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): November 17-20, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Sharon Wong, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Teves Bush, Office of Accountability and Program Support, Regional Monitor (Interviews)
Rosa Flores, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Paula Friedrich, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Patrick Morse, Office of Accountability and Program Support, Regional Supervisor (Standard 3)

Program Name: Palm Beach Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: Palm Beach County / Circuit 15
Review Date(s): November 17-20, 2020

MQI Program Code: 1417
Contract Number: 10341
Number of Beds: 82
Lead Reviewer Code: 181

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable
4.19	Licensed Medical Staff*	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 *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision 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

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Program Overview

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 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, 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 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 daytime 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.

Strengths and Innovative Approaches

- The program's healthcare staff initiated the use of a one-page written healthcare shift report which documents the daily healthcare activity, youth admissions with chronic condition, psychotropic medication, and admissions without any medications, which youth were seen by the designated health authority (DHA) and/or the psychiatrist, the number of episodic and sick call visits, any youth discharged during the shift, whether updates were made to the Department's Juvenile Justice Information System (JJIS), and the alert log, any refusals of medication or off-site medical appointments, the number of emergency rooms visit, laboratory draws, notifications mailed and Tuberculosis Skin Test (TST) purified protein derivatives placed. Also, notification of any scheduled appointments, intakes, discharges or miscellaneous information for the next day.

- Through an educational Perkins grant received, the program was successful in implementing two computer-based tracks which offers the youth an opportunity to earn certificates of industry certification.

- The program has a structured intramural sports program which enables the youth to participate in a variety of structured sports, programs, leagues, and tournaments. The youth have several former and current professional football players to work with and mentor the youth. In addition, the program had former collegiate, professional track and field stars, and a professional mixed martial arts fighter visit the youth in the program.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth 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 thirty-two new staff, who were all applicable for an initial background screening. A review of documentation for the thirty-two newly hired staff found the program received background screening clearances from the Department's Background Screening Unit (BSU)/Clearinghouse prior to their date of hire. All thirty-two newly hired staff records were hired for direct care positions. All thirty-two newly hired direct care staff records contained a copy of the pre-employment assessment tool with a passing score. Reviewed documentation confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, the Florida Department of Law Enforcement (FDLE), and 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 04, 2019, meeting the annual requirement. The program completed an Annual Affidavit of Compliance with Level 2 Screenings Standards for the teachers for the current calendar year on January 21, 2020.

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 had no volunteers or interns requiring a rescreening during the annual compliance review period.

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 trauma 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). At the time of the annual compliance review, there were two incidents reported to the CCC, and three to the Florida Abuse Hotline for physical, psychological, and emotional abuse since the last annual compliance review, at which management took immediate action to address the incidents. 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. There were no Prison Rape Elimination Act (PREA) investigations, nor any open Department of Children and Families (DCF) investigations, law enforcement, or Office of the Inspector General (OIG) investigations pending. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on February 18, 2020. 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, and verbally notify 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. 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, he 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, occasionally staff would curse at them but could not identify staff who was 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 has a written policy and procedures to ensure immediate action is taken to address incidents of physical, psychological, and emotional abuse. The program had five incidents of abuse, three towards a youth, one for falsification, and one for violation of policy/rule and improper supervision since the last annual compliance review. The program found each incident to have substantiated findings. A review of the reports indicated the facility administrator (FA) took immediate action to address the concerns by removing the staff from youth contact, retraining, and termination of employment. An interview with the FA indicated all abuse allegations are taken seriously when reported. There have been instances in which a staff member was terminated directly as a result of an allegation of abuse, also, one instance led the program to terminate an employee for an inappropriate use of force. While the case remains open, the employee is no longer employed. The program has signs posted throughout the building which display the telephone numbers for the Florida Abuse Hotline and CCC numbers. There is a telephone located on the wall for youth to utilize to call the Florida Abuse Hotline or CCC. At all times, if a youth asks to make the call, privacy is given and can place the call. Any time a complaint is submitted, it is addressed in the management meeting along with staff meetings to ensure there are no future issue.

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

The program has a written policy and procedures for reporting incidents to the Department's Central Communications Center (CCC) in accordance with the Florida Administrative Code within the required two-hour time frame. Reviewed documentation confirmed the program had sixteen 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. Each of the reviewed CCC's were documented in the facility logbook, as required. An interview with the facility administrator (FA) regarding the program's incident reporting process indicated all staff are trained during pre-service training and during annual in-service training on the process of making these calls. The CCC calls are tracked and discussed during daily morning meetings, weekly management team meetings, and during their monthly reporting process. The calls are tracked in a manner and are discussed during daily morning meetings, weekly management team meetings, and during their monthly reporting process. Additionally, CCC's are tracked by weekly management reports, and are submitted to the Sequel corporate office.

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 related to Protective Action Response (PAR) including the use of verbal and physical intervention techniques and mechanical restraints. A review of the program's PAR binder indicated there were three PAR incidents in the past six months. A review of the PAR reports indicated each was completed prior to the end of the staff's workday and included statements from all staff involved. There were no use of mechanical restraints or injury to youth or staff. In each of the reviewed reports, a PAR interview was conducted by administration, and reviewed by the facility administrator within seventy-two hours and included a post-PAR interview with the youth conducted within thirty minutes of each incident. A copy of the PAR report is placed in a centralized file within forty-eight hours of being signed by the facility administrator (FA). 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 as required by the program's policy. However, the youth refused medical help. The program has a current PAR plan approved by the Department's Office of Staff Development and Training on December 20, 2019. The program's PAR rate during the annual compliance review period was 0.68, which is below the statewide Residential PAR rate of 2.10. An interview with the FA indicated PAR incidents are discussed during daily morning meetings, weekly management team meetings, and by monthly reports which are submitted to the Department and Sequel corporate office. All PAR's are tracked on a weekly basis by management reports and submitted to the corporate office. Additionally, the program conducts monthly trend analysis of all PAR related incidents.

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

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 December 20, 2019. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. 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, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), and active shooter 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), conducted by qualified trainers and entered in the Department's Learning Management System (Skillpro) within thirty-days.

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 in-service training. The program's in-service orientation training plan was submitted and approved by the Department's Office of Staff Development and Training on December 20, 2019. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. Seven in-service training records were reviewed for in-service certification training within 180 days of hire. All staff completed at least 120 hours of in-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, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), and active shooter 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), conducted by qualified trainers and entered in SkillPro within thirty-days.

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, and in-service training plan. A review of seven staff training records confirmed all completed training on the program's grievance process and procedures during pre-service, and in-service training. Additionally, each youth is introduced to the program's grievance process during orientation and the process is 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. 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. An interview with the facility administrator (FA) indicated, all youth have access to grievance forms in their dorms and can submit them in the grievance boxes mounted throughout the program. The first phase of the process is the youth completing the grievance form, the second phase is the youth meeting with the facility grievance officer. The final phase includes a review by the FA or a meeting with the resident

and the administrator. 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 were reviewed. A review of the documentation and an interview with the assistant facility administrator (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.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program has a policy and procedures regarding delinquency interventions and facilitator training. The program's delinquency intervention models include Thinking for a Change (T4C). A review of staff training records indicated each facilitator had the level of education, training, and two to ten years of experience working with adult or juvenile offenders received training on the evidence-based model. A review of the program's activity schedule, coupled with the group sign-in sheets and the treatment sessions table identified in the program's contract, indicated groups were held as required. A review of seven youth performance plans verified a goal, identified priority need for youth, to participate in at least one of the required group sessions. An interview with the facility administrator (FA) confirms education and work experience is taken into consideration for different reasons to include but not limited to determining who delivers or facilitates specific group curriculums. Furthermore, all case managers have bachelor's-level degrees, and all the mental health therapists are master's-level professionals, and many of the direct care staff have two-year to four-year degrees and several years' experience in the field. The FA stated the program is providing the contractual intervention services and staff are appropriately trained to administer groups. Seven youth were interviewed, each stated they participate in role playing activities during groups. A review of seven youth performance plans addressed an identified priority need and each youth were involved in a delinquency intervention which addressed a priority need identified on the Residential Assessment for Youth (RAY).

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 designated mental health clinician authority (DMHCA) identified Aggression Replacement Therapy (ART) and Life Skills Training (LST) as the curricula 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 program's contract identifies ART and LST as mental health curricula with a life skills component. A review of the program's activity schedule and group sign-in sheets verified groups were held, as required, with most of the youth's time spent in structured, therapeutic activities, with a minimum of one hour of each youth's day devoted to the delivery of

treatment services. Therapists facilitate one-hour ART groups three times a week. The program's therapists and DMHCA are trained to deliver the curriculum. An interview with the DMHCA confirmed youth can practice skills during group role-play activities and interactions with staff and youth at the program. Interview with seven youth indicated youth were participating in daily life skills groups and recreational activities.

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 caused by past criminal actions. The program provides opportunities for the youth to participate in activities intended to restore victims and communities such as Valentine's Day Project, Mothers Against Murderer Association, Forgotten Soldiers Project, first responder treat bags, and a Fall feast with the Ladies of Halle' Place. The curriculum teaches youth about the impact of crime on their victims, families, and community, and is designed to expose youth to victim's perspectives through victim speakers, in person or through digital video tape, and in person. Based on a review of documentation, restorative justice activities were conducted and planned as designed. A review of sign-in sheets confirmed groups were delivered, as required. An interview with the facility administrator (FA) validates the use the IOC curriculum which is one of the primary Standardized Program Evaluation Protocol (SPEP) services. The program had many guest and victim speakers come into the facility to speak and interact with the youth. Through the work of the community liaison, the program also participated in various community reparation activities The program maintain a binder which highlights accomplishments pertaining to topics the youth and staff have completed. The program has a binder which highlights accomplishments pertaining to topics the youth and staff have completed. An interview with the designated mental health clinician authority (DMHCA) validated the program provides opportunities for youth to participate in community service projects. A review of seven youth records indicated each youth participated in an IOC group during their stay in the program.

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

A review of the program's contract of services found the gender-specific programming identified as Young Men's Work (YMW), Council for Boys and Young Men, Stopping Violence and Bullying, Journey of Great Warrior, and Trauma Focused Cognitive Behavioral Therapy (CBT). The YMW group 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 curriculum is designed to engage, challenge, celebrate, develop, and unite male youth. A review of the curriculum, attendance logs, and the program's activity schedule indicated gender-specific groups were designed to target the needs of the youth in the program and were conducted, as required. The

designated mental health clinician authority (DMHCA) stated the program provides adequate gender-specific programing with the youth. In addition to the curricula, youth participate in gender-specific activities such as football and mentoring. The program has a structured intramural sports program which enables 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. In addition, the program partners with local tattoo shop to empower youth to learn about the art of tattooing and removal of negative tattoos, by learning all aspects of the business such as creative design, health and safety measures when tattooing, leadership, managerial skills, and time management. An interview with the facility administrator (FA) indicated all youth are assigned to participate in Young Men's Work.

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 policy explained how alerts are identified, documented, updated, and communicated to staff. A review of JJIS alerts indicated medical staff were not consistently placing their first initial, last name to the alert. A review of JJIS alerts indicated medical staff were not consistently placing their first initial, last name to the alert. 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. Mental health staff enter alerts when the youth is added, removed, and/or stepped down from Precautionary Observation (PO). A review of the internal alerts compared to the alerts in the Department's JJIS was conducted and there were no inconsistencies found. The facility administrator (FA) was able to explain the procedure confirming the program has an internal alert system which reflects all safety and security alerts in addition to all medical, dietary, and mental health. Furthermore, the alert roster is updated daily by the medical department and circulated to all necessary parties. The daily alert roster is covered during all shift briefings, and the program has a portable alert board with youth pictures which is used to supplement the alert rosters. A review of the Department's JJIS alert list was reviewed and there were no issues affecting classification. A review of seven 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. 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 reiterates 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, 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 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 Code and maintained in the case management office behind a locked door within a locked cabinet. A review of the youth case management records confirms the program's practice is following the tab requirements, records, and confidential information provisions pursuant to Florida Statutes.

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

The program maintains a written policy and procedures process to promote formal constructive input by youth. A review of documentation 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 maintains a youth advisory board consisting of youth leader representatives from each dormitory who meet with upper level facility management. 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 in which youth may identify issues they are concerned with. 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 youth advisory board binder confirmed youth meetings were conducted at least once a month. Interviews

completed with seven 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 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 established a community advisory board which meets at least every ninety to 120 days to serve as a support to the program and a link to the community. The program provided a contact list for their thirty-four 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 parent(s)/guardian(s) of youth formerly involved in the juvenile justice system. In addition, the advisory board consists of representatives from the faith community, lesbian, gay, bi-sexual, transgender, questioning, and intersex (LGBTQI) community members from the National Football League's players association, a retired firefighter, a recording artist, a tattoo artist, and motivational speakers. The program provided copies of recruitment letters and letters of invitation to different individuals. A review of the community advisory board agendas and sign-in-sheets validated the program hosted quarterly advisory board meetings; however, due to the COVID-19 pandemic, each individual board member was invited by e-mail in order to have the board meeting conducted by video conferencing. The program maintains a community advisory board binder, which was reviewed. An interview with the facility administrator (FA) clarifies the program has a large community advisory board with representation from victim advocates, a judge, school board officials, law enforcement, the parent/guardian of a former Department youth, community leaders, and a local police chief. The FA confirms the board meets on a quarterly basis and many of the members play an active role in Palm Beach Youth Academy's programming throughout the year.

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 uses youth and staff surveys, weekly and monthly reports, and contractual program performance measures as a means of evaluating the program's outcome data. 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 has developed a staff moral committee to create different ideas to reduce staff turnover and provide for a healthy work environment. The program incorporates monthly birthday celebrations, baby showers, and employee of the month as incentives and as a program morale booster. An

interview with the facility administrator (FA) indicated there has been good staff retention rates at the program and have not experienced any challenges regarding excessive turnover or low morale. A binder of staff incentive activities and events are facilitated throughout the year and made available to the team to view. Additionally, the program utilizes indicators gauging insight on levels of staff morale. The program has monthly all-staff meetings which provides staff with this information; additionally, all staff receive monthly coaching which enable supervisors to share information with their staff. Six of seven interviewed staff confirmed receiving information on annual reports and parent/guardian/youth surveys, also feedback with seven staff stating communication was very good.

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. Each new employee is provided feedback on their job performance and allowed to comment. An interview with the facility administrator (FA) indicated all staff receive an annual evaluation from their direct supervisor on the anniversary of their higher 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 interviewed staff confirmed attending monthly meetings, four stated they were not briefed on annual reports and parent/guardian/youth surveys, and four stated communication was good.

Seven staff were interviewed and three responded indicating staff receive formal evaluations of their performance based on performance standards every six months, two staff indicated receiving monthly evaluations, one indicated yearly, and one was a newly hired staff member who has not received an evaluation as of this annual compliance review.

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

The program maintains a written policy and procedures regarding recreation and leisure activities. A review of the program's activity schedule was reviewed also, logbooks for the past six months indicated recreation activities are provided, a monthly calendar of indoor and outdoor recreation activities for the youth targeted to promote team building and leadership skills. A review of the program's activity schedule and facility logbook documentation reflected recreation activity is provided each afternoon for one hour; however, the recreation schedule was generic in nature and did not identify specific scheduled activities. A review of the program's logbooks for the past six months revealed the program conducts indoor and outdoor leisure activities in accordance with the program's daily schedule; however, the recreation schedule was generic in nature and did not identify specific scheduled activities. Interviews completed with seven youth revealed the youth have not participated in outdoor recreation activities for three days due to weather conditions. The program has two full-time recreational therapists who work with the

youth, 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 degree recreational specialist who holds a degree in therapeutic recreation. The second recreational specialist has a high school diploma, with an approved waiver from the Department possessing eighteen years of experience in the areas of recreation coordination and treatment of youth mental health issues utilizing recreational activities. Each recreational therapist works under the supervision of the designated mental health clinician authority (DMHCA). In addition, the wellness plans are discussed with the assigned therapist, 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. Seven staff were interviewed and each stated youth receive a minimum of one hour of indoor and outdoor activity to include basketball, football, cards, board games, and movie.

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. Seven youth case management records were reviewed, and each contained documentation indicating the youth's parent/guardian were notified by telephone within twenty-four hours of the youth's admission. In addition, the parent(s)/guardian(s) were notified in writing within forty-eight hours, as outlined in the program's facility operating procedures. All case management records included documentation of the youth's admission into the program and written notification to the committing judge and the juvenile probation officer (JPO) within five days of each youth's admission into the program.

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 elements required by Florida Administrative Code within twenty-four hours of admission. Youth were provided a copy of the program's youth handbook which includes information regarding services available, program goals, expectations, responsibilities and rules of the program rules of the program structure, emergency procedures, daily goals, expectations, responsibilities and rules for youth to abide, emergency procedures, daily schedule, room assignment, search policy including which items are considered contraband, visitation, grievance procedures, the behavioral management system (BMS), dress code, performance planning, how to access medical and mental services, access to Florida Abuse Hotline, and access to the Department's Central Communications Center (CCC). Seven youth case management records were reviewed, and each contained documentation indicating youth received an orientation on the date of admission coupled with the youth handbook. During the annual compliance review week, there were no new youth admissions for the annual compliance review team to observe. All seven interviewed youth indicated orientation to the program was completed within twenty-four hours of admission. Six of the seven youth reported having received a handbook, and the program rules or youth packet; however, one youth indicated having received the program rules and regulations but did not receive a handbook.

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 four youth were applicable. All four 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 has written policies and procedures regarding the classification process to assign youth to a living and/or sleeping room on the date of admission. The program utilizes a classification system to promote safety and security for which a youth's classification is determined by their individual needs and identified risk factors. A review of seven youth case management records indicated youth were classified and each contained an admission classification form which identified physical characteristics such as maturity level, age, history of violence, security alerts, mental health and substance abuse history, medical records, and vulnerability to victimization, as well as the effective delivery of treatment services in accordance with Florida Administrative Code. The program maintains an internal alert system which is maintained in the conference room area for accessibility, documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth's stay at the program. 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. In addition, the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment was completed prior to the classification of each youth, with the exception of one youth. According to the director of case management, the VSAB was initially completed on the incorrect referral number and deleted, which included the original VSAB, a new VSAB was completed twenty-one days after the youth was initially classified. The assessments are maintained in the Department's Juvenile Justice Information System (JJIS). Seven reviewed youth case management records documented reclassification forms were routinely completed based upon a youth's behavior and assessments for activities and tool use. An interview with the facility administrator (FA) indicated factors such as mental health, physical health status, cognitive performance, age and prior victimization are taken into consideration when assigning and placing youth in specific dorms, which are identified during pre-classification meetings.

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 three youth were applicable for gang involvement. Each of the three applicable youth records confirmed the program notified local law enforcement and the youth's home county law enforcement in writing of the youth's gang status. In addition, documentation supported the educational staff and the youth's assigned juvenile probation officer (JPO) were notified. 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. Youth were screened during the admission process to determine if they were associated with gang or active gang members. Any youth displaying gang signs, paraphernalia, slogans, participating in any gang-related activity to include flashing gang signs, wearing gang colors, tagging, recruitment, and/or promoting a gang lifestyle will be identified and addressed by administrative staff and the treatment team. Three of the seven applicable youth were eligible to have gang interventions included in their Individual Performance Plan (IPP). Each of the reviewed applicable youth case management records identified goals included in each performance plan relating to gang intervention. The program utilizes Gang Resistance and Drug Education (GRADE) curriculum, as well as Impact of Crime (IOC) as the program's gang interventions. A review of group sign-in sheets for the past six months confirmed youth participation. An interview with the facility administrator (FA) indicated the program's gang intervention and prevention strategies are addressed in each of the youth's IPP, and are addressed during therapy and group sessions.

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

The program has written policy and procedures to ensure an assessment of each youth using the Residential Assessment for Youth (RAY) is completed within thirty days of admission and RAY Reassessments are continuously completed in ninety-day intervals after completing the initial RAY assessment. Seven reviewed youth case management records indicated the RAY was completed within thirty days of each youth's admission to the program. The initial RAY was maintained in each youth's case management record and located in the Department's Juvenile Justice Information System (JJIS). Three of the seven records reviewed were applicable for a ninety-day RAY Reassessment. The three applicable reassessments were completed within ninety-days of the initial assessment. All RAY Reassessments were maintained in the youth's case management record.

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 Youth Needs Assessment Summary (YNAS) within the initial thirty-days after admission. Seven youth case management records were reviewed, and each contained a YNAS completed within thirty-days of the youth's admission and were documented in the Department's Juvenile Justice Information System (JJIS).

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

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 reviewed youth case management records contained an IPP created within thirty-days of the youth's admission. Each youth case management record were reviewed for performance plan development. All seven reviewed IPPs were developed within thirty-days of the youth's admission, contained measurable goals developed by the treatment team and the youth, identified court-ordered sanctions, contained a transition goal to address barriers for a successful release, included the responsibilities of the youth and staff, addressed the top three criminogenic needs, and identified target dates for completion. All IPPs included acknowledgement indicating the youth, treatment team leader, medical staff, therapist, administrator, education staff (or written input), and parent/guardian participated in the development of the IPP when applicable and was signed by all parties. Each reviewed IPP outlined staff and youth responsibilities to accomplish the goals. Each reviewed case

management record contained the original performance plan and a copy was provided to the youth. Seven youth case management records were reviewed for performance plan transmittals. Each record contained documentation indicating a copy of the IPP was sent to the committing court, assigned juvenile probation officer (JPO), and the parent/guardian. Seven youth were interviewed and indicate being involved in the creation of the IPP and six youth confirmed having received a copy of the IPP; however, one youth indicated they did not obtain a copy of the IPP.

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

The program maintains a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY.) The program treatment team may revise a youth's performance plan at any time a new need is discovered based upon RAY Reassessment results, or when the youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is discovered. Seven youth case management records were reviewed, and all were applicable for performance plan revisions. Each revision reflected the RAY Reassessment results, newly acquired/revealed information, and progress and/or lack of progress towards completion of the youth's performance plan goals There were two applicable youth case management records which contained the RAY Re-assessments revisions to facilitate transition activities during the youth's last sixty-days stay in the program. There were two youth applicable to the RAY Reassessments performed to facilitate transition activities during the youth's last sixty-days stay in the program.

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

The program maintains a written policy and procedures to address the transmittal of the youth's performance summary. A review of seven youth case management records found four were applicable for completion of a performance summary. Each of the reviewed records revealed the youth's performance summary was completed every ninety-days or less. Three additional closed records were reviewed, and all closed records contained supporting documentation the performance summary coupled with a discharge summary was completed and forwarded to relevant parties within ten working days. Each reviewed youth record contained a performance summary completed within ninety-days of signing the initial performance plan and addressed the youth's overall progress with education, behavior management, levels of motivation, interaction with peers, adjustment in the program, and a justification for a request for release. Each summary was signed by the youth, treatment team leader, relevant team members, and the facility administrator (FA). Supporting documentation indicated each applicable record

contained a transmittal verifying a copy of each summary was forwarded to the committing judge, parent/guardian, and juvenile probation officer (JPO). All of the youth's performance and release summaries confirmed each youth was able to provide a comment. A review of three youth closed 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. Seven youth were interviewed, and each youth reported they received a copy of their performance summary.

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

The program has a written policy and procedures to provide parental involvement in case management services. The program makes efforts to include the parent/guardian in the assessment process, progress reviews, formal treatment team meetings, and transition planning and notifications are forwarded by mail. Parent(s)/guardian(s) are afforded the opportunity to attend by telephone, video conference, or provide verbal or written input prior to the meeting. Seven youth case management records were reviewed, and each contained documentation the parent/guardian participated in the creation of the Individual Performance Plan, and treatment team meetings. An interview with the director of case management indicated parent(s)/guardian(s) are notified of and invited to all scheduled meetings involving their youth from the date of the youth's admission until the time of discharge. Observation of treatment team during the annual compliance review reflected, the parent/guardian attended the meeting by telephone and was involved in the case management process. All seven interviewed youth indicated parent(s)/guardian(s) can participate and be involved in their case management activities by way of telephone conference. An interview with the facility administrator indicated the program encourages parental involvement in case management process at the first point of contact during the youth's admission, and by inviting parent(s)/guardian(s) to participate to the youth's counseling sessions and treatment team meetings.

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

The program has a written policy and procedures identifying treatment team members. The treatment team members consist of the youth, parent/guardian, juvenile probation officer (JPO), direct care youth counselor, gang prevention specialist, recreation therapist, the registered nurse (RN), designated mental health clinician authority (DMHCA), a member from administration, and a Department of Children and Families (DCF) case worker when applicable. Each representative must participate in the case management process to ensure coordinated services are provided to each youth in the program. Seven youth case management records were reviewed, and each contained documentation indicating the required treatment team members actively participated in the case management process. The 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, when unable to attend in person. The parent/guardian and JPO participation was documented as contributing by telephone. Observations of the treatment team meeting, during

the annual compliance review, verified all members of the treatment team participated in the case management process as required in the program's facility operating procedures and Florida Administrative Code. The assigned JPOs participated by telephone in all the treatment meetings observed.

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

The program 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 were applicable for the incorporation of other plans into each youth's performance plan. One youth did not have other plans incorporated in the youth's IPP. Each of the six applicable records contained interventions which were addressed the youth's Individualized Mental Health and/or Substance Abuse Treatment Plan. One applicable reviewed record 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 has a written policy and procedures to ensure the intervention and treatment team conduct a formal treatment team meeting every thirty-days and informal treatment team meetings biweekly to review youth performance to include a review on each youth's progress on their individual performance plan goals, behavior, individual treatment plan, as well as to review their Residential Assessment for Youth (RAY) Reassessment Results. A review of seven youth case management records confirmed each youth had a formal treatment team meeting at least every thirty-days and an informal treatment team meeting biweekly with the required participants. All of the case management records contained formal and informal treatment and team meeting documentation including the youth's name, daily review, all attendees, comments from treatment team members, brief synopsis of the youth's progress in the program, and performance plan revisions, when necessary. Formal treatment team meetings included the treatment team leader, case manager, health services, mental health services, direct care staff, education staff, a representative from administration, youth, juvenile probation officer (JPO), and parent/guardian. Informal treatment team members consist of the treatment team leader, youth, and a minimum of one team representative. All youth case management records were reviewed and confirmed the practice of formal treatment team meeting taking place every thirty-days. The youth's JPO, parent/guardian, and other pertinent parties were notified by mail and/or email and were encouraged to participate in person, by telephone, or provide verbal or written input prior to the meeting. An observation of a formal treatment team meeting during the annual compliance review confirmed this practice. Seven youth were interviewed, and all indicated staff review the youth's performance to include their performance plan goals, positive and negative behavior and treatment progress. In addition, each youth indicated during treatment team meetings, they can demonstrate the skills they have learned while in the program.

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

The education program has in place written policies and procedures which addresses and ensures the instruction of a Career Education curriculum. This program of study which is conducted and supervised by the Palm Beach County School District, is identified as a Type 3 Career Educational programming. The course programming includes instruction of interpersonal communication skills, personal accountability skills, and behaviors leading to appropriate work habits for positive post-release employment and living standards. This curriculum is age appropriate, suitable to the youth's learning and ability skills, as well as the youth's length of stay within the program. The content of this programming includes an orientation to the broad scope of career choices based upon the youth's personal abilities, aptitudes and interests, and understanding of the needed pre-requisites for entry into a specific occupation. The youth participating in this course offering were introduced to and completed employment résumés and sample employment applications, all of which were included in the youth's Exit Portfolios. Three closed case management records were reviewed, and each contained completed résumés, employment application samples, as well as a post-release calendar (Plan for Success), which identified immediate post-release appointments including the location of and contact information of a Career Source either in or near the returning youth's residential address. Additionally, within the closed youth records were documented evidence of copies of appropriate documentation needed to gain employment, a birth certificate, a social security card, and a valid State of Florida driver's license or identification card. Additionally, each youth record contained documented evidence all parties involved with the planning and structuring of the youth's post-release discharge and vocational plans were aware of such planning and included the youth, parent/guardian, juvenile probation officer, and case manager. From thorough review of the prepared testimony of both the facility administrator as well as the program's lead educator, the above statements were verified as truthful.

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

The program's educational component is directly managed and supervised by the Palm Beach County School District. Reviewed documentation, as well as input from the program's lead educator, indicates each youth in the program is provided a minimum of 250 days of instruction during the calendar year and each calendar week contained no less than twenty-five hours of classroom instruction, to include ten days for teacher planning/training. A review of the program's daily academic schedule, the school day begins at 8:00 a.m. and concludes at 1:04 p.m. According to the lead educator, as well as a review of the youth's interview survey, classes were being held according to the schedule and with very minimal interruptions. It must be noted during the teacher's absence due to the COVID-19 pandemic health restrictions, all classes

were conducted virtually utilizing a video conferencing platform. All the virtually presented assignments were current and directly reflective of the districts' educational progression expectations

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

A review of three closed youth case management records found each had documentation of a program developed Education Transition Plan. This plan, which is individualized, is created with the youth's entrance to the residential program. The plan identifies educational goals, assessed needs and performance, for post-release educational placement as well as services and interventions which will assist in meeting those goals. Furthermore, each plan identified specific monitoring responsibilities by individuals who are accountable for the reintegration and coordination of support services for the youth upon release from the program. All reviewed records documented signed acknowledgements, and all individuals directly related to the Education Transition Plans creation and implementation had full knowledge and input from the youth, the parent/guardian, department and instructional personnel from the residential program, personnel from the school district (which included a certified school counselor) of which the youth would be returning to following residential release.

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

The program has a written policy and procedures to ensure a formal transition conference is conducted sixty-days prior to the youth's targeted release date. The transition conference meeting consists of the youth, treatment team leader, and facility administrator (FA) or designee. The youth's juvenile probation officer (JPO), parent/guardian, applicable Department of Children and Families (DCF), education staff, and any other pertinent parties are encouraged to participate in person, by telephone, or provide verbal or written input prior to the meeting. The program sent written notification to all required participants including the parent/guardian, the assigned juvenile probation officer (JPO), educational staff, and other pertinent parties. A review of three closed case management records and one active applicable record confirmed the

program held a transition conference at least sixty-days prior to each youth's anticipated release date. Reviewed documentation reflected the program's treatment team leader, facility administrator/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. The three closed case management records reviewed confirmed each youth participated in a Community Re-Entry Team (CRT) meeting prior to their release from the program.

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

The program has a written policy and procedures to ensure an Exit Portfolio is assembled to assist each youth once released back into the community. 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. Each Exit Portfolio was verified at the Exit Conference and included a state-issued identification card, copy of the youth's transition plan, calendar of dates, times and location of follow-up appointments, social security card, birth certificate, vocational certifications, educational records, résumé, and completed job applications. Each Exit Portfolio was discussed at the youth's Exit Conference and was provided to the youth upon their release from the program. The Exit Portfolios were forwarded to the assigned 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 has a written policy and procedures to ensure an Exit Conference is conducted to coordinate release procedures and prepare the youth for re-entry back to the community. Three closed youth case management records were reviewed and indicated an Exit Conference was conducted after the juvenile probation officer (JPO) was notified, within fourteen-days prior to the release of each youth and held separately from the Transition meeting. Further review of the Exit Conference documentation validated the required parties attended the Exit Conference either in person or by way of telephone. 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.

2.22 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 outlining the guidelines for the creation and review of safety plans for all youth. Each plan shall identify warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Each initial plan shall be developed by the multi-disciplinary team, prepared with the youth, parent/guardian, and clinical staff, within fourteen days of admission. The plan incorporates any recommendations from previous or current clinical assessments and is updated every thirty days. Seven youth safety plans were reviewed. Each contained the required elements and incorporated recommendations from previous or current clinical assessments. Each of the reviewed youth records documented the initial plans were completed within the fourteen-day time frame of the youth's admission. All seven youth records reflected the safety plans were updated every thirty days. The program maintains a safety plan on each youth and is securely located in the master control room which is easily accessible to staff. Seven of the interviewed youth stated they were involved in the development of their safety plan. A formal interview with the facility administrator (FA) verified safety plans are updated monthly or sooner if a major crisis arises with the youth.

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 ensuring a State of Florida licensed clinician will serve as the designated mental health clinician authority (DMHCA) and will be responsible for providing the coordination and implementation of mental health and substance abuse service delivery. The policy was approved by the facility administrator (FA) on September 14, 2020, the DMHCA on August 11, 2020, and the psychiatrist on September 13, 2020. The program has a full-time State of Florida licensed clinical social worker (LCSW) who serves as the DMHCA and as the program's clinical director. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:00 p.m. The program does not maintain a sign-in log for the DMHCA since they are a full-time employee. The program's contract outlines the DMHCA serves as the program's clinical director and has the final authority on all mental health issues and is supervised administratively by the FA. The DMHCA supervises one licensed clinician serving as the assistant clinical director. The assistant clinical director position became vacant on June 26, 2020 and was filled on August 16, 2020. The DMHCA also supervises one licensed clinician and six master's-level non-licensed clinicians. At the time of the annual compliance review, the licensed clinician position had been deleted as part of amendment eight of the contract with the Department, and there was one vacant non-licensed position as of October 11, 2020. In addition, the DMHCA supervises two recreational therapists and the contracted psychologist. The DMHCA is responsible for providing weekly face-to-face clinical supervision to the program's non-licensed therapists. A review of the DMHCA position description indicates they provide oversight of the mental health and substance abuse clinical staff and acts as the liaison between treatment services staff, the FA, and other departments. The DMHCA provides at least one hour of weekly on-site, face-to-face supervision either individually or in a group setting to each non-licensed therapist. The DMHCA is responsible for ensuring youth receive evidenced-based group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required primary Standardized Program Evaluation Protocol (SPEP) services, and the required specialty services through Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) addressing each youth's individual clinical needs. Additional responsibilities include oversight of diagnostic assessments, interview and examinations, Assessments of Suicide Risk, crisis intervention, and administration and interpretation of psychological and psychiatric testing. The DMHCA is available for consultation twenty-four hours a day, seven days a week. The DMHCA participates in weekly meetings with the psychiatrist to discuss each youth receiving services. A review of the DMHCA's position description validates the services provided and serving as the program's mental health and substance abuse authority.

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 ensuring the designated mental health clinician authority (DMHCA) is responsible for providing the coordination and implementation of mental health and substance abuse delivery. The policy was approved by the facility administrator on September 14, 2020, the DMHCA on August 11, 2020, and the psychiatrist on September 13, 2020. The DMHCA serves as the clinical director and is responsible for ensuring all clinical staff performing services are qualified based on education, training, and experience. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The program's contract requires for a State of Florida licensed clinician to serve as the assistant clinical director and another licensed clinician to serve as a therapist to conduct groups, individual, and family counseling and participate in all aspects of clinical services. The program's contract with the Department eliminated the one licensed clinician position in amendment eight on August 28, 2020. Prior to this, the program had each of the positions filled until the assistant clinical director resigned on June 26, 2020 and the other licensed clinician was promoted into the position on August 16, 2020. A review of the licensed clinicians' credentials indicated both are licensed in the State of Florida as a licensed mental health counselor with an expiration date of March 31, 2021. A review of the assistant clinical director position description serves as the back-up DMHCA in the event the DMHCA is on scheduled leave. The program maintains an agreement for professional services a State of Florida licensed psychologist on an as-needed basis and up to four hours a week; however, no more than twelve hours annually as outlined in the contract with the Department. The number of hours is determined by the needs of the youth and the program. The psychologist is required to complete assessments, Intelligence Quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the DMHCA. A review of the license reflected the psychologist's license was clear and active in the State of Florida with an expiration date of May 31, 2022. Interview with the DMHCA indicated the program has not required the services of the psychologist in the last twelve months. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statutes, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of January 14, 2021. The program maintains an agreement for professional services with a State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist, with a specialty in child and adolescent psychiatry, and is scheduled to be on-site weekly. A review of the license reflected the psychiatrist's license was clear and active in the State of Florida with an expiration date of January 31, 2022. The clinical director verified both the psychiatrist and DMHCA 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 ensuring the designated mental health clinician authority (DMHCA) is responsible for providing the coordination and implementation of mental health and substance abuse service delivery. The policy was approved by the facility administrator on September 14, 2020 and the DMHCA on August 11, 2020. The DMHCA ensures all non-licensed clinical staff are master's-level and are performing services they are qualified to provide based on their education, training, and experience. All mental health staff have master's-level degrees in a mental health related area in the required mental health field. A review of the contract with the Department outlines the program is required to have six master's-level non-licensed therapists; however, at the time of the annual compliance review, the program had one vacant position as of October 11, 2020. A review of the non-licensed master's-level therapist credentials and education found two held a master's-level degree in social work (MSW) and one of the MSW was a registered clinical social worker intern in the State of Florida with an expiration date of March 31, 2022. The other three non-licensed master's-level therapists held degrees in mental health counseling, forensic psychology, and marriage and family therapy, respectively. The therapist with a degree in marriage and family therapy is a registered mental health counselor intern in the State of Florida with an expiration date of May 29, 2023. At the time of the annual compliance review, the program had nineteen youth receiving Mental Health Overlay Services (MHOS) and thirty-five youth receiving Substance Abuse Treatment Overlay Services (SAOS). A review of caseload assignments reflected each therapist was twelve or below and in compliance with their contract. A review of the non-licensed therapist position description indicated the therapists provide mental health and substance abuse treatment to include individual, family, and group therapy sessions, using professionally prescribed methods and expectations, under the direct supervision of DMHCA. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statutes, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of January 14, 2021. The program's DMHCA is responsible for providing clinical supervision to the non-licensed clinical staff. Reviewed Clinical Supervision Logs found the DMHCA conducted the required weekly face-to-face supervision with each non-licensed therapist. The DMCHA conducts a group-style weekly supervision and meets individually with each therapist to discuss a sample of work and provides current clinical skill assessment ratings and discussion of specific clinical focused areas. Reviewed practice supported the form included all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The therapists and DMHCA sign each weekly group and individual clinical supervision form and the documentation is maintained in a central binder located in the DMHCA office. Reviewed training records supported two therapists completed the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Three therapists are still in the process of the completing the required training. Reviewed mental health records and documented practice supported the applicable Assessments of Suicide Risk and Crisis Assessments were completed by a either the trained non-licensed therapist or by one of the two licensed clinicians.

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 ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process which includes a review of the commitment packet information, reports and records, and review of the Department's Juvenile Justice Information System (JJIS) alerts, administration and scoring of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), or the clinical mental health and substance abuse screening. The policy was approved by the facility administrator (FA) on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. The program ensures all youth are screened for mental health and substance issues during the initial intake process. The program ensures mental health and substance abuse services are available to all youth who are determined to meet clinical criteria and certified to receive such services. Mental health and substance abuse treatment is provided on-site through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The program has a policy and procedures to ensure each youth's mental health and substance abuse needs are identified through a comprehensive screening process. Immediately, upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team staff to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. As a component of the initial intake process, the MAYSI-2 is administered by a trained staff member in the Department's JJIS. A review of seven mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for each youth. A trained case manager and trained director of case management completed all MAYSI-2 assessments. Each reviewed MAYSI-2 reflected the screening was completed in full in the Department's JJIS. Following the MAYSI-2 screening, the assigned therapist reviews all available information to include the youth's commitment packet information, pre-dispositional reports, previous psychological and/or psychiatric evaluations for information regarding suicide risk, mental health or substance abuse issues to include inpatient and/or outpatient mental health and substance abuse treatment. The review includes youth history of drug, alcohol, emotional instability, significant trauma, mental illness in the family, and any suicide risk factors. The review is documented on the program's Clinical Mental Health and Substance Abuse Intake Screening Checklist form. All seven reviewed MAYSI-2s resulted in the youth requiring a referral for further evaluation with five having a hit and two youth having an override. However, the program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results. A Mental Health Services Referral form is completed and submitted to the clinical department. There were no instances where youth had a need for a crisis intervention or emergency service as a result of the screening. There was not applicable youth with an elevated suicide ideation; however, the program completes an Assessment of Suicide Risk (ASR) regardless of the MAYSI-2 screening results. Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an ASR regardless of MAYSI-2 screening results. The program's FA reported when a youth is admitted they are seen for intake by all the disciplines including case management, mental health, medical, direct care, and education. Case management administers an electronic MAYSI-2 and submits the MAYSI-2, along with a referral form, to the

clinical department. In addition, case management submits the relevant background information, including the Pre-Disposition Report, JJIS Face Sheet, and any other relevant psychological evaluations.

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 ensuring all youth with mental health and/or substance abuse needs receive an in-depth comprehensive mental health and substance abuse comprehensive bio-psychosocial evaluation. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. Each youth, regardless of the whether the youth was admitted with a current evaluation, receive a new bio-psychosocial entitled Mental Health and Substance Abuse Comprehensive Evaluation In-Depth Assessment, which contains all required elements outlined in Florida Administrative Code. The clinical staff complete a Clinical Mental Health/Substance Abuse Intake Screening identifying the reason for clinical mental health/substance abuse screening, youth interview, current mental health status, substance abuse status, and clinical disposition. As part of the assessment process, the program assesses each youth utilizing the Beck Depression Inventory-II (BDI-II), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Department Assessment of Suicide Risk (ASR), Suicide Probability Scale, Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Adolescent Anger Rating Scale (AARS), and the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). In addition, each youth completes an initial self-statement as to what they would most like to change about themselves and the people in their lives who help make positive changes. A review of seven mental health and substance abuse records validated a new bio-psychosocial evaluation was completed for each youth within thirty calendar days of admission. Reviewed documentation supported the licensed clinical social worker completed one evaluation and the non-licensed therapists completed the other six. Each reviewed bio-psychosocial was completed in full. Reviewed practice supported each youth record had a signed Department Youth Consent for Substance Abuse Treatment form and a Department Youth Consent for Release of Substance Abuse Treatment Records form. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form and when the youth turns eighteen years of age, the youth signs a Sequel Authorization for Release of Health Information Pursuant to HIPPA (Health Insurance Portability and Accountability Act of 1996) form for release of specific information and to whom the information is shared. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statutes, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2021. Each youth signed an Orientation / Consent for Treatment form, Outline of Substance Abuse Services form, and a Sequel Notice of Privacy Practices form.

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 to ensuring all mental health and substance abuse treatment planning focuses on providing mental health and substance interventions designed to target and reduce and/or alleviate the youth's symptoms of mental disorder and substance abuse impairment and enable the youth to improve functioning within the program and upon release to the community. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. Each youth's mental health and substance abuse treatment is prescribed by an Individualized Mental Health and Substance Abuse Treatment Plan. The treatment team is responsible for assisting in developing, reviewing, and updating the youth's initial and individual treatment plan. Mental health and substance abuse treatment is guided by an Individualized Treatment Plan (ITP) addressing all youth needs. Each assigned primary therapist takes the lead in developing the youth's ITP. A review of seven youth mental health and substance abuse records and seven youth case management records documented each youth was assigned to a treatment team upon arrival to the program. Reviewed practice supported the program completes a Palm Beach Youth Academy Treatment Team Designation List form outlining treatment team members and is placed in the case management record. The program also completes a Palm Beach Youth Academy Description of Treatment Team identifying treatment team members and is placed in the mental health and substance abuse record. Reviewed practice supported each youth record had a signed Department Youth Consent for Substance Abuse Treatment form and a Department Youth Consent for Release of Substance Abuse Treatment Records form. Each reviewed record supported the youth participated in group, individual, and family therapy as prescribed by their approved ITP. The program's clinical therapists facilitate mental health and substance abuse groups. A review of mental health and substance abuse group sign-in sheets supported groups were provided daily to youth and mental health groups were limited to ten or fewer youth and substance abuse groups were limited to fifteen or fewer youth. Seven interviewed youth each validated they participated in individual and family therapy. Seven interviewed staff indicated clinical staff and trained case management staff conduct groups. The program is licensed under Florida Statutes, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021.

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 ensuring all youth determined to have a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis shall have an Initial Treatment Plan and an Individualized Mental Health and Substance Abuse Treatment Plan. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. All mental health and substance abuse (MHSA) treatment services are provided through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). Services are designed and implemented to support recovery, health or well-being of the youth and family, ensure safety and enhance the quality of life, and to reduce symptoms and build resilience. In addition, services restore and/or improve functioning for youth within the program and ultimately upon release to the community. Upon release from the program, all youth shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for MHSA services. A review of seven MHSA records found each youth had an Initial Treatment Plan completed by the treatment team on the youth's date of admission. Each reviewed youth record contained an Initial Mental Health Substance Abuse Treatment Plan documented on a program-specific form which contained all elements as outlined on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Six of the seven reviewed Initial Treatment Plans included signatures of the master's-level non-licensed therapist, licensed therapist, parent/guardian (when applicable), treatment team members, and the youth. One Initial Treatment Plan was developed and signed by the licensed clinical social worker (LCSW) and all other treatment team members including the youth. As part of the admission screening each youth completes an Initial Self Statement outlining what they would like to change about themselves in order to not get into trouble again. In addition, the youth identifies three individuals who would be pleased to see positive changes and three obstacles preventing them from making the positive changes. This information is incorporated into the Initial Treatment Plan and the Individualized Treatment Plan. Four of the seven reviewed youth records indicated the youth were admitted with prescribed psychotropic medications. The Initial Treatment Plan incorporated the youth's psychiatric needs to include the medication and frequency of monitoring by the psychiatrist. All seven reviewed youth mental health and substance abuse records contained an Individualized Mental Health and Substance Abuse Treatment Plan completed within thirty days of admission. Each completed individualized plan was documented on a program-specific form containing all elements included in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. One individualized plan was developed and signed by the LCSW and six were completed by the non-licensed master's-level therapist and signed by one of the licensed therapists on the same day of development. Each reviewed plan outlined prescribed services including individual, group, and family therapy. Each plan documented prescribed services to include individual therapy one

time each month, group therapy one time daily, and family therapy one time each month. A video review of five separate groups on various days validated compliance with documented duration time frames. Four of seven reviewed youth records indicated the youth were admitted on prescribed psychotropic medications and the individualized treatment plans incorporated the youth's psychiatric needs to include the medication and frequency of monitoring by the psychiatrist. Program practice is for the psychiatrist to review and sign the Individualized Treatment Plan for youth prescribed psychotropic medications. Reviewed weekly progress notes validated each youth received the prescribed services as outlined on the individualized plan. Six of seven reviewed youth mental health and substance abuse records documented the multi-disciplinary treatment team conducted a treatment plan review at least every thirty days. One youth was recently admitted and did not a review as of the week of the annual compliance review. There was one exception for one youth missing a review in August 2020 due to the youth's arrest and not physically being in the program. The youth returned to the program and all other reviews resumed thereafter. Three closed records were reviewed for the completion of a Mental Health and Substance Abuse Discharge Summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/ Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth being released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the Exit Conference as required. The program's practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

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 ensuring mental health and substance abuse services are provided through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The policy was approved by the facility administrator (FA) on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. A review of the program's contract, clinical program description, and interview with the FA indicated the program provides on-site mental health and substance abuse (MHSA) services through MHOS and SAOS. Youth with co-occurring substance abuse disorders receive substance abuse services. Treatment services are guided by an Individualized Mental Health and Substance Abuse Treatment Plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment is provided by the licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA), by the licensed mental health counselor who serves as the assistant clinical director, or by one of the six master's-level non-licensed therapists. At the time of the annual compliance review, the program had one vacant non-licensed therapist position as of October 11, 2020. A review of seven staff pre-service training records supported each staff received an overview training in MHOS and SAOS prior to working with the youth. Each youth is assessed upon admission

utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). At the time of the annual compliance review, the program had nineteen youth receiving MHOS services and thirty-five youth receiving SAOS services. The program provides each youth with group therapy services seven days a week. The program's contract outlines services provided to include Aggression Replacement Therapy (ART), Coping with Stress, Cannabis Youth Treatment (CYT), Adolescent Coping with Depression (CWD-A), Trauma Focused Cognitive Behavioral Therapy, Seeking Safety, Chestnut Health System Treatment Manual, Substance Abuse Group Life Skills Training, and Council for Boys and Young Men's to include Journey of the Great Warrior. Reviewed documentation supported ART was last conducted from August 10, 2020 to October 15, 2020 and is scheduled to begin a new cohort in December 2020. The program trained five therapists to conduct CYT on May 27, 2020 and started a new cohort in November 2020. Seeking Safety was last conducted on May 11, 2020 and the next cohort is scheduled for November 21, 2020. The Chestnut Health System Treatment Manual group ended on October 25, 2020 due to the therapist resigning and the next cohort is scheduled to begin November 21, 2020. Substance Abuse Group Life Skills ended in May 2020 and is scheduled to begin a new cohort in February 2021. The Council for Boys and Young Men to include Journey of the Great Warrior ended in May 2020 and the next cohort is scheduled to begin in February 2021. An interview with the DMHCA indicated Coping with Stress, Adolescent Coping with Depression, and Trauma Focused Cognitive Behavioral Therapy are all delivered through individual therapy sessions since there are not enough applicable youth to provide the services through a group setting. The program's contract requires the utilization of a State of Florida licensed psychologist on an as-needed basis. The program maintains an agreement for professional services with a licensed psychologist, expiration date of May 31, 2022. According to the DMHCA, the program has not utilized the psychologist in the last twelve months. The agreement with the psychologist indicates they will complete assessments, Intelligence Quotient (IQ) tests, provide consultation to youth who may be experiencing crisis-related situations, and communicate with the DMHCA. An interview with the FA validated the program provides MHOS and SAOS treatment to youth in the program, which includes daily therapeutic groups along with monthly individual and family therapy.

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 ensuring psychiatric services shall be provided to youth in need of such services as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medications prior to, or subsequent to, admission to the program. Psychiatric services are provided by a licensed psychiatrist who is board certified in child and adolescent psychiatry or psychiatry by the American Board of Psychiatry and Neurology. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 16, 2020. The program's psychiatrist supervises the treatment team and provides psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical and psychiatric follow-up visits are conducted on an individualized basis. The program maintains an independent

contractor agreement with a State of Florida, licensed psychiatrist, board certified in psychiatry, as well as child and adolescent psychiatry, to provide services to the youth at the program. A review of the license indicated the program's psychiatrist is a medical doctor (MD) and the reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2022. The psychiatrist maintains professional/liability insurance with an expiration date of March 3, 2021. The program does not utilize a psychiatric advanced practice registered nurse (APRN). A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave; however, no back-up coverage was provided since the last annual compliance review. A review of the back-up psychiatrist's license showed it was a clear and active MD licensure in the State of Florida with an expiration date of January 31, 2022. A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly, as required. Additional reviewed documentation supported the psychiatrist participates in the weekly clinical treatment team meetings with the program's designated mental health clinician authority (DMHCA) and the mental health therapists. Reviewed documentation supported the psychiatrist participates in formal treatment team meetings for all applicable youth prescribed psychotropic medications and signs the individualized treatment plan review documentation. The program's policy and practice are to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission. A review of seven mental health and substance abuse records indicated four youth were admitted on prescribed psychotropic medications. However, program practice is to complete a psychiatric initial diagnostic interview within seven days of admission on all youth. During the intake screening process, the mental health therapists complete a Psychiatric Referral form identifying the referral information and the services requested. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. Each reviewed record 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. Each applicable youth received a comprehensive psychiatric evaluation within thirty days of admission. Subsequent to the comprehensive psychiatric evaluation, each youth prescribed psychotropic medications is evaluated at least monthly and discussed during the treatment team. The overview of the youth's behavior and progress in the last thirty days is documented on the Physician Communication form (psychiatric) and signed by the therapist and psychiatrist. All four applicable youth were assessed by the psychiatrist at least every thirty days. The review was documented on page three of the Department's CPPN form and completed in full. There were no documented lapses in psychiatrist services for the records reviewed. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported participation in weekly treatment team meetings and weekly on-site visits. The psychiatrist reported conducting the initial psychiatric evaluation, follow-up evaluations, and medication management.

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 outlining the development and implementation of a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The policy and plan were approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. The plan outlines the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. An informal interview with the assistant facility administrator indicated staff receive suicide prevention training during pre-service and in-service trainings, as well as through mock emergency mental health drills.

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 the utilization of suicide precautions as the method for supervising, observing, monitoring, and housing youth identified through screenings, available information, and staff observations as having suicide risk factors. Any youth exhibiting suicide risk behaviors shall be placed on suicide precautions and at a minimum of constant supervision. All youth identified as having suicide risk factors by screening, information obtained regarding the youth, and staff observations shall be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). The policy was approved by the facility administrator (FA) on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on September 13, 2020. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. The program maintains two complete suicide response kits located in phase one master control and phase two master control. Interviews with seven staff and observations during the annual compliance review confirmed the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. Seven interviewed staff found six indicated the program maintains suicide response kits in master control and two staff indicated the kits are in the medical clinic. The program's practice is to conduct the Department's ASR on each during the admission screening process. A review of seven youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All seven reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. A review of three additional applicable youth records indicated through staff

observations, each youth was screened utilizing the Department's ASR and were found with an elevated suicide risk and placed on constant supervision. A review of the three applicable ASRs whereby the youth were placed on Precautionary Observation (PO) found two of the ASRs were completed by the licensed clinical social worker (LCSW) and one was completed by the registered mental health counselor intern (RMHCI). A review of the training records supported the RMHCI completed the required twenty hours of ASR and crisis assessment training. Each youth was referred and assessed on the same day determined to be at risk and was placed and maintained on a constant supervision status. Reviewed documentation supported the authorization of PO status, the completion of a Suicide Precautions Observation Log, and support services provided by the program's mental health staff. Reviewed practice supported the completion of a Follow-Up ASR the day after the ASR was completed. Upon completion of the Follow-Up ASR, the youth was transitioned to Close Supervision and remained on this level for twenty-four hours prior to being assessed by completion of a Mental Status Examination and transitioned to standard supervision. Each transition to a lower supervision level documented a discussion between the LCSW and the FA. In addition, there was telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. A review of the Department's Juvenile Justice Information System (JJIS) documented an alert was initiated and removed as required for the applicable youth. A review of the program's shift reports and logbooks documented clear updates regarding youth on PO status. Reviewed program policy and procedures and interview with the DMHCA indicated the program does not utilize Secure Observation. The program utilizes JFK North Campus in West Palm Beach, Florida for crisis stabilization for both Baker Act and Marchman Act proceedings. Seven interviewed staff each indicated when a youth expresses suicidal thoughts staff notify the mental health staff, search the youth and their room, place the youth on constant sight and sound, and document supervision.

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 staff assigned to observe a youth placed on suicide precautions shall provide the appropriate level of supervision and record the observations of the youth's behavior at intervals not to exceed thirty minutes on the Suicide Precaution Observation Logs for the duration the youth is on suicide precautions. The policy was approved by the facility administrator (FA) on September 14, 2020 and the designated mental health clinician authority (DMHCA) on August 11, 2020. A review of seven youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's Assessment of Suicide Risk (ASR) form. All seven reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. A review of three addition applicable youth records indicated through staff observations, each youth was screened utilizing the Department's ASR and were found with an elevated suicide risk and placed on constant supervision. A review of the three applicable ASRs whereby the youth were placed on Precautionary Observation (PO) found two of the ASRs were completed by the licensed clinical social worker (LCSW) and one was completed by the registered mental health counselor intern (RMHCI). All three applicable PO records and Suicide Precaution Observation (SPO) Logs were reviewed. Program practice is to complete the Department's SPO Log form. The reviewed SPO Logs and Close Supervision Visual Checks (CSCV) Logs were documented in real time and were conducted by the direct care staff. The

SPO Logs documented visual checks at least every thirty minutes and the CSCV Logs documented visual checks every five minutes. There were no documented behavioral warning signs while the youth was placed on PO. Each reviewed SPO Logs documented the shift supervisor's signature except on one incident on B-shift for two youth. The clinical mental health staff documented their signatures as required.

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

The program maintains a written policy and procedures ensuring 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. All direct care and clinical staff will be trained annually on suicide prevention and implementation of suicide precautions, which includes quarterly mock suicide drills for all staff who come in contact with youth on each shift. The policy was approved by the facility administrator on September 14, 2020 and the designated mental health clinician authority (DMHCA) on August 11, 2020. A review of seven pre-service and seven in-service training records indicated each staff completed the required six hours of annual suicide prevention and implementation of suicide precautions training. During this annual compliance review period, the program ran two twelve-hour shifts (6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m.). A review of the program's mock suicide drills confirmed the program completed quarterly drills on each shift during the past twelve months. The program had seventy-three applicable staff who were required to participate in a suicide precaution drill at least one time semi-annually and reviewed drills supported all seventy-three staff completed the required drill participation. Seven interviewed staff found four staff indicated drills are conducted monthly, two indicated bi-monthly, and one was not sure. Five of the completed mock drills on each shift included the use of life saving measures to include the use of cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED). Each reviewed emergency drill documented a description of the incident, persons involved, type of medical care given, type of mental health/crisis intervention provided, outcome of the incident, follow-up or corrective action, date shared with management team, and overall team review/critique. Each drill documented the date the information was shared with all staff.

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 the program responds 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 policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on August 16, 2020. The procedures detailed a Crisis Intervention Plan to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process. The program's Crisis Intervention Plan included a process for notification and alert system, means of referral,

communication, supervision, documentation, and review ensuring the safety and security of youth and staff.

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 ensuring a crisis assessment is administered for youth demonstrating acute psychological distress. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA) on August 11, 2020, and the psychiatrist on August 16, 2020. A review of seven youth mental health and substance abuse records found no applicable instances requiring the completion of a Crisis Assessment. An interview with the designated mental health clinician authority (DMHCA) indicated the program had only one applicable youth requiring a Crisis Assessment in the last twelve months. A review of the applicable Crisis Assessments found the program utilized the Department's Crisis Assessment form. The Crisis Assessment documented completion immediately following the determination the youth was in crisis. The Crisis Assessments was completed in full by the trained master's-level non-licensed therapist and was reviewed and signed by the licensed clinical social worker (LCSW) the same day. A Mental Health Alert form was completed by the clinical staff identifying the date of the alert, mental health issues, level of supervision, and movement restrictions. Program practice is to complete a new Crisis Assessment each day to assess the youth's overall mental status prior to transitioning the youth to standard supervision. The youth remained on constant supervision for five days prior to transitioning to close supervision where they were on for two days before moving to standard supervision. The program had no alleged Prison Rape Elimination Act (PREA) events during the annual compliance review period.

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 ensuring an emergency response plan for mental health and substance abuse emergencies shall ensue the highest quality of care, safety, and management of the youth. The purpose of the plan is to outline mental health and substance abuse emergency procedures for youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The policy was approved by the facility administrator on September 14, 2020, the designated mental health clinician authority (DMHCA)

on August 11, 2020, and the psychiatrist on August 16, 2020. The program's plan included procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. An interview with the designated mental health authority indicated there were no youth applicable for emergency mental health and/or substance abuse services since the last annual compliance review. The program utilizes JFK North Campus in West Palm Beach, Florida for crisis stabilization for both Baker Act and Marchman Act proceedings. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. Seven interviewed staff indicated all program staff have the ability to call 9-1-1 in the event of an emergency.

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

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

Standard 4: Health Services

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

The program maintains a written policy and procedures which requires a contracted designated health authority (DHA) to provide on-site medical services to youth in the program. The program currently maintains a written independent contract with a State of Florida board-certified licensed medical doctor (MD) with specialty training in pediatrics to serve as the DHA. The DHA holds an unrestricted clear and active license with an expiration date of January 31, 2022. The DHA is contracted to be on-site for a minimum of two hours weekly with no more than nine days passing between on-site visits. A review of physician sign-in logs for the prior six months validated the DHA was on-site weekly for at least two hours, as required. The program maintains a written contract with a licensed MD to provide coverage during the DHA's scheduled absences and vacations. The substitute MD has an clear and active license to practice in the State of Florida with an expiration of January 31, 2022. The program does not utilize an advanced practice registered nurse (APRN) or physician's assistant. The DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. Documentation related to healthcare services and a review of youth Individual Healthcare Records indicated the DHA provides oversite for all healthcare services at the program. The DHA is responsible for completing Comprehensive Physical Assessments (CPA) on all newly admitted youth within seven days of each youth's admission, health complaints which need to be addressed by a physician, and review of all chronic conditions at least once every three months. Informal interviews with healthcare staff indicated the DHA reviews acute and pertinent complaints, progress notes, referrals to specialists as needed, laboratory results, documentation of all specialty visits and recommendations, as well as reviews and signs the program's healthcare policy, procedures and nursing protocols.

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 policy and procedures for all health-related procedures and protocols utilized at the program. The program's designated health authority (DHA) conducts an annual review of all health-related policy, procedures, and protocols. The DHA last reviewed, signed, and dated the Facility Operating Procedures (FOP) on August 1, 2020 or August 7, 2020. Reviewed documentation validated the DHA and facility administrator conducted an annual review of the healthcare policy and procedures on July 22, 2020 and August 7, 2020. The DHA last signed to approve the treatment protocols on October 30, 2020. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry whose current license expires on January 31, 2021. The psychiatrist last signed the healthcare polices on September 13, 2020. New policy, or changes in policy, made during the year are reviewed, signed, and dated by each nurse on the FOPs cover-page. The FOPs and protocols are reviewed annually. The program's director of nursing reported no new medical staff since the last annual compliance review; however, the program does maintain a training requirement which requires newly employed

healthcare staff to complete a comprehensive clinical orientation to the Department's healthcare policy and procedures.

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 regarding the Authority for Evaluation and Treatment (AET) for all youth admitted into the program. Seven youth Individual Healthcare Records (IHCR) were reviewed for an AET. Six of the seven youth records contained a copy of the AET, and each had the word "Copy" stamped on the document maintained within the record. One of the reviewed IHCRs was applicable for and contained a court order filed in the record due to the youth being in the care of the Florida Department of Children and Families (DCF). When applicable, each IHCR included a copy of a completed parental notification behind the AET. The program utilizes the Release of Information Authorization for Youth Eighteen Years of Age and Older form, for youth eighteen years of age or older, to provide consent for release of specific information, and to identify individuals to whom the information may be released and shared. Five of the seven IHCRs were applicable for youth having turned eighteen years of age or older and documentation confirmed all signed a Release of Information Authorization Form for Youth Eighteen Years of Age or Older.

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

The program maintains a written policy and procedures requiring the parent/guardian to be informed of significant changes in the youth's condition and for the program to obtain consent for new medications or treatment prescribed. A review of seven youth Individual Healthcare Records (IHCR) validated six included documentation of parent/guardian notification and one youth who was in the custody of the Department of Children and Families (DCF). Five of the seven reviewed youth had reached eighteen years of age or older and all five applicable records contained a Release of Information Authorization form for youth eighteen years of age or older. A review of seven youth IHCRs reflected, one youth required off-site emergency care and parent/guardian notification was made by telephone and, subsequently, in writing. A review of the program's documented practice supported written notification was sent to the parent/guardian regardless of telephone notifications. Two youth were taken off-site for outside medical care and one youth had an existing prescribed medication discontinued after admission to the program. Reviewed documentation supported parental notification and consent was obtained. One applicable record contained documentation indicating the program obtained consent from the parent/guardian prior to administering psychotropic medications. Telephone consent conducted by the psychiatrist and witnessed by the nurse was documented in this instance. The parent/guardian received a written follow-up with of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. The record for youth under DCF supervision contained documentation indicating the program obtained court ordered consent prior to administering psychotropic medications. All seven youth IHCRs reflected vaccinations were verified within thirty days of the youth's admission. Each record contained a copy of the youth's immunization record received from the Florida Shots website. There was no evidence of a youth's parent/guardian refusing to consent to a

vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. An interview with the nursing staff confirmed this practice.

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 to ensure each youth receives a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. A review of seven youth Individual Healthcare Records (IHCR) validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse on the date of the youth's admission to the program. One youth had three instances of a change in custody and a review of documentation supported a new FEPHS rescreening form was completed by a registered nurse (RN) each time the youth returned to the program. An interview with the director of nursing confirmed the program's practice.

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 requiring all youth be oriented on the general process of healthcare delivery services at the program beginning within the first twenty-four hours after admission. The program's practice is to have the registered nurse provide healthcare orientation upon each youth's admission. Seven youth Individual Healthcare Records (IHCR) were reviewed for healthcare orientation and each record reflected the youth received a healthcare services orientation on the day of the youth's admission to the program. Reviewed documentation in each IHCR validated a health education packet was provided and discussed with the youth. The healthcare topics included access to medical care, sick call process, emergency situations, medication process, the right to refuse care, what to do in case of sexual assault or attempted sexual assault, the non-disciplinary role of healthcare staff, a review of healthcare contacts, and the role of the program's healthcare providers. A signed and dated receipt of healthcare orientation was maintained in all seven reviewed records. In addition to the healthcare orientation at admission, youth received health education throughout their stay in the program which was documented on the Health Education form in all seven reviewed IHCRs.

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 requiring routine notification be made to the designated health authority (DHA) of each youth's arrival at the program and immediate notification when any youth admitted to the program requires emergency care. The program's practice is to notify the DHA of all youth admissions including those with a chronic medical condition, psychotropic medication, or a medical concern. The DHA is notified by telephone, or verbally, if on-site, of all admissions. Seven youth Individual Healthcare Records (IHCR) were

reviewed and each reflected telephonic notification was made to the DHA of the youth's admission to the program which was documented on the DHA Admission Notification Form and maintained in the chronological notes tab of the IHCR. None of the youth were applicable for presenting with a condition requiring an emergency response. All records documented DHA notification in the youth's chronological progress notes. Reviewed documentation confirmed nursing staff updated the Chronic Conditions Log after the notification was completed.

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 to ensure each admitted youth receives a completed Health-Related History (HRH) prior to a Comprehensive Physical Assessment (CPA) and preceding any participation in sports, exercise, or any other strenuous activity. Seven reviewed youth Individual Healthcare Records (IHCR) reflected a new HRH was completed by a registered nurse on the day of admission for each youth. The nursing staff provide an electronic signature on each completed HRH form. Documentation further reflected the designated health authority (DHA) reviewed the HRH for each of the seven youth. HRHs were completed prior to the CPA in all seven reviewed records. An interview with the program's director of nursing confirmed this practice.

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 requiring each admitted youth to receive or have on record a current Comprehensive Physical Assessment (CPA) within seven calendar days from the date of admission into the program. A review of seven youth Individual Healthcare Records (IHCR) validated the program utilized the Department's CPA form. All CPAs were completed by the designated health authority (DHA) within seven days of the youth's admission. All sections of the CPA were completed in full utilizing "O" or "X" markings. None of the reviewed CPAs were completed in section numbers nineteen through twenty-two, as those sections were not applicable to the male program. All seven reviewed CPAs documented sections twenty-three through twenty-six were refused by the youth. Each youth's refusal was documented in writing; and the DHA documented on each CPA the youth refused those portions of the examination. The CPA in all seven records included documentation the most recent verified Tuberculosis Skin Test (TST) within the last year to determine exposure to tuberculosis (TB). Additionally, as part of the healthcare admission screening, nursing staff utilized the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening on the day of admission for each youth. Reviewed documentation found the results of the TSTs were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no current youth with symptoms suggestive of active TB. The program's policy prohibits youth from being placed into the general population until healthcare needs identified are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. Reviewed documentation in all seven records validated the Department's Problem List was updated for each youth throughout their stay, when applicable. An interview with the program's director of nursing indicated each youth is screened at admission and the CPA form is completed within seven days of each youth's admission by the DHA.

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 requiring all youth entering the program to be clinically screened, evaluated, and treated (if necessary) for sexually transmitted infections (STI) and human immunodeficiency virus (HIV). The designated health authority (DHA) is to then decide, based on the screening tool and medical evaluation, to order testing for STIs. A review of seven youth Individual Healthcare Records (IHCR) found six youth were identified as sexually active and were clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Testing was ordered and performed for each applicable youth within twenty-four hours. Test results were filed in the laboratory section of the IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. An interview with the program's director of nursing reported youth are screened for STIs and offered testing at the time of admission. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. The program maintains a written policy and procedures to ensure all youth at risk of HIV infection are offered counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. The program completes a HIV Risk Assessment and a referral for testing is based on the assessment results. A review of seven youth IHCRs validated each youth was provided the opportunity to receive counseling, testing, and treatment for HIV; however, each youth declined consent in writing. An informal interview with the director of nursing indicated when youth receive pre-counseling, testing, and post-counseling, the youth's health education record would be updated in the healthcare record. The testing results would be placed in a sealed envelope marked 'Confidential', and the DHA is to sign and date the outside of the envelope. Currently the DHA is available to provide HIV pre-test and post-test counseling services. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not include HIV status as part of the internal alert system. All seven interviewed youth indicated they could request a HIV/AIDS test at 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 to address sick call requests. Sick call care is provided by licensed medical staff, pursuant to the staff's scope of practice and according to the written protocols approved by the designated health authority (DHA). Youth are informed of the sick call process at the time of admission to the program during orientation. It is the program's practice for the youth to complete a Sick Call Request utilizing the Sick Call Request form and submit the forms in the wall-mounted locked boxes located in designated areas of the program. The program's practice is to check the boxes randomly throughout the day. Sick call is provided daily, Sunday through Saturday, at 7:30 a.m., 1:00 p.m., and 4:00 p.m. The DHA is on-call seven days a week, twenty-four hours a day for consultation. A review of seven youth Individual Healthcare Records (IHCR) found each youth completed a Sick Call

Request form at least once or more during their stay, for a total of twenty-five sick call requests. Reviewed documentation found the registered nurse (RN) documented the treatment and/or services provided to the youth during each sick call event on the Sick Call Request form in each youth's IHCR. There was one applicable youth who presented with a similar sick call complaint three times within a two-week period for a toothache and an immediate referral was made to the DHA. All twenty-five sick call incidents were documented on the Sick Call Index and the completed forms were filed in the IHCRs. All sick call incidents were documented on the Sick Call Referral Log. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be reviewed by the shift supervisor as soon as possible but no more than two hours after the request was submitted. The supervisor is to determine if the sick call requires immediate attention, or if determination cannot be made by the supervisor, the DHA will be notified and consulted by telephone. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth having severe pain with which staff are unfamiliar is treated as an emergency and requires immediate referral to licensed healthcare staff. If healthcare staff are not on-site, emergency medical services are to be obtained at Palms West Hospital. Observation of the program's sick call process was conducted during the week of the annual compliance review and validated the program utilizes an examination table to perform sick call and a curtain is drawn around the examination table to maintain privacy. Seven interviewed staff indicated nursing staff conducts sick call. One interviewed youth indicated they can see the nurse immediately and five interviewed youth reported they are able to see the nurse within one day of submitting a sick call. One interviewed youth reported never submitting a sick call. All seven interviewed youth indicated they are allowed to see a dentist or the doctor if needed.

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 requiring provision of twenty-four-hour emergency medical, mental health, and dental care to youth, as needed, in response to unexpected illnesses, accidents, or conditions requiring immediate attention or an immediate professional assessment to determine the severity. Episodic care is provided by a registered nurse (RN), documented in the chronological progress notes, and tracked on the Episodic Care Log. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and whether off-site care is needed. Episodic care provided by a non-licensed staff person requires a follow-up evaluation by a licensed healthcare professional the next time this person is on-site, or sooner, if indicated. In such instances, the healthcare staff would then document the follow-up evaluation in the nursing chronological progress notes. A review of seven youth Individual Healthcare Records (IHCR) found six youth required episodic and/or first aid care. All treatment services were provided by nursing staff and the nursing chronological progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff documented on the log all episodic, first aid, and emergency care incidents by date, name of youth, Department identification number, the treatment rendered, staff initials, and whether the youth was referred to the designated health authority (DHA) or off-site care. Suicide response kits are maintained in phase one master control and phase two master control. The program maintains first aid kits for each of the program's three transport vehicles and the program's kitchen. Each first aid kit is secured with a numbered snap tag and inspected weekly by the licensed healthcare staff to confirm the kits have not been opened. If the kit has been opened, as evidenced by a snapped kit tag, the kit is inspected, restocked as

necessary, then secured with a new numbered snap tag. The program maintains one automated external defibrillator (AED) in a wall mounted cabinet in the locked medical clinic. The AED provides step-by-step audio instructions and written procedures are located in a binder under the AED bag within the wall-mounted AED cabinet. The AED batteries are due to expire in October 10, 2022 and were last changed August 14, 2017. The AED pads are due to expire on October 20, 2022 and were last changed August 14, 2017. The program conducts emergency medical drills monthly on each shift. A review of emergency drills for the prior twelve months confirmed emergency drills were conducted monthly on each shift and included a range of scenarios and the demonstration of cardiopulmonary resuscitation (CPR) in five drills on each shift. A review of seven staff training records supported each maintained a current certification in first aid and CPR. Training records supported supervisory staff were trained in assisting youth in self-administration of the Epinephrine Auto-Injector. Each registered nurse maintained current certification in CPR/AED and basic first aid. The program maintains a list of emergency telephone numbers, including the Poison Information Control Center, which is accessible to staff but inaccessible to youth. All seven interviewed staff reported they can call 9-1-1 if a youth has a medical emergency and those without direct access to a telephone would contact the supervisor or master control.

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 for the provision of off-site medical or emergency care and treatment. Evaluations conducted off-site are to be recorded on the Department's Summary of Off-Site Care form and stored in the Individual Healthcare Record (IHCR). The designated health authority (DHA) is to review, sign, and date the off-site care instructions. A review of seven youth IHCRs indicated five youth required off-site care and/or emergency care. Reviewed documentation validated each parent/guardian was notified, as required. The Department's Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the IHCR. Documentation supported the DHA reviewed each completed Summary of Off-Site Care form and associated discharge paperwork, as evidenced by the DHA signature and date. Two of the seven youth were applicable for required follow-up care and there was evidence the referrals were tracked, and the youth received the appropriate care, as needed. An interview with the program's director of nursing confirmed this practice.

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 to ensure youth identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards, but at least at the minimum of every three months. A review of seven youth Individual Healthcare Records (IHCR) indicated one youth was admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening form. Therefore, two additional applicable records were selected for review of periodic evaluation of chronic conditions. All three applicable youth were classified with a medical grade of two through five. All three youth were taking prescribed medication on an

ongoing basis and one youth was currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program tracks the youth requiring periodic evaluations on the Chronic Physical Health Conditions and Physical Disability form to include the youth's name, Department identification number, specific chronic health condition and next visit date. Reviewed records supported each youth received periodic evaluations, as required. There was no indication of lapses in care or missed periodic evaluations in the reviewed records. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. All three youth IHCRs documented the Department's Problem List was updated as changes occurred. The designated health authority (DHA) reported youth with chronic conditions are evaluated every three months and as needed. The DHA indicated a calendar is maintained for chronic clinic follow-up every three months to ensure youth are being evaluated in accordance to policy. An interview with the director of nursing confirmed this practice. An interview with the facility administrator (FA) indicated program management team, including the director of nursing or a healthcare representative, meet daily to discuss important youth medical issues. Additionally, the FA reported he meets with the DHA weekly for an update on the well-being and medical condition of the youth in the program.

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 which outlines the process for medications to be received, stored, inventoried, and administered in a safe and effective manner. Medications which arrive to the program with a youth shall be pursuant to a physician's order and verified by healthcare staff utilizing the Department's Prescription Medication Verification Checklist and noted in the chronological progress notes. The designated health authority (DHA), and when applicable, the psychiatrist, are contacted to obtain an order to resume/continue the specified medication prescribed prior to admission. The registered nurse (RN) completes the Prescription Medication Verification Checklist when youth are admitted with current prescribed medications ensuring all medications have a current and valid order and are given pursuant to a current prescription. A review of seven youth Individual Healthcare Records (IHCR) indicated four youth were admitted into the program on prescribed medication. A review of nursing Chronological/Notification Progress Notes confirmed the DHA and the psychiatrist were notified by telephone of each youth's admission providing a history, obtaining admission orders, and to continue the prescribed medications. In each instance, the RN completed the DHA Notification of Admission form documenting current medications, applicable chronic conditions, allergies, and medical grade. Documentation indicated the DHA or psychiatrist resumed the prescribed medication for each youth and reviewed Medication Administration Records (MAR) validated the continuation of medications. All four reviewed applicable youth IHCRs reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. The initial MAR for each record matched the medication(s) listed. The medications are maintained in blister packs documenting the number of pills in each prescription order. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventories of controlled medications are conducted by RNs. All four applicable reviewed MARs supported the youth received the medications, as

prescribed. Each youth's MAR clearly documented medication start and stop dates. The nurse initialed the MAR for each administered medication entry, and when applicable, the nurse and youth signed a Refusal of Care form indicating when a youth refused the medication. The refusal is documented on the applicable MAR with the youth initialing the MAR. There was no undocumented explanation for lapses or errors in medication administration observed. Nursing staff documented side-effect monitoring on each MAR each time medication was administered. A medication pass was observed during the annual compliance review. The medication cart was observed to be clean and well organized with youth-specific medications. The program's practice is to ensure the Six Rights of Medication Delivery/Administration is maintained for the youth, and interviews with three applicable youth validated the program's practice. The program maintains a written policy and procedures to ensure all controlled substances are inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program's procedures outline all controlled substances are to be maintained in a securely locked box, within a locked medication cart, located in a locked closet in the locked medical clinic which is inaccessible to youth. The program maintains a locked refrigerator in a locked closet in the locked medical clinic solely for the storage of medication. Seven youth were interviewed, and three reported medication is administered by the nurse, one reported mediation is administered by staff, and three reported not taking any medication. Seven staff were interviewed and all seven confirmed the nurse provides youth with medication.

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 requiring medical equipment classified as medications/sharps to be secured and inventoried using a routine perpetual inventory. All medications were securely stored in the medical clinic inaccessible to youth. The program's practice is for over-the-counter (OTC) medications to be inventoried using a perpetual inventory daily and verified weekly and reviewed documentation confirmed the practice. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly. Narcotics and other controlled medications are securely stored in a locked box located within the locked medication cart which is stored in a locked closet within the locked medical clinic. Reviewed inventories supported the program maintained daily, weekly, and monthly inventories of medications and sharps. Oral medications are stored separately from injectable and/or topical medications. The program maintains a locked refrigerator in a locked closet in the locked medical clinic solely for the storage of medication. The program securely stores sharps and syringes separately from medications. Observation was conducted of inventory counts of three OTC medications, three sharps, and two controlled medications. All inventories were validated as correct. 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 contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The consultant retrieves all expired medication, unused medication, disposal of narcotics, and other controlled substances at the end of the month for proper disposal. Reviewed documentation supports the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. All disposed medications are documented on the Consultant Pharmacist Monthly Inspection form and on the applicable

Controlled Medication Inventory Record in the disposition of remaining doses box. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Drug Buster Pharmaceutical Disposal System. The program reported not having any instances of inventory discrepancies.

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 requiring an approved written plan for infection control and exposure control to ensure staff, youth, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan addresses common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral and bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C, and Human Immunodeficiency Virus (HIV), infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other antibiotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The program's plan includes a comprehensive process for needle stick post-exposure evaluation. The plan includes risk assessment and methods of compliance. In the event of an incident, the facility administrator (FA) has a process in place to establish a separate record containing all documents for youth and staff who have experienced a facility or occupational exposure. The program's plan was reviewed and approved by the FA on August 1, 2020, and the designated health authority (DHA) on August 7, 2020. The program's registered nurses last reviewed the plan on August 1, 2020 or November 2, 2020. The program maintains procedures for staff adherence to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations. The program has obtained a significant amount of personal protective equipment (PPE) for use at the program. The program maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program reported applicable incidents to the Department's Central Communications Center (CCC) involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. A review of seven pre-service training records confirmed staff received training in the program's Exposure Control Plan/Infection Control Plan. The FA reported a copy of the program's Exposure Control and Infection Control Plans are maintained in the medical clinic and the FAs office. In addition, the FA confirmed the plan is reviewed with staff bi-annually as part of in-service training and a review by the program's director of nursing.

4.18 Prenatal Care/Education	Non-Applicable

The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.

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

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program maintains a written policy and procedures which assigns clinical responsibility to the designated health authority (DHA) for the provision of on-site medical services to youth in the program. Daily clinical care is performed by licensed registered nurses (RN), in accordance with developed authorized protocols. An interview with the program's medical staff confirmed this practice. At the time of the annual compliance review, the program had three RNs, including the director of nursing. Reviewed documentation confirmed each licensed nurse holds an unrestricted clear and active license in the State of Florida. A review of all nurses training records confirmed each nurse maintains a current cardiopulmonary resuscitation (CPR) certification.

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 maintains a written policy and procedures requiring all program staff to promote 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 observing behavior of youth, and consistently applying the program's behavior management system (BMS). The program has a daily youth activity schedule which was posted throughout the program. The program staff are required to account for the whereabouts of youth under their supervision and ensure staff-to-youth ratios are compliant with contract requirements. The program's contract requires staff-to-youth ratios to be one-to-eight during awake hours and one-to-twelve during sleep hours. The ratio for off-site activities, transportation, and visitation is one staff to five youth. In an informal interview, the assistant facility administrator stated the driver is not considered as part of ratio when transporting youth.

Observations of staff supervision for four days during the annual compliance review week included classroom activities, line movement, school breaks, youth head counts, youth using Class B tools, mental health groups, and outdoor recreation activities. The observations ensured staff-to-youth ratios were maintained as required. A check of fifteen cars in the program parking lot verified fourteen cars were locked and one was unlocked. A program tour of the facility verified, the facility and dormitories were clean, well maintained and graffiti free. There were no unsecured chemicals and tools. Staff and youth were appropriately attired. The facility administrator (FA) reported the program has 102 security cameras, and all cameras were in working order. During outdoor activities and/or movement, observations showed staff were strategically positioned to ensure proper supervision of youth and to ensure there were no physical obstructions in their view of the youth. Observations of interactions between program staff and youth reflected the interactions were positive and consistent with the program's BMS. Seven formally interviewed staff explained youth counts are conducted every hour, if there is a discrepancy in the count, all movement stops, and an emergency count is conducted.

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

The program has a 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 rules, 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. Review of the BMS confirms 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 does have an agreement with the Palm Beach County School District related to the BMS and documentation provided indicated the teachers were trained on November 3, 2020, by the training manager. A review of seven pre-service training records confirm each of the staff were trained on the program's BMS. Youth learn about 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. In addition, the parent/guardian handbook includes a description of the BMS. A review of seven youth case management records indicated each youth participated in orientation upon arrival to the program and received a copy of the youth handbook. Observations found the BMS was posted throughout the facility. Observations during school hours of staff and youth interactions verified staff were 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 included not earning points, losing a spot of the football team, not being able to purchase items from the canteen store, and/or having an emergency treatment team. Seven youth were interviewed about the rewards used in the program. Each youth stated they can receive a later bedtime, use of the game room, purchases from the canteen store, use of the music studio, and the good citizen awards. Seven interviewed staff explained the BMS consists of a level system where youth earn points and rewards and consequences are based on the youth's behavior. All seven staff stated the BMS is located in the youth handbook and posted throughout the facility. All seven interviewed staff stated youth can earn points to buy items from the canteen store, play video games and have extra telephone time. Each staff stated nothing can be taken away from the youth as a consequence. An interview with the FA indicated the program utilizes a system which consists of five levels. The FA was able to explain all of the levels of the BMS and how youth move from level to level.

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). 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. 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 by the training manager. Seven youth were interviewed, and each youth had a good understanding of how to earn points and advance through the different levels. Six of seven interviewed youth indicate they are never allowed to punish other youth. One interviewed youth stated if a youth starts a fight with him, they come off restriction before him and have no additional consequences. Seven youth were interviewed and two rated the BMS as very good, one rated it as good, three rated it as fair and one youth rated it as poor. Six of seven youth were interviewed and explained staff are consistent with rewards because all youth are treated the same. One youth stated staff do not always tally the behavior points correctly. The youth's concerns were discussed with the assistant facility administrator (AFA). The youth's concerns were discussed with the assistant facility administrator (AFA). A random review of seven staff position descriptions indicated the 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 allowed to explain their behavior during the daily behavior report reviews or during treatment team. All seven interviewed staff stated they receive feedback on the implementation of BMS during daily briefings, or one-on-one coaching. An interview with the facility administrator (FA) indicated the BMS is monitored on a weekly basis by the designated mental health clinician authority (DMHCA) who notifies the FA of all issues which presents itself through the week with completion of the point sheets pertaining to youth's performance which includes rewards and consequences.

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

The program has a written policy and procedures in place to conduct and document ten-minute checks during sleep hours, or at other times, such as during an illness or room restriction. 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 to 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 when youth are sleeping. A review of six ten-minute checks, from six different days and from four different dorms, verified staff were conducting checks every ten minutes and documented the times accurately in the ten-minute check logbook. Seven interviewed staff verified room checks were conducted every ten minutes when a youth is placed in their room for sleeping or 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 maintains a written policy and procedures to ensure youth are always accounted through a system of physically counting youth at various times throughout each day. The program conducts formal head counts each hour and after outdoor activities. The program's policy indicates counts are conducted during power outages, escapes, program disturbances or any other disruptions which may occur. A review of randomly selected dates and times in the facility logbooks for the previous six months validated head counts and movements were conducted at the beginning of each shift, after outdoor activities, during emergency situations such as program disturbances and during drills, (actual or simulated). In addition, the program logbooks included documentation of new admissions, releases, transfers and youth temporarily away from the program. An informal interview with the assistant facility administrator (AFA) verified there were no youth temporarily away from the program during the annual compliance review. Observations made during the annual compliance review week indicated it is the program's practice to conduct hourly youth counts. Seven interviewed staff explained formal counts are conducted every hour and if there is a discrepancy in the count, all movement stops, and an emergency count is conducted.

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 maintains a written policy and procedures to ensure the maintenance of a chronological record of events, incidents, and activities in a central logbook. The program maintains a bound logbook with numbered pages for each month. Observations and review of logbooks for the previous six months found logbook entries were documented in ink with no erasures or white-out areas. Errors were typically struck through with a single line, dated, and initialed by the person correcting the error. Reviewed documentation of randomly selected days within the logbooks reflected each entry included the date and time of the event, the name of

the staff and youth involved, as well as a brief description, the name, and signature of the staff making the entry. Logbooks included entries for emergency situations, population counts, law enforcement access to youth, perimeter checks, and youth movement. In addition, admissions and releases were documented as well as transports away from the program. The program ensures direct care staff, including each supervisor, are briefed when coming on duty. Each staff signs the shift briefing sign-in sheet to acknowledge receiving the information. Reviewed logbooks reflected they consistently documented internal incidents reported to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC).

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 maintains a written policy and procedures for key control and security which includes assignment, inventory, tracking, and storage of keys. The system includes key assignment with restrictions on usage, inventory and tracking of keys, secure storage, and procedures for addressing and reporting missing and/or damaged keys. The maintenance manager has overall responsibility for key control management, which includes replacing a damaged key. Observations made throughout the annual compliance review week found all staff and visitors surrendered their personal keys to sub control upon entering the facility. Staff's and visitor's personal keys are collected upon the individual entering the program and stored in a locked cabinet in sub control. Facility keys are located in a locked box in phase one master control and phase two master control. 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 key logbook. A review of the six months key logbook entries verified the program's practice. The program 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. All key rings are tagged to record the ring number, keys assigned, and number of keys on the ring. A random review of three staff and their permanently assigned keys matched the permanent key log. The program reported not having any lost keys in the last six months. Interviews with seven staff confirmed each was knowledgeable of the key control process including how keys are assigned as well as 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 maintains a written policy and procedures to identify materials considered to be contraband, to prevent contraband from entering the facility and consequences when found in the possession of youth in the program. The program's youth handbook includes a list of contraband items and informs youth of the consequences if found with contraband. Each youth is provided with a written copy of the youth handbook upon admission into the program and each are oriented to the program rules including the list of items considered to be contraband. The program's policy and youth handbook included all items considered contraband as outlined in Florida Administrative Code. The list of contraband items included personal cellular telephones and/or equipment or electronic devices capable of taking pictures or video recordings, as well as smart watches, which are prohibited. The program's policy specifies the manner in which any unauthorized or contraband item is to be disposed, to include return to the sender, mailed to the youth's home, returned to the youth upon release, or in the case of illegal contraband, turned over to law enforcement. Unannounced room searches are conducted at least weekly at irregular and unpredictable times and common area searches are conducted daily. A review of shift reports, the master control logbook, visitation forms, and common area search forms validated the program's practice of consistently monitoring areas of the facility, grounds, and youth rooms for contraband. The program's policy requires case managers to inspect all outgoing and incoming correspondence in the presence of the youth for unauthorized items, contraband, or information which may breach the security of the program. The program's policy and procedures, with orientation training provided to all new staff stipulates staff found in possession of contraband will be subject to disciplinary action up to and including dismissal. All instances involving confiscation of illegal contraband require the program to turn the item over to local law enforcement authorities and file a criminal report. The interviewed facility administrator (FA) confirms if any contraband is discovered at the facility, it is immediately removed and forwarded to the FA or assistant facility administrator (AFA), who will then make the required notifications. Youth will receive a behavior report and special treatment team if found with contraband. Contraband will then be forwarded to the facility investigator and held for 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 maintains a written policy and procedures to ensure searches, and full body visual searches, are conducted according to Florida Administrative Code at the time of admission, after off-campus activities, and visitation. Parent(s)/guardian(s) are notified of searches during visitation by way of the parent/guardian intake letter, which is mailed at the time of each youth's admission. Youth are searched after school, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus activities and/or appointments, suspected of contraband, or are a security risk are searched, as validated by a review of program search forms. Observations made throughout the annual compliance review week validated youth are provided instruction regarding the search, youth searches were conducted by staff of the same gender as the youth, were conducted in a manner so as not to degrade the youth and were based on the Protective Action Response (PAR) training manual. Searches observed during the annual compliance review week verified youth were searched after every movement. During the annual compliance review, full body visual searches were not observed due to no transports, new admissions, visitations and/or off campus activities scheduled. Seven staff were interviewed, and each stated youth are searched after every movement by same gender staff. Seven youth were interviewed, and all indicated searches occur during all movement, when items are missing, after visitation and when returning from off-site activities.

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 three transport vans but mainly uses one van to transport youth due to reliability issues. transport vans but mainly uses one van to transport youth due to reliability issues. All three vans received an annual safety inspection. Documentation provided verified all three vans have extensive maintenance and repair invoices. Two vans were inspected during the annual compliance review, one van was at the mechanic shop for repairs. Each inspected van had a safety screen separating the front seat from the rear passenger's compartment, all the seat belts were working, and the passenger doors could not be opened from the inside. Each inspected van included a fire extinguisher, seat belt cutter, first aid kit, and window punch. The two inspected vans were in poor condition. Each of the vans had extensive rust damage on the roofs. Van number two had torn seats and damaged rear-view mirror. In an informal interview, the assistant facility administrator stated the Department approved the replacement of the vehicles in February 2020; however, the vehicles were not delivered as of the annual compliance review week. Random observations of fifteen staff personal vehicles indicated one was found to be unlocked. Random observations of fifteen staff personal vehicles indicated one of the two vans was found to be unlocked This incident was

brought to the program's attention, the appropriate staff were notified, and the vehicle was secured.

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

The program maintains a written policy and procedures to ensure the safety and security of youth and the community when youth are transported outside of the facility. Reviewed documentation verified all approved drivers had a valid driver's license. The program assigns a ratio of one staff to five youth during transport, not including the driver. The program provides secure transportation for high-risk and secure maximum risk youth determined to be at greater risk. Observations of a transport could not be conducted because there were no transportations scheduled during the annual compliance review week. Seven staff were interviewed, and all verified they use a cellular telephone during transports. An informal interview with the assistant facility administrator (AFA) confirmed dedicated transportation staff use their personal cellular telephones during transportation of youth, staff use their personal cellular telephones during transportation of youth, , staff and youth always wear seatbelts and youth are never left unsupervised in the vehicle. Six out of seven interviewed staff stated the safety equipment in the transport vehicles included a first aid kit, seat belt cutter, fire extinguisher, and window punch. One staff was not sure which safety equipment is included. All seven staff confirmed they are not allowed to use personal vehicles to transport youth. Each staff interviewed stated the transport vehicles are searched for contraband prior to and after each use. Each interviewed staff stated they would call 9-1-1 and/or contact the program if an emergency response arises during vehicle transport. Seven interviewed youth stated they never witnessed anyone placing contraband in a transport vehicle and they indicate staff are driving transport vehicles safely.

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

The program maintains a written policy and procedures requiring a safe and secure physical plant, grounds, and perimeter to be maintained and for weekly safety and security audits to be conducted. The program's facility administrator (FA), assistant facility administrator (AFA) or the maintenance manager are responsible for conducting weekly safety and security audits and submitting them to the Department. Identified deficiencies were documented on the reports, including the status and due date of any needed corrective action, and were added to the program's tracking document. 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 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 FA indicated the program conducts weekly safety and security inspections and report it to the Department's inspection auditor. All safety and security deficiencies are then issued responsibility and time frames for issues to be addressed. The program receives visits and follow-ups from the Department's inspection auditor to ensure compliance.

The program receives visits and follow-ups from the Department's inspection auditor 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 maintains a written policy and procedures to have a tool management system which ensures youth do not use tools or equipment as weapons or for security breaches. The policy addresses the issuance, inventory, and control of equipment and tools. A review of inventory logs and the tool storage room located in the maintenance shop, verified tools are securely stored when not in use, easily marked for identification, inventoried prior to and following work activities. All sharp edged and pointed tools are inventoried daily when in use. The maintenance staff are responsible for conducting the inventories and securely maintaining all Class A tools and equipment. The maintenance staff completes a Daily Tool Log Inventory List which documents each tool in inventory. All maintenance tools were inaccessible to youth and were observed to be secured in the maintenance shop. Tools were primarily stored using a shadow-board system within the locked maintenance shop and were marked for easy identification. Observations of the tool storage area found it was well organized and secure. Class B tools, including mops, brooms, and buckets are maintained in a locked closet which is inaccessible to the youth. The items are used by staff and youth when performing daily cleanup activities. Staff are required to complete a sign-out and sign-in log when items are taken and are returned to the designated storage room. A review of seven staff training records and seven youth case management records indicated staff and youth are trained in the safe use of Class B tools. In addition, a Youth Risk Assessment is conducted monthly by the case manager in order to qualify youth to use Class B tools. Youth are not permitted to use Class A tools. There was no instances of missing or lost tools for the last six months. Prohibited tools at the facility include machetes, bowie knives, and other long bladed knives. If a tool is broken or inoperable, the maintenance manager is responsible for replacing the broken tool. If a tool is missing, staff will notify administration, the program will stop all youth movement, a red tag is placed on the shadow board, and the program will be searched until the tool is found. All seven interviewed staff stated youth can use brooms and mops. In addition, two staff stated youth can use scrub brushes.

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 maintains a written policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries. A review of the program's procedures verified staff are required to complete a sign-out and sign-in log when Class B tools are taken and are returned to the designated storage room. A Youth Risk Assessment is conducted monthly by the case manager for youth to use Class B tools. Seven youth case management records were reviewed, and each youth had a Youth Risk Assessment completed by the case manager. The program staff-to-youth ratio during a work project is no less than two staff to five youth. Program staff search youth after a work detail has been completed. An observation of a youth cleaning was conducted by viewing camera footage. The youth was properly supervised while sweeping and searched after the job was completed. Seven youth were interviewed, and all responded they use mops and brooms with four youth indicating they also use scrub brushes.

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 are provided a contract agreement form which indicates a list of 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 of the contractor's agreement forms contained an inventory of the tool used for the repairs and their signature. An informal interview with the assistant facility administrator (AFA) 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 completed and all tools are secured.

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 maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on March 13, 2020, and a written policy and procedures to ensure drills are consistent with the program's COOP. The COOP requires the program to conduct unannounced fire drills once every month for each shift. Reviewed documentation validated fire drills were conducted for all shifts each month, as required. In addition, the program conducted monthly emergency drills on each shift ensuring fire, severe weather, disturbances, escapes, medical situations, and active shooter were covered on a rotating basis. Drill documentation included the type of drill, date and time, participants, a brief scenario description, deficiencies identified during the drill, and applicable corrective actions. The program reviews and debriefs staff on how well drills were conducted during the monthly all staff meetings. The fire evacuation routes are posted throughout the facility. All fire extinguishers were inspected annually. The fire marshal conducted a fire safety inspection on December 23, 2019.

Six of seven interviewed staff all reported they had participated in a fire drill during the previous twelve months. Two staff indicated their participation in suicide drills and five staff participated in medical drills. Two staff reported taking part in drills related to severe weather. One staff indicated they participated in an escape drill. All seven interviewed youth responded fire drills are conducted once a month. Six of seven interviewed youth stated they had participated in fire drills and have been instructed as to what to do in the event of a fire. One interviewed youth stated they did not participate in fire drills but acknowledged fire drills are held monthly. An interview conducted with the facility administrator (FA) confirmed the program conducts monthly COOP drills on all shifts, additionally the program conducts monthly fire drills, monthly medical drills, and quarterly mental health/suicide drills for all shifts.

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

The program maintains a Department approved Continuity of Operations Plan (COOP) available for all staff to review. The facility administrator (FA) was interviewed and indicated the COOP is available to all staff and is located in the administration building and in master control. The plan was approved by the Department on March 13, 2020 and provides for basic care and custody of youth in the event of an emergency or disaster. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery.

The COOP addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing has been identified should the program require evacuation due to an emergency or disaster. Reviewed documentation confirmed the program maintains critical identifying information in hardcopy binders including case management, mental health, and medical. The program's hard copy records are easily accessible and mobile in the event of an emergency resulting in the program relocating quickly or in the event needed information cannot be accessed electronically for all youth in the program. A review of seven hard copy records found each contained all required elements. An informal interview with assistant facility administrator verified there is a generator which powers the facility for continuous operation and services during emergency or disaster situations.

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 maintains a written policy and procedures specific to the storage and inventory of flammable, poisonous, and toxic items and materials which requires a perpetual inventory system to be maintained and current. Youth are prohibited from locations where toxic items and chemicals are stored. Toxic items 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 hazardous chemicals 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 maintenance manager is responsible for the inventory of toxic 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 are 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 maintains a policy and procedures prohibiting youth from handling any flammable, poisonous, and/or toxic items or materials. Youth are not to clean, handle, or dispose of any toxic, bio-hazardous bodily fluids, or human waste. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. Six of seven interviewed youth stated they do not handle any chemicals and/or cleaning products. One interviewed youth stated they use floor wax, bleach, laundry soap, and cleaners. Three interviewed youth stated staff apply the cleaning chemicals and youth wipe it up. One interviewed youth stated youth spray the chemicals and wipe it up. A follow up interview with the assistant facility administrator (AFA) verified youth do not handle chemicals and/or cleaning products. An observation by security video of the youth sweeping the classroom confirms the youth did not use any chemicals. A review of the program's preventative maintenance checklist verified maintenance schedules, and repairs are being conducted as outlined in Florida Administrative Code 63E-7.109.

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 maintains a written policy and procedures for the disposal of toxic and/or hazardous materials. The policy requires adherence to procedures in accordance with Occupational Safety and Health Administration (OSHA) federal regulations. An interview with the assistant facility administrator (AFA) indicated the program utilizes Household Hazardous Waste for the disposal of toxic or hazardous materials. 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 kitchen grease and waste on a quarterly basis. The program maintains a policy and procedures regarding chemical spills which are reported immediately 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 AFA, the program has not had a chemical spill since the last annual compliance review. An interview with the FA indicated the program has 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 maintains a written policy and procedures to ensure youth are provided the opportunity to receive visitation and communication with approved family members. During admission, each youth is provided with the program's visitation, telephone, and mail policies and

guidelines. The program's visitation policy indicated consideration for requests of alternative visitation arrangements with parent(s)/guardian(s), if needed. Visitation is held in on Saturdays and Sundays from 1:00 p.m. to 4:00 p.m. Due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control (CDC) on-site visitation was been suspended at the Department's direction on March 13, 2020; however, visitation resumed on August 2020. Youth can write letters or make telephone calls at least once a week to approved family members. A review of the telephone and mail log verified youth have consistent communication with family members. Seven reviewed youth case management records documented each youth signed acknowledging the receipt of information concerning visitation, telephone, and mail procedures upon admission. According to the assistant facility administrator, all incoming and outgoing mail is checked for contraband in the presence of the youth. The program contacts the youth's juvenile probation officer (JPO) to verify the youth's parent/guardian and other family members are not under current or past investigation for youth with a history of human trafficking. The program posted visitation schedules and rules at the front of the facility outside the administration building. Six of seven interviewed youth reported they have been provided opportunities to communicate with their family members by mail, telephone, and/or at visitation. One interviewed youth stated they did not have an opportunity to communicate with their family members; however reviewed case notes in the Department's Juvenile Justice Information System (JJIS) verified the youth's parent/guardian participates in the youth's treatment team meetings.

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

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