STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Palmetto Youth Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
14494 Harlee Road
Palmetto, Florida 34221

Review Date(s): October 1-4, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Jonathan F. Thompson, Office of Program Accountability, Lead Reviewer (Standard 1)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 1)
Edia Ghnaim, Charles Britt Academy, Registered Nurse (Standard 4)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 2)
Amanda Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Joey Nice, Office of Education, Education Coordinator (Standard 2)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 5)
Sherri Wilson, Office of Program Accountability, Technical Assistance Specialist (SPEP)

Program Name: Palmetto Youth Academy
Provider Name: TrueCore Behavioral Solutions
Location: Manatee County / Circuit 12
Review Date(s): October 1-4, 2019

MQI Program Code: 1139
Contract Number: 10144
Number of Beds: 48
Lead Reviewer Code: 176

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
4.15 Medication Management	
5.04 Ten Minute Checks *	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Non-Applicable
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	Limited
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Palmetto Youth Academy is a forty-eight-bed program which services fourteen to twenty-one-year-old males, located in Palmetto, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides an array of substance abuse overlay services (SAOS) and evidence-based programs such as Thinking for Change (T4C), Living in Balance, Impact of Crime, and Life Skills Training, as well as Cannabis Youth Treatment. In addition, the program fosters each youth by providing gender-specific programming using the Young Men's Work. Program administration is comprised of a facility administrator and an assistant facility administrator. Case management services are provided by a director of case management and three case managers. Mental health staff at the program includes a psychiatrist, a designated mental health clinician authority, a licensed mental health professional, and three non-licensed mental health and substance abuse therapists. Medical services are offered seven-days a week, 7:00 a.m. to 7:00 p.m., and services are provided by three registered nurses and a medical doctor. Educational services are provided by TrueCore staff through an agreement with the Manatee County School District. Palmetto Youth Academy's campus consists of the main building which includes all administrative offices, three living units, medical clinic, three educational classrooms, and a fully functioning kitchen. There is a sally-port located in the secured area behind the kitchen. There are two basketball courts along with three small recreation areas outside of each dormitory. The entire program has a fence secured with no-climb on the upper half with razor wire attached at top. The program monitors security of the program by utilizing thirty-two security cameras.

Strengths and Innovative Approaches

- The program offers Health Fathers/Healthy Families for youth during their stay. The Jewish Family and Children's Services has a partnership with the program to provide programing with focus on fatherhood/parenting classes. Classes meet weekly for thirteen weeks in duration. The curriculum is evidence-based for nurturing skills for families.

- Manatee County multi-agency has a reentry initiative to address issues to ensure youth offenders are reintegrated back into their community successfully. The plan is to create a foundation to guide policies and service for youth transitioning from residential programs into the community with general outcome goals of reducing recidivism, improving public safety, and assisting individuals in transitioning back into society.

- The program offers Minds in the Making, which is an initiative to share science of children's learning with the general public, families and professionals who work with children and their families.

- McDonalds the Casper Company conducts motivational presentations to the youth covering life skills issues and employment expectations. The company also provided seventy-five free meal cards to be used as a part of the reward incentive for the positive performance system.

- The program works in correlation of the Manatee Sherriff's Department in the development of a horticulture project with youth.

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 policy and procedures to address required background screenings upon hire. A supplemental visit was conducted during the annual compliance review period on August 7, 2019 and twenty-seven new hires were applicable for an initial background screening. The supplemental visit resulted in three discrepancies and the opening of a minor deficiency due to the findings. The first verification for this deficiency was conducted on September 16, 2019 and four personnel were applicable for background screenings. In all four cases, the background screenings were completed prior to the hiring date and completion of on-the-job training. The minor deficiency was closed on September 24, 2019 as it was determined the program exhibited a standing practice while gaining compliance with background screenings. From closure date of the first verification on September 24th to the first day of the annual compliance review, there were no new hires. Therefore, no applicable background screenings were required at the time of the annual compliance review. Review of the twenty-seven records verified each of the employee records contained a copy of the pre-employment assessment tool, as well as the passing score. All the staff were included on the Department's Background Screening Unit (BSU)/Clearinghouse employee roster. 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, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS). The program submitted an Annual Affidavit of Compliance with Level 2 Screening Standards for to the Department's BSU on December 3, 2018, meeting the annual requirement.

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 policy and procedures to address 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. A supplemental visit was conducted during the annual compliance review period on August 7, 2019, in which, one staff was applicable for five-year rescreening. A rescreening/resubmission was submitted to BSU/Clearinghouse at

least ten business days prior to the five-year anniversary or retained prints expiration date. There were no employees requiring a five-year rescreening from August 7, 2019 to the annual compliance review date, therefore, no new five-year screenings were required at the time of the annual compliance review. Additionally, there were no volunteers eligible for a five-year background rescreening.

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

The program has a policy and procedures for abuse reporting and for providing an abuse-free environment. The policy reflects youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. All staff sign the Department's Code of Conduct and Ethics training upon hiring by utilizing the electronic Departmental on-boarding program and training system. A facility tour was conducted and postings of the Florida Abuse Hotline and Central Communications Center (CCC) telephone numbers throughout the program were observed. The program's policy clearly outlines reporting procedures for all staff in the event of a youth reporting abuse. A resident handbook includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC telephone numbers is provided to each youth upon admission. The facility administrator stated youth have unimpeded access to the Florida Abuse Hotline and the CCC for youth who are eighteen years of age. If a youth requests to call the Florida Abuse Hotline, the youth care worker radios for a team leader, and the youth is then taken to a telephone where they may make the call in private. The program completed a yearly Trauma Informed and Caring Environment (TRACE) self-assessment on March 15, 2019 which includes surveys geared to gauge the progress in implementing a trauma-responsive approach and caring environment for youth and staff.

Documentation within the last six months was reviewed for allegations of abuse to the Florida Abuse Hotline or CCC and two reports alleging abuse were found. In both cases, reviewed documentation confirmed a report was made by staff to the CCC within two hours of staff being

made aware of the incident. In both cases, management took immediate action to gather the facts concerning the allegation and determined during the investigation both allegations were unsubstantiated. A child protective investigator reported to the program to follow-up on the allegation and the investigator advised there were no signs of abuse, and there were no findings of abuse. Seven interviewed staff, as well as an interview with the facility administrator (FA) confirmed the program's abuse reporting practice. Seven interviewed youth reported feeling safe in the program and indicated all staff are fair and consistent in their treatment of the youth. Each youth reported never being denied access to contact the Florida Abuse Hotline but they confirmed staff would ensure them the opportunity to call if needed.

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

The program maintains a written policy and procedures which address management's response to allegations. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) found the program had two incidents concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. Documentation confirmed a call was made by staff to the CCC within two hours of staff being made aware of the incident. Reviewed documentation for the incident reflected management immediately initiated an internal investigation and took appropriate precautions until findings of the cases were determined. Only one of the two incidents required law enforcement intervention to investigate the claim and law enforcement agreed with the internal investigation findings. During an interview with the facility administrator (FA), it was reported staff are trained on incident reporting as part of their pre-service training. An interview with the facility administrator (FA) indicated there was one staff disciplinary action due to allegations of abuse towards a youth in the program since the last annual compliance review.

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

The program maintains a written policy and procedures to address reporting incidents occurring at the program to the Department's Central Communications Center (CCC). The program had twenty-three incidents reported to the CCC during the last six months, of which five were reviewed. The reviewed documentation validated each incident was reported to the CCC within the mandatory two-hour timeframe and in accordance with CCC reporting procedures. Four of the five reviewed CCC's required an accompanying logbook entry and all four were properly documented. A comparison of reportable incidents during the last review period showed an increase of the reportable incidents from eleven incidents during the previous review period, to twenty-three incidents this year. Program administration attributed the increase to high employee turn-over, influx of medical CCC's, and older youth who are more experienced with the Department's reporting system. The program's facility administrator stated all youth are explained their rights and how to report abuse during their orientation.

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

The program has a policy and procedures regulating the employment of Protective Action Response (PAR) tactics on-site. The program's PAR plan was submitted and approved by the Department's Office of Staff Development and Training on December 21, 2018. The program had three PAR reports since the last annual compliance review, therefore, the minimum sampling of five PAR reports could not be met. All three reports reflected a review by a PAR-certified instructor, reports were processed within the seventy-two-hour required timeframe by all required parties, and a post-PAR interview was conducted within thirty-minutes of each incident. A review of the PAR incident reports and comments by the facility administrator (FA) or designee within seventy-two hours of the incident, was found in each PAR report. Two of the three PAR instances required a medical PAR report and both cases they were properly completed. Each report was examined by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. None of the three PAR incidents included the use of mechanical restraints. The program's PAR rate has decreased since the last annual compliance review. The program's PAR rate during the annual compliance review period was .72 which is below the statewide Residential PAR rate of 1.69. An interview with the FA indicated PAR incidents are documented in the facility logbook, discussed with management team during the daily meetings, and a PAR report is completed for each PAR incident which is maintained in a binder organized by month.

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 has policy and procedures addressing pre-service training. The program utilizes a pre-service training plan curriculum for all new staff which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. The fourteen-day pre-service training is facilitated to new employees by utilizing a combination of instructor-led, web-based courses, and on-the-job training. Seven staff training records were reviewed for pre-service training. All records reflected staff completed the certification process within 180 days of hire and completed all required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. Additionally, a review of all seven staff training records showed documentation to support each staff exceeded the required 120 hours of pre-service training. All seven members reviewed reflected the full fourteen days completion of pre-service training documented within the Department's Learning Management System (SkillPro) which met the contractual requirements for training.

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 policy and procedures which governs annual in-service training. The program has an in-service annual training plan which was submitted and approved by the Department's Office of Staff Development and Training on April 12, 2019. Reviewed documentation confirmed the training plan is a fluid document which is updated as changes occur. Seven staff training records, including three supervisory records, were reviewed for completion of in-service training and all staff had current certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). Each of the seven staff exceeded the twenty-four hours of required in-service training. Managerial staff are contractually required to complete eight hours of management training and twenty-four hours of in-service training. All three supervisors reflected the required amount of training in the Department's Learning Management System (SkillPro). The program has two licensed nursing staff and both have a current certification in both cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) techniques.

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

The program has a policy and procedures which regulates training and implementation requirements regarding the grievance process. The policy explains the grievance process is threefold (informal, formal, and appeal). The informal phase is accomplished through a "Can We Discuss" form which is checked each shift by supervisors. If the informal stage does not gain resolution, then youth may progress to the formal stage by filling out the formal grievance form. Supervisors have seventy-two hours to review, investigate, and respond to the youth. If resolution is not achieved with the supervisor, then the youth may pursue an appeal which will be fielded with the assistant facility administrator who serves as the facility grievance officer. The final stage of the grievance lies with the facility administrator (FA) who must respond within seventy-two hours of receiving the grievance. The program grievance binder is sorted by months of the year and each month has a dedicated grievance log along with the grievances filed for each month. There were forty-eight total grievance filed since the last review period, of which, a random sampling of five were reviewed. All five grievances were resolved during the formal phase and within seventy-two hours of the youth filing the grievance. Seven youth were interviewed and were able to explain the process for completing a grievance and thee timeframes in which the grievances are to be handled. The seven reviewed pre-service training records confirmed all staff received grievance process and procedural training as required. Seven staff were interviewed and explained the process when youth request for a grievance, aid in completing the grievance form if needed, and the timeframes in each phase. The FA interview

provided confirmation on the processing of grievances to include all three phases and the timeframes associated with each phase.

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

The program provides contractually prescribed evidence-based practices, promising practices, and practices with demonstrated effectiveness groups to youth. These services include; Thinking for a Change (T4C), LifeSkills Training (LST), Pathways to Self-Discovery and Change, Boys Council, Living in Balance, Anger Management, Don't Let Your Emotions Run Your Life, Teen Relationship, Seeking Safety, Impact of Crime (IOC) and Cannabis Youth Treatment (CYT) intervention curriculum. A review of the program's activity schedule and an observation of groups conducted at the time of the annual compliance review confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. Group sessions are held daily and are one hour in duration. A review of the group sign-in sheets validated groups were delivered as scheduled. The facility administrator and staff training records identified ten staff who were trained by a certified trainer to facilitate groups. An interview with the clinical director confirmed youth are matched with clinicians based on the youth's individual needs identified in the pre-classification meeting during the youth's admission. The pre-classification meeting involves consideration of intake information, assessments, youth and parent/guardian input, departmental head reports on interaction with the youth, security risk, medical risk, and staff experience. Youth are matched to the proper evidence-based, promising practice, or a practice with demonstrated effectiveness which is best geared to address youths' individual criminogenic needs as outlined in the youth's treatment plan. Youth have the opportunity to demonstrate skills during treatment team meetings and through interactions with other youth and staff.

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

The program provides life skills training through LifeSkills Training (LST) and Living in Balance curriculum. The curriculum includes decision-making, problem-solving, critical thinking, interpersonal relationships and interactions, non-violent conflict resolution, and anger management training. A review of the program's activity schedule confirmed groups are provided to the youth as scheduled. A review of seven case management records and the corresponding group sign-in sheets indicated services are delivered, as required, and confirmed each youth participated in LST. All staff facilitating groups received formal training and on-the-job training to deliver these groups. Five interviewed youth indicated they learn anger management, coping skills, staying drug free, think before acting, stress management, separating from negative peers, and can use the skills they learn in their daily interaction.

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 provides restorative justice activities through the Impact of Crime (IOC) curriculum. The curriculum includes victim impact, restorative justice, personal accountability, introduction to harm, consequences of making decisions, personal accountability, managing conflict, the road to reparation, and the impact of crime on victims, families, and the surrounding community. The reviewed documentation reflected IOC groups occur twice a week for one hour in duration. Review of the daily schedule and group sign-in sheets indicated groups are held on-site as outlined. Other restorative justice efforts include a guest speaker who was a victim and speakers with previous criminal history. The program also has a partnership with Manatee County CareerSource to provide internships for youth and work experience compliment the IOC curriculum. A review of seven case management records and group sign-in sheets indicated services are being delivered, as required. All seven interviewed youth reported they participated in IOC group and were able to explain what they do in groups.

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.	

All youth in the program participate in Young Men's Work groups, which is an evidence-based gender-specific curriculum educating the youth in the areas of equality, violence, drug use, role modeling, peer selection and leadership development skills. The classes are geared to open youth's perception on different ways to look as a situation, what they believe, and gives hope youth can influence change to their circumstances by making weighed decisions instead of emotional responses. Seven case management records were reviewed and confirmed all youth were participating in Young Men's Work groups twice a week, for one hour in duration, and were offered as the program's activity schedule specified. During the annual compliance review week, a group was observed, and the therapist facilitated the group, as required, by the curriculum. All seven interviewed youth reported they are actively participating in groups.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance

The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status.

When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.

The program maintains a policy and procedures regarding security, medical, and mental health alerts to ensure all staff are made aware when medical or mental health issues exist which may affect the security and safety of the youth in the program. The program's policies regarding alerts detail the alert system, how and when management reviews the alerts, who is responsible for updating the Department's Juvenile Justice Information System (JJIS), and how staff are informed of youth alert updates. The program utilizes the JJIS daily youth detail report to capture all open alerts and alert updates on youth in the production of their internal medical alert log, chronic conditions listing, and their master alert board located in the conference room. Reviewed documentation indicated the program's internal alert information is actively reviewed daily, during shift briefings, and by the program's supervisory staff. Seven youth records were reviewed for case management, medical, and mental health and substance abuse alerts, and all applicable alerts were accurately entered into JJIS. Discontinued or downgraded internal and JJIS alerts must be approved by medical staff, the program's assistant facility administrator (AFA), and/or a licensed mental health staff. Seven staff were interviewed and all reported they are informed of youth alerts during shift meetings, and they can review the program's alert board for youth alerts in the conference room.

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 individual healthcare, mental health and substance abuse, and case management records for each youth. All seven reviewed case management, healthcare, mental health, and substance abuse records were marked "confidential" and each record contained all of the required documents. The case management records contained all required documentation on the spine and front of the binder, including each youth's name, Department Identification Number (DJJID), date of birth, county of residence, date of admission, and committing offense. The documents were organized into the required sections. All case management records, mental health and substance abuse records, and healthcare records were secured inside in a file cabinet in a locked room, when not in use. The program's file cabinets were marked "confidential."

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

The program promotes the gathering of constructive input from youth by using multiple feedback platforms. The program has a youth advisory board which allows youth to provide feedback through monthly meetings. There is a youth president to provide input and to address their needs during the youth advisory board meetings. The program maintains a binder of youth advisory board meeting minutes with agendas and sign-in logs. The program also utilizes multiple feedback platforms to gather youth input which include quarterly youth surveys, and youth and parent/guardian entrance and exit surveys. Survey results are sent to the corporate office, formally reviewed and discussed during morning management meetings and monthly all staff meetings. Seven youth were interviewed and reported the process which youth can provide input through meetings. An interview with the facility administrator indicated the youth complete and sign the Can We Discuss form as a first attempt to voice issues and concerns in the program and during the youth daily meeting. Also, the youth advisory board has a formal process to promote constructive input by youth to the program.

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

The program has a nine-member community advisory board consisting of representatives of the Manatee and Palmetto Police Department's, community partners, the business community, the school district, volunteers, victim advocate, judiciary, faith community, and a parent/guardian of a former youth. A review of the community advisory board agendas and sign-in-sheets validated the program hosts quarterly advisory board meetings, with no more than 90 to one hundred and twenty days apart. The program maintains a community advisory board binder which was reviewed. An interview conducted with a current board member confirmed the board's frequent involvement in the program activities. An interview with the facility administrator (FA) revealed the program's community advisory board meetings are held quarterly and invitations are sent by email and a follow-up telephone call or reminder maybe conducted.

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

The program holds a multitude of meetings at various times and frequency which serve to assist in program planning and to ensure proper provisions for staffing. The meetings consist of morning management meetings, daily shift briefings, and all staff monthly meetings, as well as on an as-needed basis, and supervisors are informally updated of any development changes. Additionally, to assist with employee morale, the program has an employee of the month and weekly staff appreciation events and incentives for standout performers. The facility administrator (FA) explained how data is used for future program planning including the use of youth and parent/guardian entrance and exit surveys, youth and staff quarterly surveys, and employee satisfaction surveys. Results are discussed with staff and improvements are made with any deficiencies noted. The program provided a sample of the survey results to the review team. Pertinent information, such as published reports, are discussed during monthly staff meetings and reflected on meeting minutes. Seven staff were interviewed, and all indicated staff meetings are held daily to discuss array of topics.

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

Staff are evaluated at ninety-days and then annually by their departmental head which included staff comments, signatures and dates, as well as the supervisor's signatures, dates, and performance rating calculations. The performance evaluations were specific to the applicable staff's job description. All performance evaluations are confirmed by human resources and the facility administrator. A review of staff records indicated the program maintains position descriptions for each position title which outlines the position expectations and essential functions, requirements of the position, knowledge, skills and abilities, physical requirements, and work environment. The staff evaluations rate the staff's quality of work, modeling appropriate behavior, and each evaluation included ratings on the staff's job-specific responsibilities. Three of the seven interviewed staff reported they receive a formal evaluation yearly, and two could not recall the last time their receiving an evaluation, two were new employees awaiting their ninety-day evaluation.

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

The program has policy and procedures which governs recreation and leisure activities. The program currently has one recreational therapist in accordance with the contract. The therapist is a master's-level recreational specialist who holds a degree in sports management which meets the contract's requirements. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth targeted to promote team building and leadership skills. Supervised and structured indoor and outdoor recreation activities available to youth include basketball, flag football, table tennis, card tournaments, arts and crafts, cards, work-outs and board games. Seven interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. The recreational therapist develops a Wellness Plan to achieve each youth's desired goals while in the program. A review of the logbook reflected a minimum of an hour of recreation activity is provided daily for all youth. During an interview with the recreation therapist, it was indicated the recreation activities promote community wellness which allows youth to contribute to the group culture, promotes social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Seven interviewed youth and seven interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. Youth are provided an opportunity to provide input to program on recreation and leisure activities program along with other subject matter through the youth advisory board. Seven interviewed youth indicated they view the youth advisory board as a positive process.

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.	

In all seven records reviewed, the program notified the youth's parent/guardian by telephone within twenty-four hours and in writing within forty-eight hours of the youth's admission. In all records the youth's committing judge and assigned juvenile probation officer were notified in writing within five working days of the youth's admission.

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

In all seven records reviewed the program provided the youth with an orientation including; expectations and responsibilities of youth, written behavioral management system (BMS) in the youth handbook, availability and access to medical and mental health services, access to the Florida Abuse Hotline and the Central Communications Center (CCC), the program's zero-tolerance policy regarding sexual misconduct, including how to report incidents or suspicions of sexual misconduct, special accommodations for youth with limited reading skills, visually impaired, deaf, or otherwise disabled youth regarding sexual misconduct, right to be free from sexual misconduct, and rights to be free from retaliation for reporting such misconduct. It also encompassed items considered contraband, performance planning process, dress code and hygiene practices, procedures regarding visitation, mail and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, medical topics and assignment to a living unit and room, as well as treatment team. A youth admission could not be observed during the annual compliance review week since no new youth were admitted. The program has the daily schedule posted in each dorm. All seven interviewed youth indicated orientation to the program began within twenty-four hours after admission. All seven youth indicated they received a handbook with program expectations and rules, or were explained the rules and procedures of the program during the orientation process. Two also stated they received a tour of the program.

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.	

In two of seven records reviewed the youth was eighteen years or older. One more youth record was requested for youth applicable regarding written consent completed. In the three applicable records the program obtained written consent for providing youth physical or mental health information to the parent/guardian for youth eighteen years or older.

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

The program has a policy and procedures outlining the classification process, including a classification system which promotes safety and security. The policy also addresses when a reassessment is warranted based upon changes in the youth's supervision status, new/updated alerts, relevant information and/or behavioral concerns.

In all seven records reviewed the program's classification system included physical characteristics, age and maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified or suspected risk. Each of the youth were assigned to a dormitory and room based on the classification system. In all seven records the program completed a Victimization and Sexually Aggressive Behavior (VSAB) form and maintained it in each record; none were updated in the Department's Juvenile Justice Information System (JJIS) until three days prior to the annual compliance review. The program indicated this task was not completed in JJIS in the required timeframe due to lack of management oversight. In all seven records, the youth were reclassified monthly to increase privileges and in six to participate in work projects.

The program has an internal alert system which is updated when necessary. The internal alert system is a board in the conference room which has all youth's alerts who are currently in the program. The board gets updated as new information is received. During each shift briefing new information on alerts is shared with the staff, as well as new alert information being captured on the shift briefing form.

The facility administrator (FA) was interviewed and was questioned regarding how factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a dormitory and sleeping room. The FA stated the re-classification meeting is where these, and other factors are reviewed and considered prior to room assignment.

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.	

In only one of seven records reviewed the youth was applicable for gang status; therefore, two more examples were requested. In all three applicable records, the youth was identified as a suspected gang member and local law enforcement, as well as the educational provider were notified of the youth's status. In one of three, the youth was identified while at the program by an outside source, who also entered the alert into the Department's Juvenile Justice Information

System, and therefore law enforcement and the youth's juvenile probation officer were notified; the other two the youth had been on suspected gang status prior to entering the program.

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

The program's policy and procedures included the youth being educated on the negative consequences of gang membership and activity through victim awareness groups, as well as social and life skills groups. In only one of seven records reviewed the youth was applicable for gang status; therefore, two more examples were requested. In all three applicable records, the youth was identified as suspected gang member and participated in gang prevention and intervention strategies. In each record the performance plan included relevant goals relating to gang intervention strategies for the youth to complete prior to release from the program, and the gang prevention specialist participates in monthly treatment team meetings. The program utilizes Gangs: Fifty Plus Stories of Fractured Lives and Gang Resistance and Drug Education (GRADE) as their curriculum for youth to participate in once a month.

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.	

In five of seven records reviewed, the program conducted an initial Residential Assessment for Youth (RAY) within the first thirty days of admission, maintained in the Department's Juvenile Justice Information System (JJIS). In the remaining two records, the program conducted a Residential Positive Achievement Change Tool (R-PACT) maintained in JJIS and then entered a RAY when it became applicable. The seven youth records reviewed only included two youth who had RAY reassessments completed; therefore, another record was requested. Three of the total eight records reviewed were applicable regarding completion of reassessments. In all three, the RAY reassessment was conducted within the ninety days after completion of the initial RAY.

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.	

In all seven records reviewed, the Youth Needs Assessment Summary (YNAS) was conducted within thirty days of admission. In six of seven documentation was found in the Department's Juvenile Justice Information System (JJIS) at the time of completion. In one record there was a JJIS issue and the YNAS was entered into JJIS eight days late.

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.*	

In six of seven records reviewed the individualized performance plan (IPP) was developed within thirty days of youth's admission and included input from all members of the treatment team. The one remaining record, the IPP was completed eight days late due to issues with the Department's Juvenile Justice Information System (JJIS) and included input from all members of the treatment team. All the IPPs included specific delinquency interventions with measurable outcomes for the youth, the three top criminogenic needs, and identified transition activities. In each record, the IPP included the youth's responsibilities to accomplish goals as well as staff tasks, and target dates for the completion of each goal. Each of the seven IPPs were signed by the youth, the intervention treatment team leader, and all other required parties. In two records, the parent/guardian signature was on the IPP. In the other five, the program sent a copy of the IPP to the parent/guardian but did not receive the signature sheet back. The original IPP was kept in the youth record and a copy was provided to the youth. A copy of the IPP was sent to the committing court, the juvenile probation officer (JPO), and parent/guardian within ten working days of plan completion. Seven youth were asked if they had a copy of their performance plan; they indicated they do. All seven were questioned regarding if the program's treatment process included development of youth performance plan, treatment team meetings, and goals they are currently working on. All seven youth indicated the treatment team is held to discuss what goals they are working on and performance in the program, as well as three stating in more detail who participates in the meetings, and one being able to give more about the goals he is working on.

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.	

Two of seven records reviewed were applicable for performance plan revisions, therefore, one of the closed youth records was reviewed. The three applicable records had performance plan revisions completed due to Residential Assessment for Youth reassessment results, and youth demonstrating progress toward completion of goals, as well as one for facilitating activities during the last sixty days of the youth's stay.

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.*	

Three of seven records reviewed were applicable for completion of a Performance Summary. In the applicable three records, one was entered into the Department's Juvenile Justice Information System (JJIS) nine days late due to issues with JJIS. The remaining two records were completed within the ninety days following the signing of the performance plan. In all three records the performance summary included the youth status on each performance plan goal, overall treatment progress, academic status, youth's behavior, including significant positive and negative incidents or events, level of motivation to change, interaction with peers and staff, and overall behavior adjustment to the program. In each record the performance summary was completed every ninety calendar days, the youth read and added comments to the plan, and a copy of the plan was provided to the youth and filed in the youth record. The performance summary was signed by the intervention and treatment team leader, the youth and the facility administrator. In all three records, the performance plan was sent to court, the juvenile probation officer (JPO), and the parent/guardian. In all three closed records reviewed the original performance summary along with justification for release was sent with the Pre-Release Notification (PRN) at least forty-five days prior to the projected release to the JPO. A signed copy was retained in the youth's record. In all three the program provided written notification to the youth's parent/guardian when the PRN was approved and a Residential-Positive Achievement Change Tool (R-PACT) or a Residential Assessment for Youth (RAY) was completed once release was approved. The three records contained documentation the program provided the JPO with the performance summary, transition plan and any psychological/psychiatric report, upon the youth's release from the program. Seven youth interviews indicated they had received a copy of the performance summary sent to the court.

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 written correspondence with the parent/guardian to advise them of treatment team, performance plan, transition, and exit meetings, as well as during admission to advise of length of stay, visitation hours, and program rules. In the letters the parent/guardian is encouraged to participate in person or telephonically. The program staff also contact the parent/guardian telephonically on the day of admission and during the youth's weekly phone call to encourage parental involvement, as well as facilitating quarterly family days. The facility administrator was interviewed and questioned regarding how the program encourages parental involvement in the case management process. The facility administrator indicated through weekly phone calls, family day once a month, conference calls, monthly progress meetings, juvenile probation officer (JPO) efforts to communicate with parents within the community, judges' order, case managers developing a relationship with the parent/guardian and services

on program boards. All seven youth interviews indicated the parent/guardian was involved in the case management process.

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.	

In all seven records reviewed the youth's juvenile probation officer (JPO), parent/guardian and any other pertinent parties were invited and encouraged through advanced notification to participate in the monthly treatment team meetings. The treatment team members included the treatment team leader, the youth, administrative representative, living unit representative, treatment staff, educational staff, juvenile probation officer, parent/guardian, and transition services manager were applicable. The program's recreational therapist reports directly to the clinical director, providing feedback regarding each youth. Each youth has a goal area in the mental health substance abuse treatment plan addressing the wellness plan, in turn the clinical department representative will provide information regarding the recreational therapy input during the treatment team meetings. One of the seven youth records reviewed included a suspected gang youth. In four of five treatment team meetings, the gang prevention specialist was present. In none of the seven records reviewed was the youth in the care of the Department of Children and Families (DCF) and therefore, three more records were requested for review. The program had only two applicable records. In the two records reviewed, the program made attempts to contact the DCF worker during treatment team meetings.

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.	

In all seven records reviewed, the youth had additional plans incorporated into the individualized performance plan (IPP), including academic, wellness, safety and mental health/substance abuse plans. In none of the seven records reviewed was the youth in the care of the Department of Children and Families (DCF) and therefore, three more records were requested. The program had only two applicable records. In the two records reviewed the DCF plan was incorporated in the IPP.

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.	

In all seven records reviewed a formal treatment team was conducted every thirty days. The documentation included the youth name, date of review, any comments from the treatment team members, brief synopsis of youth's progress in the program, performance plan revisions, if needed, progress on performance plan goals, treatment progress and Residential Positive Achievement Change Tool (R-PACT) or Residential Assessment for Youth (RAY) results if warranted, positive and negative behaviors, as well as those resulting in physical interventions. In all seven, the youth had the opportunity to demonstrate skills learned in the program. In all

seven records reviewed the informal reviews were conducted bi-weekly each month and included the youth name, date of review, meeting attendees, brief synopsis of youth's progress in the program, performance plan revisions, if needed, progress on performance plan goals, positive and negative behaviors, as well as those resulting in physical interventions, treatment progress and R-PACT or RAY results if warranted. Seven youth were interviewed and asked if they were given an opportunity during treatment team meetings to demonstrate any skills they have learned in the program and if staff review youth performance to include progress on performance plan goals, positive and negative behavior, and treatment progress; they all confirmed.

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

The program has a policy and procedures for the development and implementation of a vocational program. An interview with the lead educator confirmed career education is part of the daily planning for academics. Built into core academic classes are opportunities for youth to develop abilities in communication, interpersonal skills, and decision-making skills. Career assessments allow students to explore and gain knowledge of occupation and vocational options. Youth in the program have opportunities to gain vocational certification in the food industry. Three closed youth records were reviewed. All records have evidence of a completed sample employment application and résumé, and documentation of an appointment with the Career Source Center. All records reviewed contained evidence of a sample résumé, appropriate documents to obtain employment, documentation of notification to the parent/guardian being made aware of vocational plan. Documentation in the youth records supported the parent/guardian and juvenile probation officer (JPO) were made aware of this information. This program has a contracted minimum length of stay of nine months and must therefore provide Council for American Private Education (CAPE) courses leading to pre-apprentice certifications and industry certification. While there are opportunities for youth in the program to obtain industry recognized certification, the program has not met the requirements for CAPE. This is a systemic exception; however, documentation supports corrective action has been applied and is ongoing with the education branch of the Department of Juvenile Justice and the Department of Education. The facility administrator was interviewed and questioned regarding what career or vocation services are offered to youth in the program. The facility administrator indicated a paid internship program, SafeServ program, computer-based certificates, résumé builders, Regions Bank training course, educational efforts during placement and life skills program. The lead teacher interview indicated résumés, mock job applications, typing, Gmetrix Microsoft Suite, oil change program, Florida Ready to Work are career education services and assessments offered to the youth in the program. This is documented in the logbook.

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 operates on a year-round academic calendar providing educational and career related programs for 250 days of instruction distributed over a twelve-month period with a minimum of twenty-five hours of instruction weekly. Youth receive credits for educational and training experience. Review of logbooks and interviews with education staff and youth

supported education is taking place as scheduled. All seven interviewed youth indicated there are not a lot of interruptions during educational instruction. The lead teacher interview indicated the program's educational instruction schedule is Monday through Friday 7:35 a.m. to 1:35 p.m. with a lunch break.

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

The program has a policy and procedures in place regarding educational transition planning. Applicable staff and youth at the program complete an education transition plan prior to release including provisions for continuation of education and/or employment. Three closed youth case management records were reviewed, and all contained documentation of an individual education transition plan. Transitions plans were developed with youth's post release goals attended by the youth, parent/guardian, education representative, and post release staff. The reviewed records documented participation of a certified school counselor and registrar (or designee) in the education planning. All reviewed records contained documentation of services and interventions based on the student's assessed educational needs and post release education plans, a recommended educational placement for post-release and specific monitoring responsibilities for coordination of the provision of support services, provisions for continuation of education/employment, a résumé, appropriate documents essential to obtaining employment, and evidence of the youth's case manager and parent/guardian are aware of the plan.

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

All seven open records reviewed were not applicable regarding transition, exit or Community Re-entry Team (CRT) meetings. Three closed records were reviewed. In all three the transition conference was held at least sixty days prior to the targeted release date and the youth, treatment team leader, facility administrator/designee and other team members participated in the conference. The juvenile probation officer (JPO), parent/guardian, education staff and other pertinent parties were invited and encouraged to attend the transition conference. During the transition conference, the team reviewed transition activities on the youth's performance plan in all three records. In two of three records, the team identified target completion dates and persons responsible for completion of the goals; in the other one this was missing. In all

records, the treatment team leader obtained signatures of all attendees and a copy of the plan was sent with a request for return with signature to anyone not physically present during the meeting. Three records maintained documentation a CRT meeting was conducted prior to the youth's release and the program and youth were invited and participated in the meeting.

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

Three closed records were reviewed. In all three records, the exit portfolio was discussed and initiated at the transition meeting. All three had a state-issued identification card, copy of the transition plan, calendar with all dates/times/locations of upcoming appointments, social security card, birth certificate, educational and vocational certificates earned in the program, educational records/documents, school transcripts, résumé, and completed sample of a job application. In all three, the exit portfolio was verified at the exit conference and provided to the youth upon release and forwarded to the juvenile probation officer and it was documented in the closed youth record.

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

Three closed records were reviewed. In all three, the exit conference was conducted at least fourteen days prior to release and after the program notified the juvenile probation officer (JPO) of the youth's release. The exit conference was documented in the youth closed record, included the date, signatures, a summary of pending transition goals, as well as finalized plans for the youth's release. In all three, the date of admission and termination documented in the program's records correlated with the Department's Juvenile Justice Information System (JJIS). The intervention and treatment team leader, parent/guardian, education representative, JPO, youth, and other pertinent parties participated in the exit conference. The transition, Community Re-entry Team and exit meetings were conducted on separate occasions for all three 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 has a full-time licensed clinical social worker (LCSW) serving as the designated mental health clinician authority (DMHCA) and the clinical director. The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2021. The DMHCA is on-site a minimum of five days a week, for a total of forty hours. The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for coordination and implementation of mental health, substance abuse, and specialized services at the program. The DMHCA has a back-up licensed mental health counselor (LMHC) on the clinical staff who covers when the DMHCA is on leave. The program provides substance abuse overlay services (SAOS) to all youth in the program. The DMHCA ensures clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. An interview with the DMHCA indicated he provides daily face-to-face clinical support to all clinical staff and meets with the clinical staff weekly to discuss youth-specific clinical issues and ensures documentation deadlines are met. Clinical staff includes one LMHC and three non-licensed masters-level therapists. Review of the weekly supervision binder confirmed this practice. The DMHCA meets twice a month with the psychiatrist regarding each new youth for admissions, for an initial psychiatric evaluation to determine what, if any, psychiatric interventions or psychotropic medications are needed. The DMHCA communicates psychiatric concerns for each youth on psychotropic medications or refers youth already in the program for newly developed concerns. A review of the DMHCA's position description validates the services provided. The DMHCA indicated they are on-site weekly, and they review and sign weekly progress notes completed by the three non-licensed therapists, conduct treatment planning, Assessments of Suicide Risk (ASR), and follow-up ASRs.

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

The program has a policy and procedures in place addressing the program's contractual requirement to have at least one licensed professional on-site five days a week. The program has one licensed mental health counselor (LMHC) in addition to the designated mental health clinician authority (DMHCA) who is a licensed clinical social worker. The LMHC provides services five days a week, for at least forty hours weekly. The LMHC also provides coverage for the DMHCA when the DMHCA is on vacation or sick leave. A review of the Florida Department

of Health Medical Quality Assurance Search website indicated the LMHC has a clear and active license in the State of Florida which expires on March 31, 2021. The program also contracts with a licensed psychiatrist. A review of the Florida Department of Health website confirmed the psychiatrist's license is also clear and active in the state of Florida expires in January 31, 2021.

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

The program has a policy and procedures in place indicating 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 policy further indicates all non-licensed staff shall receive direct supervision from a licensed clinical professional on a weekly basis and master's-level staff who perform Assessments of Suicide Risk (ASR) shall have twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The program holds a regular license in accordance with Chapter 397 of the Florida Statutes to provide substance abuse treatment services to the youth in the program. The program has three non-licensed clinicians who provide regular mental health and substance abuse services to the youth in the program. A review of each clinician's personnel records revealed one clinician has a Master of Science in community mental health, one has a Master of Science in human services, and the other non-licensed clinician has a Master of Science in mental health counseling. The only staff who completes ASRs is the designated mental health clinician authority (DMHCA), the licensed mental health counselor (LMHC), and the non-licensed clinician with a Master of Science in mental health counseling. The other two non-licensed clinicians do not complete ASRs. A review of the training record of the one non-licensed clinician who completes ASRs revealed they had twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training also included the administration of at least five ASRs conducted under the supervision of a licensed professional. A review of the program's clinical supervision binder for the six months prior to the annual compliance review indicated all three non-licensed clinicians received weekly supervision, when they provided services to the youth, from the DMHCA, who is a licensed clinical social worker (LCSW). Weekly documentation included the date the supervision was held, time and hours the supervision was provided, names of the clinicians in attendance, signatures of the attendees, and the signature of the licensed professional who provided the supervision. The weekly supervision documentation also contained a summary of the supervision sessions, instructions and directions to clinicians, and a review of sample treatment or summary notes.

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

The program has a comprehensive plan for delivery of mental health services which describes the screening process for all newly admitted youth. The program utilizes the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) to screen every youth upon admission.

The MAYSI-2 is completed by a trained staff member on the day of admission in a confidential manner, however, the MAYSI-2 was not inputted into the Department's Juvenile Justice Information System (JJIS) on the day of admission. Program was made aware at the end of July 2019 they must be entering the MAYSI-2 into JJIS on the day of admission and has been doing so ever since. Seven youth mental health and substance abuse records were reviewed for completion of MAYSI-2 screening. All screenings were completed on the day of admission and by a non-licensed mental health clinician or the designated mental health clinician authority (DMHCA). Five out of seven youth scored for further assessments on the MAYSI-2, the other two youth had their MAYSI-2 overrode for further assessment due to collateral information. It is the program's current practice to refer all youth at the time of admission for a new comprehensive mental health and substance abuse evaluation and an Assessment of Suicide Risk (ASR), regardless of the MAYSI-2 results. Additionally, the program also completes a Screening of Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and an Adolescent Substance Abuse Subtle Screening Inventory (SASSI) on all youth to identify those youth at risk for mental health and substance abuse issues. All records contained a records review form giving a summary of the commitment documentation reviewed at admission which included but was not limited to family history, history of trauma, drug/alcohol use, emotional instability, and risk and protective factors. The licensed mental health professional also reviewed and signed all ASRs conducted by non-licensed clinical staff within twenty-four hours of completion. An interview with the facility administrator (FA) confirmed the program's practice and stated all youth are thoroughly screened at admission to identify all treatment needs. The FA further indicated, the program also provides comprehensive mental health and substance abuse evaluations on all youth within thirty days of admission.

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.	

On the day of admission, each youth is referred for a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation regardless of their results on the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2). A review of seven youth mental health and substance abuse records found each of the records contained a new evaluation completed within thirty days of admission. Collateral information such as psychiatric evaluations, interviews with family members and the juvenile probation officer (JPO) are also utilized in developing the evaluation results. All youth had the required screening/testing/assessments completed prior to the completion of their comprehensive evaluations. All evaluations were extremely thorough and detailed and included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Health Disorders Version Five (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. All evaluations were comprehensive and included information from prior evaluations to include the psychiatric evaluation which was completed within fourteen days of youth's admission. Three of the seven youth's evaluations were completed by a licensed professional and all were signed off by the designated mental health clinician authority within ten calendar days. The evaluations were used in the development of each youth's Individualized Treatment Plan.

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

The program has a policy and procedures in place outlining the program's mental health and substance abuse treatment services. The program's policy indicates each youth is assigned to a multi-disciplinary treatment team and the program's clinical staff provides youth with mental health groups, substance abuse groups, individual counseling, family counseling, behavioral therapy, psychosocial skills, and supportive counseling, as needed. The program is licensed by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services under Chapter 397 of the Florida Statutes. A review of seven youth mental health and substance abuse records revealed all youth were assigned to a multi-disciplinary treatment team on the day of admission. The reviewed documentation supported each youth's treatment team was comprised of individual's program administration, residential living unit representative, mental health, case manager, medical staff, education staff, juvenile probation officer, the youth, and the parent/guardian, if applicable. All seven records contained a comprehensive evaluation indicating a substance abuse diagnosis and were receiving substance abuse treatment. Each of the records contained a properly executed Authorization for Evaluation and Treatment (AET), a signed Youth Consent for Substance Abuse Treatment form, and a Youth Consent for Substance Abuse Treatment Records form. All seven records contained documentation each youth was receiving services from a trained clinician working under the direct supervision of a licensed professional. The clinicians were using a program form for progress notes, which contained all required elements of the Department's Counseling/Therapy Progress Note form. A review of all seven youth's counseling/therapy progress notes, as well as group sign-in sheets validated mental health groups had no more than ten youth in a group and substance abuse groups had no more than fifteen youth in a group. During the annual compliance review, observations of a substance abuse group also found there were no more than fifteen youth in the group. Further review of each of the seven youth's progress notes indicated each youth received individual and family counseling, as well as psychosocial skills training. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health groups, substance abuse groups, family counseling, and individual counseling. The DMHCA also indicated the program provides the youth with Cannabis Youth Treatment (CYT), Impact of Crime (IOC) groups, and Young Men's Work groups. Seven interviewed youth indicated they were each participating in group treatment. Seven interviewed staff indicated they do not facilitate mental health or substance abuse groups. Review team was unable to observe a multi-disciplinary treatment team meeting during the annual compliance review as there were no treatment team meetings conducted during the annual compliance review.

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

Seven youth mental health and substance abuse records were reviewed. All records contained an initial Mental Health and Substance Abuse Treatment Plan completed on the day of admission, and an Individualized Treatment Plan (ITP) completed within thirty days of admission. Both the initial and individualized plans were documented on a form which includes all elements listed in the Department's form. Each of the initial plans included a goal for youth to obtain a psychiatric evaluation within fourteen days. A review of the ITP is conducted every thirty days, and the ITP review form contained all elements required in the Department's form. The plans were signed by all members of the treatment team to include the mental health professional within ten days of completion. Each plan was mailed out to the parent/guardian if they participated by telephone. All plans were signed by the licensed mental health professional within ten days of completion. Each plan was mailed out to the parent/guardian with a request to sign the signature page and send back to the program except for the one youth who was eighteen years old upon admission to the program. None of the plans has a signature page returned from the applicable youth's parent/guardian, however, all applicable records contained at minimum three attempts to obtain a parent/guardian signature. A review of the ITP is conducted every thirty calendar days and the review form contained all elements required in the Department's form. ITP also includes wellness goals and input about the progress of wellness goals are provided by clinical staff. All seven ITPs included the most recent psychiatric evaluation recommendations in which three youth were prescribed psychotropic medication at the time of admission. All three applicable youth had a goal on their ITP pertaining to psychotropic medication compliance. A review of progress notes determined youth are receiving treatment services as agreed upon on their ITP. In one out of three applicable records, youth did not receive psychiatric services for the month of August 2019, however, youth was out of placement for half of the month and missed their scheduled appointment with the program psychiatrist. Youth did receive psychiatric service in September 2019, upon their return to the program. A total of three closed youth mental health and substance abuse records were reviewed. Each contained a completed discharge summary signed by the youth and therapist. The discharge plan was documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. Documentation confirmed the discharge summary was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. None of the youth were at risk for suicide at the time of release. The summary form considered the services needed for daily maintenance of the positive improvement in skills made by the youth during treatment. A release form was signed by parent/guardian in two out of three records. The other record did not contain as release form, but a progress note was provided which stated parent did sign a release form which contained the Mental Health/Substance Abuse Treatment Discharge Summary form upon discharge from the program.

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."	

Then program has a policy and procedures in place indicating the program is designated as substance abuse overlay services (SAOS) program, is licensed under Chapter 397, and has a qualified professional on-site at least five days a week. The program provides evidence-based services such as Cannabis Youth Treatment (CYT) services. As part of the SAOS provided, each youth is given a urinalysis drug screening upon arrival and readmission to the program as well as randomly throughout their stay in the program. A review of seven youth mental health and substance abused records revealed each youth received services every day they were present at the program. The reviewed records indicated each youth received individual therapy, group mental health and substance abuse services, family counseling, psychosocial skills, and psychiatric services, when necessary. Based on the provided documentation, each therapist manages a caseload of twelve youth. A review of the provided documentation supports substance abuse groups do not exceed fifteen youth. An interview with the designated mental health clinician authority (DMHCA) and the facility administrator confirmed the program provides SAOS services to all youth in the program.

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 an agreement for professional services with a licensed psychiatrist who is designated to oversee the psychiatric services in the program. Services include the provision of psychiatric evaluations; participating in treatment planning, and supervision of the treatment of youth who are prescribed psychotropic medications, in coordination with the designated mental health clinician authority (DMHCA) and the multi-disciplinary treatment team. The psychiatrist is a medical doctor with experience and training in family medicine and psychiatry and is licensed in the State of Florida with an expiration date of January 31, 2020. A review of weekly sign-in logs for the past six months revealed the psychiatrist has been on-site every other week for a minimum of two hours. The program's practice is to refer every admitted youth for a psychiatric evaluation within fourteen days of admission. A review of seven youth mental health and substance abuse records indicated an evaluation was completed within fourteen days on each youth. The initial evaluation was completed on a form developed by the program and included all elements required by the Department in addition to page three of the Clinical Psychotropic Progress Note. Three of the seven youth reviewed records indicated youth were admitted with and continued on psychotropic medication. All three records for youth on medication documented medication evaluations and management conducted every thirty calendar days after the initial evaluation continuing them on medication, except for one youth missing medication management for the month of August 2019, due to youth being out of placement. While on-site, the psychiatrist meets with at least one member of the treatment team to review the status of all youth evaluated and/or prescribed psychotropic medication. Sign-in

sheets and minutes were present for all meetings which took placed within the last six months. An interview with the psychiatrist confirmed the program's practice.

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

The program has a policy and maintains a comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The MHSA plan was last updated and approved by the facility administrator (FA) on December 13, 2018 and the designated mental health clinician authority (DMHCA) on June 2, 2018. Upon being notified the plan had not been reviewed within the past year by the DMHCA, the program rectified this and provided review team with a suicide prevention plan which was reviewed and updated by the FA and DMHCA on October 1, 2019. The program's plan detailed suicide prevention procedures and included all the required elements, as outlined in Florida Administrative Code 63N-1. The plan included but was not limited to: identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and recognizing verbal and behavioral cues. Additionally, regardless of screening results, each youth receives a comprehensive evaluation within thirty days of admission. An interview with the FA indicated the program provides suicide prevention training throughout the year and conducts quarterly mock emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury.

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

The program has a policy and procedures addressing suicide prevention services which include the administration of an Assessment of Suicide Risk (ASR) to all admitted youth, regardless of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) results. Seven youth mental health and substance abuse records were reviewed for verification of program practice. All records contained a completed ASR on the day of admission; in addition to a MAYSI-2. None of the seven youth records indicated the youth had been referred for suicide prevention services post-admission. The facility provided the only applicable youth record which reflected a youth who was referred for suicide prevention service after admission. There were no instances of secure observation being utilized by the program during the annual compliance review period. Of the one applicable youth referred for suicide prevention precaution post admission, the youth was referred due to staff observations. The youth was placed on constant

supervision and then referred for an ASR. Documentation indicated the ASR was completed by mental health staff and was reviewed and signed on the same day by the designated mental health clinician authority (DMHCA). After the completion of the ASR, the youth was stepped down to close supervision, in accordance with the program's suicide prevention plan. The transition to close supervision from precautionary observation only took place once the DMHCA and facility administrator (FA) conferred and agreed the youth will be stepped down. Verbal parental notification was evidenced on the ASR and Follow-up ASR (FUASR) with each transition in the level of supervision. Juvenile probation officer (JPO) was notified by email as evidenced on the ASR and FUASR, however, the program did not first attempt to notify the JPO verbally as required. The ASR documented consultation between the mental health staff member and FA. A review of precautionary observation logs indicated they were consistently completed correctly, and youth was appropriately supervised during their time on precautionary observation. In the one instance in which precautionary observation was required, the youth's status was not noted in the facility log book, however, an alert was entered into the Department's Juvenile Justice Information System (JJIS). The JJIS alert was closed when the youth was stepped down from precautionary observation. Documentation was found in the log when youth was stepped down from precautionary observation to close supervision, but not when youth was originally placed on precautionary observation. The precautionary observation level did not limit or restrict the youth to their sleeping area and allowed them to participate in select activities with other youth in the designated safe housing areas. While there were no serious suicide attempts reported during the annual compliance review period, the program has a documented review process for such events. The review process includes the gathering of information regarding the circumstances surrounding the even, relevant facility procedures related to the incident, relevant training received by involved staff, pertinent medical and mental health services related to the victim, possibly precipitating factors, and recommendations for changes in policy, training, physical plant, and medical or mental health services, in any were needed. Two suicide response kits were observed, and the kits included a knife-for-life, wire cutters, and needle nose pliers and basic first aid supplies. Seven staff were interviewed regarding their responsibilities if a youth expressed suicidal ideations to them. Six of seven staff indicated they would notify mental health and search youth's room for sharp objects. All seven stated they would place the youth on sight and sound supervision and document the youth's behaviors. One of the seven indicated they would notify their supervisor. All seven staff indicated the program maintains a suicide response kit in master control. Three out of seven interviewed staff stated there are suicide response kits in medical and sub-control.

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.	

None of the seven youth mental health and substance abuse records were applicable for precautionary observation logs. The program reported there was only one instance of a youth being placed on precautionary observation during the annual compliance review period and the observation logs for this youth was reviewed. The program uses the Department's Suicide Precautions Observations Log form printed on orange card stock to document observations of youth placed on precautionary observation. Each of the reviewed logs contained documentation of and responses to warning signs, a list of safe housing areas, and documented observations of the youth in real time and at no more than thirty-minute intervals. The logs were reviewed and signed by shift supervisors and mental health clinical staff indicating their review of the logs. An

interview with this youth indicated staff was always with youth while on precautionary observation and they were never left alone.

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

The program has a policy and procedures to ensure all staff who work with youth shall receive six hours of suicide prevention training to include: recognition of verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Seven pre-service and seven in-service training records were reviewed for required suicide training. All fourteen records contained a minimum of two hours of the Department's Learning Management System (SkillPro) training and four hours of instructor led training. Mock suicide and mental health emergency drills were reviewed for the last four quarters (September 2018-September 2019) and a drill was conducted on each shift in all quarters. The program conducted a total of twenty-six drills during this timeframe. Drill participation was reviewed for fifteen random staff (fifty percent of the total direct care staff who are not on pro re nata status) and the results show all fifteen staff members participated in at least one drill each quarter. Staff participate in mock suicide and mental health emergency drills. All staff reviewed participated in a mock suicide drill which contained the use of cardiopulmonary resuscitation (CPR), first-aid, and the use of a suicide response kit. The drills detailed all participants role during the drill and detailed the methods for contacting other program staff, the Central Communications Center (CCC), medical and mental health personnel, and emergency medical services. An interview with the facility administrator confirmed mock suicide and mental health emergency drills are conducted at minimum of once a quarter for all staff on all shifts. Seven staff were interviewed about various drills they have participated in in the past twelve months, and all staff indicated they had participated in medical and mental health drills quarterly.

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

The program has a policy and procedures in place to respond to youth in crisis in the least restrictive method possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program maintains a crisis intervention plan. The plan detailed crisis intervention procedures to include: notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process.

3.15 Crisis Assessments (Critical)	Non-Applicable
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.	

During the annual compliance review period, the program did not have any youth who required the completion of a crisis assessment; therefore, this indicator rates as non-applicable.

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

The program has an emergency mental health and substance abuse and crisis intervention plan. The plan contains, but is not limited to: immediate staff response, notification, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 of the Florida Statutes (Baker Act), transport for emergency substance abuse assessments and treatment under Chapter 397 (Marchman Act), documentation, training (including mock drills), and review.

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

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

Standard 4: Health Services

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

The program has a policy and procedures to address the designated health authority (DHA). The policy states the DHA is responsible for all healthcare related services at the program. The program has an agreement with the DHA, who is an independent contractor, to meet all the health services needs for the program. The DHA, who is a licensed osteopathic physician (DO), holds an unrestricted clear and active license to practice medicine in the State of Florida. The DHA specializes in internal medicine, and his license expires on March 31, 2020. The written policy and procedures clearly state the DHA is required to be on-site two hours a week. This was verified by reviewing the sign-in and sign-out logs for the past six months, there was no lapse in coverage and duration was within the two-hour minimum requirement. Furthermore, the contract between the program and DHA clearly outlines the medical doctor's responsibilities which include; communication with program staff regarding all youth medical needs, medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical medications. The program staff can contact the DHA by telephone twenty-four hours a day, seven days a week for all medical needs; emergency situations, medication management, sick call related concerns and off-site care. In situations where DHA is unable to be on-site weekly, the program also has a contract with a secondary medical provider. The back-up medical doctor holds an unrestricted clear and active license in the State of Florida which expires January 31, 2021.The reviewed sign-in logs did not indicate within the past six months the backup MD services were ever utilized. The interview with the DHA revealed all the youth's medical needs were being addressed appropriately at the program and he communicated he had no concerns.

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

The program has written Facility Operating Procedures (FOP) which addresses all health-related procedures and protocols. On June 27, 2019, an annual review of youth health-related policies and procedures was completed. The signatures of the designated health authority (DHA) and the facility administrator (FA) indicate approval of the annual review. Furthermore, the annual review of the nursing protocols manual was also completed on the same date, June 27, 2019. After approval from DHA and FA of all the program's policies, procedures, and the nursing protocol manual, all medical staff signed the cover page confirming they have reviewed them. Two nurses hired after the annual review was completed, reviewed and signed the cover page on July 18, 2019 and July 19, 2019. The two newly employed healthcare nurses received a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, the training was conducted by the health services administrator (HSA). In addition, the new nurses received the required pre-service and orientation training to include on-the-job training with the HSA.

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

The program has a policy and procedures in place regarding the Authority for Evaluation and Treatment (AET). The AET serves as informed consent and is signed by the youth's parent/guardian for non-invasive medical procedures or minor condition which can be treated by healthcare member with over-the-counter (OTC) medications. Seven youth Individual Healthcare Records (IHCR) were reviewed for a valid AET and all included a valid copy, stamped as 'Copy'. None of the seven IHCRs had the original AET filed within IHCRs. On admission, two of the seven youth were eighteen years old. The two applicable eighteen-year old youth signed the correct consent documentation. In chronological order, all copies of parental notifications were maintained behind the AET. Of the seven IHCRs reviewed, two applicable youth were under the care of the Department of Children and Families (DCF). The AETs for the youth involved with DCF were completed as required. The health services administrator (HSA) was interviewed and follows program procedure by reviewing all potential admissions in the Department's Juvenile Justice Information System (JJIS) and validating the AET prior to youth's admission. If the AET is invalid, the HSA reports the findings to the juvenile probation officer (JPO), as the JPO is responsible for obtaining a valid AET or court order prior to the youth arriving at the program.

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

The program has a policy and procedures confirming the parent/guardian is notified of significant changes in the youth's condition, off-site referrals, medical emergencies, hospitalizations and surgeries. Policy also states parental notification is required to obtain consent when new medications, beyond those covered in Authority for Evaluation and Treatment (AET) are ordered. If a youth is prescribed psychotropic medication, procedures in place ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Additionally, the policy also requires the third page of the Clinical Psychotropic Progress Note (CPPN) to be sent along with written parental notification to the youth's parent/guardian by mail. Medical staff confirm a youth's immunization status upon intake, if youth requires any additional vaccinations there is a policy in place for proper parent/guardian notification and consent.

A review of seven youth Individual Healthcare Records (IHCRs) supported two youth were eighteen years of age or older. The other five IHCRs were applicable for parental notification for new medication and the reviewed documentation confirmed both verbal consents were documented in the progress notes and written notification was mailed to the parent/guardian in each record. Notifications were also sent, as needed for issues such as the discontinuation of medication, changes in condition/medication for youth with chronic conditions, non-routine dental procedures, and off-site medical treatment. Two of the five underage youth IHCRs had orders to initiate psychotropic medications and in each record, the proper forms were utilized in obtaining consent for treatment from parent/guardian prior to initiating treatment. All five IHCRs reflected all telephone calls and/or attempts were witnessed by a staff member and a written notification and/or follow-up copy of the CPPN outlining the medication prescribed, reasons for the medication, and an Acknowledgement of Receipt request for each CPPN was mailed, as

required. All seven youth had their immunization history verified within thirty days of the youth's admission, were up to date and a copy of the youth's immunization record received from the Department, the Florida Shots website, and/or school records were filed in the appropriate section of IHCR. These records were initialed as reviewed by the designated health authority (DHA). Medications were not given to youth until the proper consent was received. Two youth were in the custody of the Department of Children and Families (DCF) and had valid court orders for treatment. A review of the DCF youth's IHCR verified the proper DCF Medical Report for Prescribing Psychotropic Medication to a Child in Out-of-Home Care form was completed and program was awaiting the judge's written approval prior to initiating psychotropic medication. Nursing staff acknowledged during the interview parents/guardians are contracted by phone to inform and obtain verbal consent for new medication, status changes in youth's health, or as needed and a written parental notification is mailed.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed and each included a Facility Entry Physical Health Screening (FEPHS) form completed on the day of admission by a registered nurse. Two of the reviewed seven youth IHCR contained a change of custody. A FEPHS re-screen was completed for these youth on the date they were readmitted into the program.

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

The program has a policy and procedures to address how a youth is oriented to healthcare services either upon admission or next available opportunity provided by the healthcare staff. The orientation packets covered all required topics; how to access medical care and sick call, what constitutes an emergency, how medication is administered and possible side-effects, the right to refuse care and how it is documented, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. The orientation also covers what to do in case of a sexual assault and the non-disciplinary role provided by medical staff. A review of seven youth healthcare records validated each youth received a healthcare orientation on the day of admission, as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed and there was evidence the designated health authority (DHA) was notified by telephone of the youth's admission regardless of the youth's health status. When a youth is admitted on prescribed psychotropic medication, it is the program's practice for the psychiatrist to also be notified by telephone. None of the seven youth presented a condition requiring an emergency response upon admission.

There was written documentation in all seven IHCR to support the DHA/psychiatrist was notified in the youth's chronological progress notes by utilizing the DHA Notification of Admission form. The nurse and DHA sign the form at the next on-site visit. During an interview with the nurse, it was reported the nurse completing the admission is responsible for notifying DHA of a youth's arrival at the program. The nursing staff update the Chronic Conditions Log after the notification and youth are placed on the DHA list after documentation on the Facility Entry Physical Health Screening form is 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 has a policy and procedures which stipulates a Health-Related History (HRH) must be completed upon admission to the program prior to the completion of the Comprehensive Physical Assessment (CPA) form. Both the HRH and CPA forms utilized by the program are provided by the Department of Juvenile Justice. Seven youth Individual Healthcare Records (IHCR) were reviewed and each included a new HRH form completed on the day of admission by a registered nurse. Each HRH was completed prior to the CPA. There was evidence the designated health authority (DHA) who completed the CPA reviewed the completed HRH by placing a check mark indicating the HRH was reviewed. An interview with nursing staff validated the practice and indicated the HRH form is also updated whenever any new significant medical event or change occurs.

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

The program has a policy and procedures ensuring the completion of the Department's standardized Comprehensive Physical Assessment (CPA) form prior to the youth participating in any strenuous activity. Seven youth Individual Healthcare Records (IHCR) were reviewed, all contained a new CPA completed by the designated health authority (DHA) within seven calendar days of youth's admission. Each CPA was completed as required, and any part of the exam which was deferred was documented as required. Each CPA documented the youth's medical grade and was completed in accordance with the Department's requirements. All seven youth IHCRs included documentation to support a Tuberculin Skin Test (TST) was completed within the last year and the results was recorded on the CPA and Infectious and Communicable Disease (ICD) form. The youth were assessed prior to placement in the general population. None of the youth required further testing or procedures. Reviewed documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. During an interview with the nursing staff, it was confirmed the CPA form is completed within seven days by the designated health authority (DHA) and each youth is screened for TB at admission.

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

The program has a policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI) and human immunodeficiency virus (HIV). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. Seven youth Individual Healthcare Records (IHCR) were reviewed and documentation was found to support each youth was screened for STI upon admission. Six of the seven youth were referred to the DHA for further evaluation. The DHA ordered STI testing for five youth; three youth refused testing by signing a 'Refusal Form' and the remaining two youth were tested two days after the DHA ordered it. Test results were filed in the youth's IHCR in the laboratory results sections and were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the program's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews validated the practice. HIV pre-counseling, testing, and post-counseling is provided by Manatee County Health Department for the program. Current 500/501 HIV training certificate of completion were reviewed for the provider facilitators. IHCRs were reviewed for seven youth, all were offered the opportunity to receive counseling and testing for HIV. During the annual compliance review period, one youth consented to receive counseling and testing signed the Department's HIV Antibody Test Youth Consent form. A review of the youth's records validated he received pre-counseling, testing, and post-counseling services by the contracted provider and youth's Health Education Record section was updated in the respective IHCR to reflect the HIV services provided. Test results were placed in a sealed envelope marked 'confidential' with the youth's name, date of test, and the DHAs signature documented on the outside of the envelope and filed in the laboratory test section of the IHCR. The program does not include HIV status as part of the internal alert system. All seven interviewed youth stated they could request a HIV/AIDS test at any time. Nursing staff interviews indicated the confidential results are given to only the youth upon discharge, if youth declines to take results upon discharge the results are then shredded by the RNs.

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

The program has a policy and procedures for all youth to submit Sick call Requests. The Sick Call Process is intended to provide care of non-emergency nature; headache, toothache, sprains/strains and acne were most common complaints. Sick call hours are posted and conducted daily by a registered nurse (RN): weekdays from 7:00 a.m. to 7:35 a.m. and 4:30 p.m. to 5:00 p.m. and on weekends 8:30 a.m. to 9:00 a.m. and again at 4:00 p.m. through 5:00 p.m. Youth must request a Sick Call form from floor staff because the forms are located behind closed doors in Master Control. Once a Sick Call Request form is completed it is placed in a secure box, so the RNs can retrieve them. If a nurse is not on-site for a sick call, the shift supervisor reviews the Sick Call Request and utilize the non-healthcare protocols if applicable. For sick calls not applicable for non-healthcare protocols, the shift supervisor will contact the RN

by telephone to discuss the youth's status. The RN will then notify the DHA if the youth requires emergency care. During the interview, the RN explained if a youth is in confinement, they are questioned daily of any health complaints; however, no youth were placed in confinement or room restriction during the review period. All sick calls were documented in accordance with Health Service Rule with completed vital signs, in subjective, objective, assessment, plan (SOAP) format, on the Sick Call Index and the Sick Call Referral Log was in compliance. All seven youth Individual Healthcare Records (IHCR) were applicable for completed sick call requests. All seven youth had a Sick Call Request form completed by the nurse, filed in the progress notes with a related educational document reviewed and signed by youth in reverse chronological order. The educational document provided to the youth provided information about the youth's current ailment and the instructions given to assist the ailment. There were no applicable youth with three or more sick call complaints in a two-week period. No youth submitted a sick call during the annual compliance review; therefore, no sick calls were observed. Six of the seven interviewed youth indicated they can see a dentist and doctor within one day. One youth indicated they never requested a sick call. All seven interviewed staff indicated sick call is held twice daily by an RN.

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

The program has a policy and procedures for providing twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. The plan provides episodic care, including basic first aid procedures to all youth in need. All healthcare and non-healthcare staff can call 9-1-1 at any time and have current certifications in first aid and basic cardiopulmonary resuscitation (CPR), automated external defibrillator (AED) training, and epinephrine auto injector training. The review of staff training records confirmed healthcare and non-healthcare staff held current certifications in CPR, first aid, and AED. The program has an AED located on top of the key locker in Master Control. The AED contains automated instructions on usage, but no written manual was noted. A review of the AED found the battery was last changed in November 20, 2015 with an expiration date of November 20, 2019. No data was available for when the AED shock pads were changed but the expiration date of current AED pads is September 30, 2020 with back-up AED pads expiring July 31, 2021. The nurse performed an appropriate self-test of the AED for the annual compliance review team member. AED checks were reviewed since the program's last annual review and were conducted weekly. All seven youth's Individual Healthcare Records (IHCR) were reviewed, three required on-site episodic care. In all three incidents, episodic care was provided by the nurse. One of the three youths required off-site emergency care so was transported to Manatee Memorial Hospital emergency department. The other two youth were provided over-the-counter medications and educational instructions. None of the three incidents required to be placed on the alert list. Appropriate documentation utilizing subjective, objective, assessment, plan (SOAP) format, for episodic care and a twenty-four-hour follow-up care form, was completed by RN in the progress chronological notes and tracked in the episodic log. The episodic logs were reviewed for six months and compared with on-site and off-site events in the matching youth's IHCR. No discrepancies were noted. The program maintains seven first aid kits: one in kitchen, one Master Control, one Sub Control, one administration lobby area and three available in medical office to be utilized for off-site transports for transportation vehicles. The program also has two suicide response kits: one Master Control and the other in Sub Control. Each first aid and suicide response kit were verified during the annual compliance review to contain all approved contents. All supplies were up-to-date and replenished as needed. Documentation was found to support the nursing staff checks the first aid kits and documents the expiration dates of all contents on a weekly basis

while suicide response kits are checked monthly. A review of drills conducted for the last twelve months supported drills were conducted on each shift and included CPR/AED demonstration at least quarterly. Medical drills were reviewed with all staff during monthly all staff meeting so staff who had not participated in medical drills had the opportunity to learn and ask questions. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers, which includes the Poison Information Control Center, were in the conference room and the medical clinic inaccessible to youth. Six of the seven interviewed staff reported they can call 9-1-1 if needed. One staff indicated they were not sure if they could call 9-1-1.

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 has a policy and procedures to provide timely referrals, coordination, and documentation of medical services to off-site health providers for youth with emergent or non-emergent needs. Off-site evaluations are recorded on the Department's Summary of Off-Site Care form and the designated health authority (DHA) reviews, signs, and dates the off-site care instructions during his weekly clinics and additional follow-up for the youth was scheduled and completed as necessary. Two of seven records reviewed qualified for off-site health services. An additional record was reviewed for off-site care. In all three records, nurses reviewed the off-site summary upon youth's return to program, informed DHA of discharge orders and implemented them accordingly. The DHA reviewed and signed the off-site care findings. The parent/guardian was notified of the need for services prior to scheduled appointments. The Summary of Off-Site Care form was completed for all three youth and was filed in the appropriate section of the healthcare record.

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 has a policy and procedures ensuring youth who have been identified with a chronic illness on the Facility Entry Physical Health Screening (FEPHS) receives regularly scheduled evaluations. Of the seven youth Individual Healthcare Records (IHCRs) reviewed, only three were applicable for having a chronic condition. Of these three youth, none of the conditions were communicable diseases or obesity related. All three youths were taking prescribed medications on a regular basis and classified with a medical grade five. Each of the youth were administered periodic evaluations at least every three months and were legible. Youth on psychotropic medication were seen on a thirty-day basis by the psychiatrist and prior to the renewal of prescription medication. It was noted one youth had a lapse in the thirty day follow-up with psychiatrist because he was off-site at court. Youth was evaluated by psychiatrist the same day he returned to program. The IHCR for each of the youth was reviewed to confirm documentation in the chronological notes as well as Problem List was updated. No off-site periodic evaluations occurred during the past six months. An interview with the facility administrator (FA) and designated health authority (DHA) confirmed the nursing staff maintain a chronic conditions list to track necessary periodic evaluations. The FA also has daily weekday morning meetings with medical staff to discuss all elements of healthcare services: alert board, alert logs, medical drills, DHA/psychiatrist clinics, off-site upcoming appointments and any other

medical related concerns. In addition, the DHA sees the youth for periodic evaluations every ninety days or sooner if needed.

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

The program has a policy and procedures which outline the process of how medications are to be received, stored, inventoried, and administered in a safe and effective manner. Seven youth Individual Healthcare Records (IHCR) were reviewed and three were applicable for admission with psychotropic medications. All medications admitted with youth into the program were verified by the nurse using the medical records, intact labels, verified with pharmacy, valid physician orders, Medication Administration Record (MAR) and the youth's parent/guardian. Youth admitted with medication had the medication documented on the Facility Entry Physical Health Screening (FEPHS) and Health-Related History (HRH) forms. Reviewed nursing admission notes documented the youth's current medication and the designated health authority (DHA) and psychiatrist being notified by telephone of admitted medication. Only after the DHA or psychiatrist provide verbal telephone order for admitted medication is a MAR created for future administration. All medication is in a separate and locked medicine cart which is maintained in the medical office, inaccessible to youth. No oral medications are stored with injectables or topical medications. The medications are maintained in blister packs provided by a contracted pharmacy. A separate refrigerator with a lock, also located in medical office, marked biohazard is only utilized for medications requiring refrigeration. There were no applicable medications requiring refrigeration during the annual compliance review week. Currently, there are no youth in the program with prescribed narcotics. The interviewed nursing staff reported if a youth is prescribed a narcotic; the medication is stored in a separate compartment which is double locked. All medication is documented in the Individual Health Care Record (IHCR) and on the MAR which are supplied and preprinted by the pharmacy. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade and possible side effects. It was noted one youth's MAR did not have side effects printed. Each entry is initialed by staff. Youth have start and stop dates for medications and receive medications as ordered in a timely manner. Weekly side effects monitoring is documented on the MAR. All refusals of medication by youth are documented on the MAR with the uppercase letter "R" and a correlated Refusal Form can be found in youth's IHCR, completed by the nurse and signed by both the youth and nurse. There were no standing orders, emergency treatment orders, or as needed orders for psychotropic medications. All youth had a current and valid order for the medications. Each reviewed youth IHCR indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. Each time the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered according to instructions. Eight youth were observed being administered their morning medications during the annual compliance review. Each youth understood the process to state their name, date of birth, allergies, side effects they were experiencing from medication and the name and dose of the medications they are taking. After nurse verified all information and administered the medication, the nurse would conduct a mouth sweep to check for pills/tablets, and the youth was instructed to cough for the nurse and staff supervising medication administration. There were no youth placed on restricted housing who required medications. Trained non-licensed staff are permitted to assist youth in over-the-counter medications when nursing staff are not on-site. During the annual compliance review, fraudulent documentation was noted on one of the

youth's MARs for the month of August. Documentation from various sources including logbooks and Health Discharge Summary Transfer Note, found all notes reflected the youth was not on-site from approximately 1:31 p.m. on August 20, 2019 and did not return to program until September 11, 2019; however, the MAR, which had been initialed by RN, indicated youth had been administered his morning and evening medication from the evening of August 20, 2019 through August 24, 2019. This discrepancy was pointed out to medical staff, but no appropriate response was provided. The program called Department's Central Communications Center (CCC) and report was filed on October 3, 2019. Five of the seven interviewed youth stated the nurse gives them their medication. The other two youth indicated they did not take medication. All seven interviewed staff indicated the nurse administers medication. One staff indicated the staff is able to provide medication to the youth. Four staff indicated the supervisor is able to provide medication to the youth.

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

The program has a policy and procedures regarding requirements for the storage and inventory of medications and sharps. The policy accounts for the destruction of medication through the program's pharmacy and the procedures in the event there is a discrepancy in the medication or sharps counts. In addition, the policy requires nursing staff to conduct shift-to-shift counts of controlled medications; however, the program did not have controlled medications during the annual compliance review. All medications and sharps are kept in the locked nursing office. The stock sharps and over-the-counter (OTC) medications are maintained in locked cabinets and all working sharps, OTC medications, and youth medications are kept in the locked medication cart. Any controlled medication is kept in a separate locked box inside the medication cart. Topical and oral medications are divided, and any refrigerated medications are kept in a designated fridge. All storage areas and the medication cart are clean and well-organized. Weekly and perpetual inventories were found for all stock medications and sharps. It was noted in one incident a container of tablets was inventoried as one instead of total number of tablets within the container. Perpetual inventories were found for all youth medications and working OTC medications and sharps. Three OTC medications, three sharps, and two youth medications, neither of which were a controlled medication as the program did not have controlled medication on-site during the annual compliance review, were conducted. Each of the counts matched the inventory. An interview with the health services administrator (HSA) confirmed the program's processes for the destruction of medication and procedures for instances of medication or sharp discrepancies. The nursing staff who discovered the discrepancy would immediately notify additional parties, including the Central Communications Center (CCC), and an investigation would be initiated.

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

The program has a policy and procedures in place to prevent, contain, treat, and report requirements related to infectious diseases as required by the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC). The procedures include risk assessment and methods of compliance which is in master control and available to all staff. The program includes pre-service and in-service training for all staff and education for the youth at intake; and as needed inclusive of hand washing, preventative measures of communicable diseases, and infection control. The infection control procedures for the program include all necessary elements required. Staff have access to protective equipment and follow standard universal precautions. The program has a policy to administer a needlestick post-exposure evaluation for staff if they are exposed. There were no instances in which the program was required to report an infectious disease to the local health department, CDC, or Central Communications Center (CCC). Exposure plans are reviewed with staff upon hire and annually during pre-service and in-service training.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures ensuring active and sound supervision of youth at all times by staff. During the annual compliance review, observations of education, recreation, meals, breaks, and movement were conducted daily. It was observed staff conducted counts and searches for all movements. When asked, staff were able to immediately advise of how many youth they were supervising and where each youth was located. Each day the staff to youth ratio was met during the awake and sleeping hours. Each of the youth were in school during the annual compliance review. While youth were in school or on their dorms, the staff positioned themselves to maintain active sight and sound supervision. It was observed youth and staff had appropriate interaction during scheduled activities.

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

The program has a policy and procedures addressing the behavior management system (BMS). The BMS was last updated on July 17, 2018, which was prior to the last annual compliance review. The program’s BMS is given to each youth upon their admission, during orientation to the program and the BMS was posted in each dorm. Each of the seven pre-service staff reviewed had documentation of completing BMS training. The program had documentation of the education staff completing BMS training. The education staff are hired by the program, they are not provided by the local public school system; therefore, an agreement is not necessary. The BMS is clearly written which includes all the required elements. During treatment team, the youth’s positive and negative behaviors are discussed. If necessary, special treatment teams are held to address negative behaviors when the youth may not have a formal treatment team. Each of the seven interviewed youth reported receiving daily and weekly incentives such as playing video games, canteen or special food from an outside restaurant. Each of the seven interviewed staff reported the BMS includes the point and level system, rewards and consequences. Each reported the youth receive the BMS upon admission as part of the orientation process and is posted throughout the program. Seven interviewed staff reported rewards include weekly and daily incentives such as canteen, extra phone calls, and food items. One of the seven staff reported things can be taken from youth as a consequence such as television and video games. The remaining six staff reported things cannot be taken away as a consequence.

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.*	

Each of the job descriptions for positions at the program included implementation of the behavior management system (BMS). The BMS included the process for staff to explain to youth reason for consequences and for youth to explain his behavior and discuss alternative acceptable behavior. The program has room restriction; however, has not used this since the last annual compliance review. The program's BMS does not include increased length of stay, denial of youth rights/services, promotion of group punishment, punishment of youth by other youth and confinement. Each of the seven pre-service staff records had training on the implementation of the BMS. Each of the seven youth reported youth are not allowed to punish another youth. Each of the seven youth explained a special treatment team is held when consequences are discussed. When each of the seven youth were asked about the level system, each were able to explain the differences between each level. The youth reported they receive daily and weekly incentives and the staff are consistent with the use of rewards for youth. Three of the seven youth reported the BMS is fair and four reported it being good. The facility administrator (FA) reported the program uses positive performance system as part of their BMS. The rewards are monitored by a point system on a four to one ratio and ensures a youth does not drop below a certain point level. The FA reported consequences are delivered by way of special treatment team, the infraction or rule violation is recorded on the special treatment report and the youth is informed consequences levied by the special treatment team. In addition, the process is a team approach, all members of the team have equal votes.

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

The program has a policy and procedures on the process of conducting six-minute checks. The program has thirty-two cameras, with thirty working at the time of the annual compliance review. There is documentation the program submitted a work order to resolve this issue. During the annual compliance review, the technicians were on-site to fix the cameras. It should be noted on September 16, 2019, a deficiency was assigned to this indicator for falsification of checks; therefore, video reviewed for the annual compliance review started from September 16, 2019. A review of five days of video footage and logs, totaling six checks was conducted by the annual compliance review team. Checks were conducted on each of the three dorms. A review of checks was conducted on both the third (10:00 p.m. – 6:00 a.m.) and second (2:00 p.m. – 10:00 p.m.) shifts. Six-minute check observations revealed checks conducted followed proper procedure by looking into each youth's room and pulling on the door handles to ensure they

were secured; however, during a couple of checks conducted the staff member looked into every other room instead of each room as required. Two of the six days, the staff had youth out of their rooms watching television at 1:00 a.m. and 3:00 a.m. in the morning. All seven interviewed staff reported checks are to be conducted every six minutes. According to the interview with the facility administrator, the program has thirty-two total security cameras and thirty are operational. The cameras maintain video for a period of thirty days.

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

The program has a policy and procedures on the process of maintaining census, counts, and tracking of youth in the program. During the annual compliance review, the review team observed headcounts being conducted throughout the day. Staff conducted counts at the beginning and ending of each shift, randomly throughout the day, releases, new admissions, and for all youth movement. During the annual compliance review, it was observed, when youth were on transport staff reporting movement to and from transport. The adjusted census was located in the logbook. Each of the counts were located in the logbook located in master control. All seven interviewed staff reported counts are conducted informally every hour, formal counts at scheduled times, and when counts are not accurate.

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

The program has a policy and procedures on the process of documentation in the master control logbook. The program maintains one logbook which is located in the master control. Each of the logbooks were bound with numbered pages and there were no pages missing from the logbooks. A review of six months of logbooks revealed all entries were in ink with no erasures or white-out areas. Entries included date, time, event and name of youth and staff in the event, and the name of the staff making the entry. There is documentation the Central Communications Center (CCC) calls are documented in the logbook. Due to staff being held over to the next shift, a mock shift briefing was conducted to show practice of what occurs during a briefing for incoming staff. The staff turned in personal keys in the sub-control room,

and the supervisor briefed the staff on youth behaviors, change in schedule and dorm assignment and each staff sign the shift report acknowledging receiving briefing information.

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

The program has a policy and procedures on the process of key control. The system includes key assignment, inventory/tracking of keys, secure storage of keys not in use, procedures addressing missing, lost or damaged keys. The key inventory is maintained by the physical plant manager. Each of the program keys are assigned a color tag to identify between restricted, permanent, and active. The restricted and active keys are secured in the key box in master control. The permanent keys were issued to the facility administrator and assistant facility administrator. Emergency keys are located in a red locked key box in master control. Only the master control operator has access to each of the locked key boxes. Observed direct care, therapist, and teachers sign in/out keys during the annual compliance review. The sign in/out sheet includes the name of staff, key assigned, key type, key control number, if personal keys were secured and signature of the staff. Since the last review, there were no Central Communications Center reports due to missing or lost keys. However, there were incident reports in regard to an active key being broken. The staff reported the incident was reported to administration and the physical plant manager in order to be replaced. The keys of one direct care staff, one supervisor and the physical plant manager was checked to confirm it matched the key inventory list. During an interview with the master control operator, it was reported only the master control operator has access to the key box which includes restrictive and active keys. When staff arrive to work, personal keys are collected at sub-control upon entry. Staff are to provide a chit, which is taken to master control. Staff sign the key control log, provide the chit to the master control operator and given a facility key specific to their duties. At the end the shift, the staff turn in key in order to receive their chit, sign in keys, and receive personal keys at sub-control. Each of the seven staff interviewed were able to explain the key control procedures for both visitor and employees entering the facility.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program has a policy and procedures for the process of preventing contraband entering the program. The program defines what items considered contraband for both youth and staff. The list of items includes all required items. Upon admission, each youth are informed what items are contraband and consequences if found with contraband. The program conducts perimeter checks, which includes the physical plant, daily. According to policy and procedures, youth are to be searched, this practice was observed during the annual compliance review. Youth were searched before and after every movement. The review team was unable to observe incoming and outgoing mail during the annual compliance review; however, a binder is maintained documenting when youth received in coming or out-going mail. The program conducts random room searches on all three dorms by staff. During the review period, there were four incidents of contraband being found at the program. In each case, the program conducted an internal investigation and reported to Central Communications Center (CCC). In addition, the youth and staff identified with contraband received consequences according to policy and procedures. According to the facility administrator, contraband is handled by a chain of custody system, items are recorded and stored, once the investigation is complete the items are disposed of or destroyed.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

The program has a policy and procedures for the process of conducting youth searches. During the annual compliance review, members of the review team observed youth searched before and after movements from school, dorms, and recreation. Since the youth in the program are male, only male staff searched the youth. The review team was unable to observe if youth were searched before and after visitation, transportation, admission, or youth using tools due to these situations did not occur during the annual compliance review or was missed. Each of the seven interviewed staff reported youth are searched every movement by male staff. The seven interviewed youth reported they are searched before and after every movement, returning from off campus activity, when items are missing, after visitation, and after meals.

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 received two new vehicles in March 2019. Both vehicles had working seat belts for each person in the vehicle, seat belt cutters, fire extinguisher, there is a safety screen separating the front from the back of the vehicle and window puncher. A twelve-point inspection was conducted on each enterprise fleet management vehicle prior to acquisition in March 2019. The first aid kits are kept in master control when not in use. The doors to the youth passenger areas cannot be opened from inside. Youth are not attached to any part of the vehicle other than the seat belts. Each of the vehicles were secured within the facility fence and locked. During the annual compliance review, random checks of vehicles were conducted and were found to be secured.

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

The program has a policy and procedures for the process of transporting youth. Due to scheduling conflicts, observation of transportation was not conducted during the annual compliance review. Each of the vehicles used for transportation is equipped with required safety and security items. All seven of the interviewed staff reported they are equipped with a radio and cell phone when transporting youth. None of the seven staff reported staff are allowed to use their personal vehicles for transportation of youth. There is no documentation of youth being left unsupervised in a vehicle. Youth are not allowed to drive program or staff vehicles. The program has an approved driver's list with staff who maintain current driver's license which was confirmed through the Department of Highway Safety and Motor Vehicles.

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

The program has a policy and procedures for the process of conducting weekly safety and security audits. The physical plant manager is responsible for conducting weekly security audits and safety inspections. The policy includes all required elements. A review of six months of weekly safety and security audits revealed the audits were conducted weekly and signed by the person completing the form weekly and an administrator monthly. The facility administrator reported maintenance logs and repair/work orders assist in tracking safety and security deficiencies.

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

The program has a policy and procedures for the process of tool inventory and management. The facility has a secured room with all the tools, each of the tools are on a shadow board, which includes pictures for identification. Each time a tool is used, it is signed in/out with name of person using the tool. All tools class A and B are inventoried weekly by the physical plant manager and the facility administrator/designee review and sign monthly. The tool inventory was completed for the last six months. Any tools damaged were either disposed of or in the process of being replaced. Review of youth and staff interviews confirmed youth do not have access to any tools except for brooms, mops, and 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 has a policy and procedures for the process for youth tool handling and supervision. The procedures include staff to youth ratio, tool distribution and collection and search requirements activities when tools are used by youth. Each youth had a risk assessment before usage of tools which was located each of the youth records. All seven interviewed youth and seven interviewed staff reported youth are only allowed to use mops and brooms.

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

The program has a policy and procedures for the process of outside contractors entering the facility. The program uses written notification and guidelines for outside contractors for youth to sign in and log tools brought on-site. The forms include tools checked in upon arrival and departure, tool restrictions, youth are restricted from the work area and missing tool follow-up. A review of a total of six invoices were compared to the sign-in logs. Each of the six invoices had a corresponding notification and guidelines for outside contractor signed by the vendor and program staff.

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

The program has a policy and procedures regarding the Continuity of Operations Plan (COOP) which includes directions on how often drills are to be conducted. According to the program's COOP, evacuation, program disturbances, terrorism, bomb threat, hostage, chemical, severe weather and emergency response drills are to be conducted monthly for each shift. The program had documentation drills were conducted monthly according to the COOP on the first and second shift; however, the third shift did not have monthly COOP drills for the months of June and August. The program combined drills for the second and third shift by holding over staff in order to gain drill exposure. The documentation included the type of drill, date and time, brief scenario, participants and findings/recommendations. During the facility tour, it was

observed the evacuation routes and egress plans were posted throughout the facility. Each of the twelve fire extinguishers were inspected annually. Of the seven youth interviewed, six youth reported participating in drills monthly. One youth reported not being sure and does not keep track. Interviews with staff revealed participating in weather, fire, medical, and suicide drills. The facility administrator reported drills are conducted monthly on each shift.

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

The program has a policy and procedures for the Continuity of Operations Plan (COOP). The COOP was submitted and signed by the facility administrator on March 15, 2019, the program's regional director and the Department of Juvenile Justice residential services on March 15, 2019. The COOP is located in sub-control, master control, and administration for easy access for staff. Included in the COOP is alternative housing plans in the event of evacuation, emergency contacts, drills, and responsibilities. In the master control there is a binder which includes a hard copy record for each youth. The facility administrator reported the COOP plan was located in master control, assistant facility administrator, and facility administrator office.

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

The program has a policy and procedures for the process of storing and inventorying flammable, poisonous, toxic items, and materials. The program has documentation the physical plant manager conducts chemical inventory of all flammable, poisonous, toxic items, and materials daily for the last six months. The Safety Data Sheets were compared to the chemicals and the sheets matched all chemicals on-site. All chemicals were located in a locked cabinet, which is locked at all times. The cabinet with the chemicals is not accessible to youth. The program's flammable, poisonous, toxic items, and materials inventory log was compared to actual chemicals in storage; the inventory log and chemicals matched. The program has a roster which has a list of staff positions approved to have access to chemicals. The roster was last updated December 20, 2018.

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

The program has a policy and procedures on the process of supervision and handling of flammable, poisonous, toxic items, and materials for youth. All flammable, poisonous, toxic items, and materials are locked in a secured area at the program. Youth do not use or have access to flammable, poisonous, toxic items, and materials. Of the seven youth interviewed, six reported they do not use any chemicals or cleaning products; however, one youth reported spraying his room with bleach.

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

The program has a policy and procedures on the process of disposal of flammable, toxic, caustic, and poisonous items. The program has a list of staff trained and approved to dispose of all items and materials. The policy and procedures include the requirements from the Occupational Safety and Health Administration (OSHA) standards. Disposal of all hazardous wastes are disposed of by bio-hazardous waste contractor. Since the last annual compliance review, the program has not had any items for disposal or had any chemical spills. Liquid wastes such as dirty mop water is disposed of in a plumbing drain and grease is placed in a container/barrel located outside the kitchen. The facility administrator reported all flammable, toxic, caustic and poisonous items are disposed of according to the instructions located each flammable binder.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program has a policy and procedures regarding the process of youth receiving visitation and communication while in the program. The visitation schedule is posted throughout the program. The program provides opportunity for visitation to occur when parent/guardian is available. Visitation occurs on Saturday and Sunday. The program maintains an approved /unapproved phone, mail and visitation list for each youth in the program. The youth and staff signs acknowledging receiving phone calls and mail. Each youth is assigned a day when they are to receive their weekly phone call. There is a separate visitation sign in/out log. This information is kept in a binder for staff to review when needed. During the annual compliance review, youth did not receive any incoming mail and there was no outgoing mail. Each of the seven interviewed youth reported being able to communicate with family member by mail, visitation, and telephone.

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.

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

The program has a policy and procedures on the process of safety plans for youth. The safety plans for youth are located in three locations: sub-control, master control, and the director of clinical office. The initial safety plan is placed in a binder for youth and staff to review. The safety plans include warning signs, baseline behaviors, crisis recognition, coping and intervention strategies, and debriefing preferences. All parties involved in the development signed and dated the form. All seven interviewed youth indicate a safety plan was completed within fourteen days during the completion of the initial mental health/substance abuse treatment plan. Within thirty days another safety plan is completed and placed in the binders for staff access. Updates of safety plans are completed during monthly treatment plan reviews to ensure they are updated. Four of the youth interviewed were aware of what a safety plan is; however, the remaining three youth were not aware of what a safety plan is. Seven of the staff interviewed were not aware of the process of reviewing safety plans; one of the seven staff reported the plans are reviewed during treatment team. Three of the seven staff were not aware of where the safety plans are located; four staff reported the safety plans are located in the clinical director's office and master control.