provided feedback regarding the implementation of the behavioral management system (BMS). Review of the BMS indicated it is not used solely to increase a youth's length of stay, deny basic rights, or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program includes a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity to explain their behavior during the treatment team process. Special treatment team meetings are held for those youth whose behavior need immediate intervention. The program does not utilize room restriction for major infractions. Seven youth were interviewed and three rated the BMS as very good, three rated it as good, and one rated it as fair. Seven youth were interviewed and explained staff are consistent with rewards because all youth are treated the same. A random

review of seven staff program descriptions indicated BMS implementation is addressed as a part of the staff's daily functions. Seven staff were interviewed, and stated youth are informed of consequences and are the youth allowed to explain their behavior during treatment team. An interview with the facility administrator (FA) indicated the BMS is monitored on a weekly basis by the clinical director who notifies the program director of all issues which presents itself through the week with completion of the point sheets pertaining to youth's performance. Seven staff were interviewed and indicated supervisors provide feedback to staff regarding the implementation of the BMS during morning briefings, monthly evaluations, coaching sessions, and one-on-one.

5.04 Ten-Minute Checks (Critical)	**Failed 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 written policy and procedures in place to conduct and document ten-minute checks during sleep hours. The program has a total of 102 operational motion sensitive video cameras capable of recording thirty-days of video footage. Prior to conducting checks, staff are situated where they are able see any movement within the dorm. Staff are required to conduct room checks every ten-minutes and document the time of the check on the ten-minute check log. A review of six ten-minute checks from five different days and from five different dorms indicated staff were documenting checks on the ten-minute logs; however, a review of corresponding video footage indicated the physical checks were not conducted. Video footage was observed on September 21, 2019 from 1:00 a.m. and 2:30 a.m. on the Alpha dormitory which indicated five of nine checks were not conducted but documented on the ten-minute logs as nine checks were conducted. Video footage was observed on October 12, 2019 on the Bravo dormitory form 3:00 a.m. to 4:00 a.m. indicated one of six checks was not conducted; however, review of the ten-minute check log documented all six checks were conducted. A review of video footage on September 20, 2019 from 4:00 a.m. to 5:00 a.m. on the Echo dormitory indicated three of six checks were not completed; however, review of the ten-minute check log documented six checks were conducted. A review of video footage on October 12, 2019 from 3:00 a.m. to 4:00 a.m. on the Echo dormitory indicated one of six ten-minute check was not conducted, but a review of the ten-minute check logs documented six checks were conducted. Video footage was reviewed on October 4, 2019 from 2:00 a.m. to 3:00 a.m. on the Fox dormitory indicated staff did not conduct four of six checks; however, review of the ten-minute check log inducted staff documented six checks were conducted. The incident was reported by the program to the Department's Central Communications Center (CCC). The program experienced a power outage October 15, 2019 which the program thought could have damaged the recording capabilities of the system. On October 18, 2019, during the annual compliance review week, a video surveillance system contractor was called on-site by the program to check the video recording system for any malfunctions. It was explained by the contractor the system can have frequent glitches which may not be noticed and will cause video footage to not be recorded during the time span of the glitch. The contractor indicated the outage which occurred on October 15, 2019 would not cause previously recorded video footage to be deleted. While the contractor reviewed the previously selected ten-minute check videos to give feedback regarding any video glitches, it was discovered the motion sensors of the cameras in each of the dorms did not consistently detect the staff's movement. The undetected motion caused the video recording to freeze and resume when motion is detected giving the effect of a recording

malfunction. A review of program's ten-minute fidelity checks for the days reviewed did not indicate any of these issues. When asked, the contractor was unable to determine if the missed ten-minute checks were due to either a glitch in the recording or if the checks were not conducted. Seven staff were interviewed, and each indicated room checks are conducted every ten-minutes when youth are in their rooms for sleeping for non-punishment reasons.

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

The program has a written policy and procedures to track the daily census. The program tracks daily census information to include the daily count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by a physical count and a random head count. The program has an approved escape response plan to ensure appropriate levels of supervision is maintained to provide adequate safety and security in order to prevent escapes. A review of the facility log books for the past six months found documentation of youth counts at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. During the annual compliance review week, the program experienced a power outage. Master control announced an emergency count to ensure all youth were accounted for. A review of the active logbook documented this practice. The program's escape response plan is reviewed with staff to ensure the procedures are followed in the event of a youth escape. Observation of youth count during the annual compliance review indicated prior to any youth movement, staff make a formal count of supervised youth and inform master control of the count. Random interview with staff indicated when the count is not reconciled, all movement stops, an emergency count is conducted. Seven staff were interviewed and indicated counts are conducted every hour and in emergency counts if there is a discrepancy.

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 for logbook documentation. The program maintains a bound logbook with numbered pages which documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), and the Florida Abuse Hotline. Supervisors are able to leave special instructions pertaining to supervision of youth. Each entry was made in ink with no erasures or white-out; however, errors were not consistently struck threw with a single line and are not initialed by the staff correcting the error. The program conducts staff briefings prior to the beginning of each shift. Incoming staff are briefed on the previous shift and sign the shift briefing to acknowledge the information has been shared. A review of shift briefings for the past six months validated his practice.

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 for assignment, inventory, tracking, and storage of facility keys. The program maintains a master key inventory of all active and un-issued keys which are stored in a locked box and remains locked when not in use. Keys are bound on a tamper-resistant color-coded ring. A review of the program policy indicated when staff arrive to work, personal keys are stored in lockers designated for staff which are located outside the program. Staff will enter the program and will receive a facility key by way of master control. At the end of the shift, staff return the facility keys to master control. An informal interview with the master control operator and the assistant program director (AFA) indicated this is not the program's practice. There is one set of facility keys designated for each of the four dorms. Staff who are coming on duty will receive the facility keys for their assigned dormitory and a two-way radio from the staff who is going off duty. Staff who receive the keys will notify master control by way of two-way radio which set of dormitory keys they have received. The master control operator will document the information in the facility logbook. A review of the logbook verified this practice. During the annual compliance review week, the program's policy was updated to reflect their current practice. Damaged keys are turned over to the physical planet manager to have the key replaced. The program also has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff signs an acknowledgment form indicating a key identification number and the number of keys issued. A random check of three staff found none were in possession of personal keys. An interview with AFA indicated there were no lost keys reported in the past six months. If any keys are lost, staff indicated all program movement is stopped and a search is conducted. If the keys have not been found within two hours, a report is made to the Department's Central Communications Center (CCC).

Seven staff were interviewed and were able to explain the program's updated key control process including how keys are assigned, reconciled, the process for missing or lost keys, damaged keys, and restricted keys.

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 identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor contraband list verified a list of unauthorized items not permitted to include personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program conducts unannounced search of rooms on each of the two shifts and document on search forms any contraband found and who disposed of the contraband. A random review of search forms verified this practice. A review of the Department's Central Communications Center (CCC) reports for the past six months indicated illegal contraband was confiscated on four separate occasions. In each instance an internal incident report was completed and documented how the contraband was disposed. A review of the facility logbooks for the past six months indicated perimeter searches are documented in the logbook. An interview with the facility administrator (FA) indicated when contraband and illegal contraband is discovered, it is immediately removed from the facility by FA or assistant FA who makes the required notification. Any youth found with illegal contraband will receive a behavior report and a special treatment team. Illegal contraband will be held and turned over to law enforcement.

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

The program has a written policy and procedures to ensure searches and full body visual searches are conducted according to Florida Administrative Code. Youth are searched at the time of admission, after off campus activity, and visitation. Searches are conducted by two staff

of the same gender as the youth being searched and are conducted in a private area. Parents/guardians are notified of searches during visitation by way of the parent handbook which is sent at the time of the youth's admission. Youth are searched after school, after transport, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off campus, suspected of contraband, or a security risk are searched prior to returning to the general population. Observations of searches were conducted of youth after school, after lunch, and after group indicated searched are conducted by a same gender staff, conducted in a manner not to degrade the youth, based on the Protective Action Response (PAR) training manual and reflect trauma informed practices. Seven staff were interviewed and indicated youth searches are conducted before and after every youth movement. Seven youth were interviewed and indicated searches are conducted by a male staff when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail.

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

The program has a written policy and procedures to ensure vehicles used to transport youth are properly maintained in working order. The program has two operable vans to transport youth. Observations of both vehicles indicated rust on the roof each vehicle, as well as missing rear air conditioner vents. In addition, van number one has a cracked windshield and van number two has torn drive and passenger seat. During the facility tour, it was observed by the annual compliance review team, van number two doors were unlocked. This was brought to the program's attention and the doors were immediately secured. A review of automotive vehicle invoices validated each of the two vehicles received an annual safety inspection. Both observed vehicles are equipped with an up-to-date fire extinguisher, first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each passenger. A transport was unable to be observed during the annual compliance review; however, informal interviews with youth and staff indicated seatbelts are worn during all transports by youth and staff.

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 to ensure the safe secure transportation of youth and staff. The program has two operable vehicles to transport youth. Inspection of both vehicles verified an up-to-date fire extinguisher, first aid kit, seatbelt cutter and window punch. First aid kits remain in the master control until ready for use. Both vehicles rear passenger doors are unable to be open from the inside. The program maintains a list of staff who have eligible driver's licenses which is updated monthly. The program also provides a ratio of one staff to five youth during transport. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Seven staff were interviewed and stated cellular telephones and two-way-radios are provided during transport. Seven staff were interviewed, and

each verified staff are not allowed to transport youth in their personal vehicles. Random observations of twenty staff personal vehicles indicated four were found to be unlocked. This was brought the program's attention. The appropriate staff were notified, and the vehicles were secured.

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 to ensure safety and security of the facility is maintained. The policy addressed who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. Weekly safety and security audits are conducted by the assistant facility administrator (AFA) and documented on the safety and security audit inspection form. Any deficiencies are addressed on the form and a work order submitted to the appropriate staff for corrections. Deficiencies are also discussed during the morning managers meeting. A review of the safety and security inspections forms for the past six months indicated inspections were completed, as required, which documented deficiencies and repair updates. Supervisors also conduct perimeter checks on each shift and are documented in the facility logbook. A review of the facility logbooks for the past six months verified checks are conducted, as required. An interview with the facility administrator (FA) indicated the program conduct weekly safety and security inspections an provide the feedback to the Department. All safety and security deficiencies are assigned and given a timeframe for correction. The program also receives site-visits from the Department to ensure compliance.

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

The program has a written policy and procedures for tool management. The policy addresses storing and inventory of tools as well as class type. The program's physical plant manager is responsible for the inventory of maintenance tools. The program maintenance tools are kept in the maintenance shop located within the facility with limited staff access and a daily tool inventory is kept on each tool when the shop is in use. Tools in the maintenance shop are classified as class A tools and are labeled with an inventory number, stored on a shadow board with a color photo of the tool, and inventoried daily. A review of the inventory list for the past six months indicated the tools were being inventoried. A random observation of tools indicated the tools on the inventory list were being stored. Observations of the maintenance shop indicated it was clean and neat. Kitchen knives are stored on a shadow board in a locked cabinet within the kitchen with limited access to kitchen staff. Kitchen staff are responsible for daily inventory. When kitchen utensils are in use, staff sign out the tool. A review of the daily perpetual inventory of class A kitchen tools for the past six months validated the tools on the list were being stored.

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

The program has a written policy and procedures for youth tool handling and supervision. Class B tools are stored in the supervisor's office which is accessible to staff. The program provides

vocational training through the on-site Home Builders Institute (HBI) program were youth use class A tools in carpentry training under the certified HBI instructors supervision. Youth are not allowed to handle any tools unless a risk assessment has been completed to determine the youth is not at risk and when the youth has been trained in the use of the tool. Youth are trained in the use of class B tools by staff who were previously trained by the program. Class A tool training is provided by the certified HBI instructor. A review of seven youth case management records verified risk assessments are completed during treatment team and identify if a youth is eligible to handle tools for work detail. A review of seven staff in-service training records indicated each were trained in the use of class B tools. Seven youth were interviewed and asked what type of tools they use in the program. One youth stated screwdrivers, hammers, and a saw. Four youth stated scrub brushes, and all seven youth stated mops and brooms. Seven staff were interviewed, and each stated youth are allowed to use scrub bushes, mops, and brooms.

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 establishing guidelines for outside contractors who come on-site to complete repairs. When a contractor arrives on campus, they sign the visitors sign-in log and provided a contract agreement form which list unauthorized items. After review of the agreement form, the contractor signs the form confirming notification of what items are considered unauthorized. If any unauthorized items are needed by the contractor while in the facility, approval is obtained by the facility administrator (FA) or designee. Any tools required to be used within the facility is inventoried and recorded on the contractor's agreement form before and after the repair is completed. A review of the sign-in sheet and the contractor's agreement form along with the corresponding work invoices verified the contractors were on-site on the same date the documents were signed. Each contractors form contained an inventory of the tool used for the repairs and their signature. An interview with the physical plant manager indicated when contractors are on-site, youth are not allowed near the work area. A staff is assigned to the contractor to ensure the work is being competed and all tools are accounted for.

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

The program's Continuity of Operations Plan (COOP) which addresses fire, safety, and evacuation emergency drills are to be conducted monthly, at random times, and under varied conditions. Drills are documented on the program's facility drill form which indicates the type of drill, date and time of the drill, participants, a brief scenario, who conducted the drill, and recommendations. Each drill is reviewed by the facility administrator (FA) and by the program's staff development. A review of the program's facility drill forms from the past six months verified drills were performed on each of the shifts and included all staff on duty. Each reviewed drill form was signed by staff development and the FA, indicating the drill was reviewed. The forms also included debriefing documentation and feedback on how the drills were performed. Observations of the program during the annual compliance review indicated egress plans are posted throughout the facility. Seven youth were interviewed, and each indicated fire drills are conducted at least monthly and they have been instructed on what to do in the case of an emergency. Seven staff were interviewed and stated in the past twelve months they participated

in weather, major disturbance, bomb threat, hostage situation, chemical spill, flooding, terrorism, escape, and fire drills. An interview with the FA indicated the program conducts monthly COOP drills on all three shifts, additionally the program conducts monthly fire drills, monthly medical, and quarterly mental health drills for each shift.

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 identifies a coordinated disaster plan. The COOP provides for a continuity of mission essential functions across a wide range of potential emergency situations. A review of the COOP indicated the plan was submitted and approved by the Department's Residential Services regional director on May 17, 2019. Further review indicated the plan contained a contingency for alternative housing, ensures a hard-copy of critical identifying information on each youth in the program is maintained, and the plan is readily accessible in the event an emergency situation results in relocation. An interview with assistant facility administrator (AFA) indicated a copy of the COOP is maintained in the administration office and master control.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous and toxic materials. Toxics are stored outside the facility in locked storage cabinets labeled hazardous materials. A list of staff who are authorized to handle chemicals is posted on the inside of the storage door. All caustic materials are stored according to type and use. A safety data sheet (SDS) binder is located inside the storage cabinet with a picture of each material corresponding to the SDS. A perpetual chemical inventory list is maintained, and the chemicals are checked daily. The program's physical plant manager is responsible for the inventory of materials. A review of the inventory list for the past six months verified this practice as well as the inventory corresponding with the appropriate SDS. Pre-mixed household chemicals used to clean the facility is stored in a closet with limited access to staff. Observations of the storage closet indicated chemicals are being stored with an SDS binder of each chemical. Further review indicated a daily inventory of the chemicals is conducted.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance

The program shall maintain strict control of flammable, poisonous, and toxic items and materials.

Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.

The program shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, and toxic items and materials. Authorized staff maintain control over all flammable, poisonous, toxic items with limited access. Pre-mixed household cleaning chemicals are stored in a closet with limited access to staff. When needed, authorized staff will obtain a supply of chemicals and sign the inventory list. Review of the chemical logs validated this practice. Youth are not allowed to possess flammable, poisonous, toxic and caustic items. When necessary, staff will apply the chemical and youth will wipe it up. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waist. Seven youth were interviewed, and each stated they do no handle any chemicals. Staff would spray the chemical and the youth would wipe it up.

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 to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials are kept in the locked storage cabinet located outside the facility campus and are disposed of according to the safety data sheet (SDS). The program's physical plant manager is responsible for ensuring chemicals are disposed of according to the Occupational Safety and Health Administration (OSHA) standards. The program utilizes the Palm Beach County Hazard Waist collection center to dispose of unused chemicals. A review of the chemical disposal logs indicated materials were taken to the county disposal center by the physical plant manager. Used kitchen grease and waste is stored in a large container outside the kitchen area. The program has a contract with Flamingo Plumbing and Backflow to dispose of used grease on a quarterly basis. The program maintains a policy and procedures regarding chemical spills which are reported immediacy to the shift supervisor. The direct shut down of the air handler and ventilation system is performed. An evacuation of the affected area is conducted, and a determination is made by the facility administrator (FA) whether to contact outside assistance to contain the spill. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional. According to the assistant facility administrator (AFA), the program has not had a chemical spill since the last annual compliance review. An interview with the FA indicated the

program an identified site locally where these items can be taken for disposal. Furthermore, the facility has an agreement with a local waste management company who will come on-site and pick these items up if needed.

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.

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures for youth to have visitation and communication with family members in order to re-establish family and community relationships. Youth are informed of visitation upon admission during the orientation process. Upon the youth’s admission, the program forwards a welcome letter to the parent/guardian encouraging visitation. The letter informs the parent/guardian of the days and time of visitation, who is allowed to visit, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in the youth’s case management records and updated as needed. A review of seven youth case management records verified each record contained an

approved correspondence, visitation, and telephone logs. The program also maintains a visitation binder which includes the youth's authorized visitor, visitor sign-in sheets, and a photocopy of the visitor's identification. Visitation is held in on Saturdays and Sundays from 1:00 p.m. to 4:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate in the regularly scheduled visitation day. The program also provides Family Day visitation which is conducted quarterly. A review of the facility logbooks for the past six months verified visitation and special visitation are conducted as required. Youth are also provided weekly telephone calls, writing material and a self-addressed stamped envelope to talk and send letters to approved family members. A review of telephone and mail logs indicated youth are provided access. Youth can have unimpeded access with the courts, attorneys, the assigned juvenile probation officer, and/or the Department of Children and Families case worker. Observations verified the visitation and telephone schedules were visibly posted in the youth's living area. Seven youth were interviewed, and each indicated they are given the opportunity to communicate with family members by mail, telephone, and visitation.

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

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

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

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

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

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

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

The program has a written policy and procedures to ensure an on-going safety plan process is provided for each youth in the program. Safety plans are developed to identify warning signs, youth baseline behaviors, crisis recognition, coping strategies to include people and health environments, and intervention strategies. The plans are reviewed by staff who have contact with youth and are centrally located for staff access. A review of seven youth mental health records indicated each contained an initial safety plan which was jointly prepared with the youth,

parent/guardian, clinical staff, and contained the required topic areas. Each reviewed plan incorporated recommendations form collateral sources, previous clinical assessment, reviewed monthly during treatment team meeting, and updated, as required. Further review of the youth records validated the safety plans were updated, as needed, every thirty-days. A copy of the plans was observed to be maintained in a binder located in master control for staff access. Seven youth were interviewed, and each stated they were involved in the development of their safety plan with the clinical staff.