STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Polk Halfway House

TrueCore Behavioral Solutions, LLC
(Contract Provider)
2145 Bob Phillips Road
Bartow, Florida 33830

Review Date(s): December 8-11, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marvin Bliss, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Kara Brown, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Brenda Comadore, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Melissa Johnson, Office of Accountability and Program Support, Central Region Supervisor (Standard 5)
Cindy Jones, Office of Education, Deputy Education Director (Standard 2)
Stephanie Shay, Office of Accountability and Program Support, Deputy Supervisor, Central Region (Standard 5)
Jonathan Thompson, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Greg MahoumNassar, Office of Accountability and Program Support, Regional Monitor (Interviews)

Program Name: Polk Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Polk County / Circuit 10
Review Date(s): December 8-11, 2020

MQI Program Code: 1049
Contract Number: 10359
Number of Beds: 24
Lead Reviewer Code: 173

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

Overall Rating Summary

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Polk Halfway House is a twenty-four bed program, for fourteen to eighteen year old males, located in Bartow, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides Mental Health Overlay Services: Thinking for a Change (T4C) and Impact of Crime (IOC) as evidenced-based practices as well as the following groups; Anger Management/Strategies for Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, Thinking for Change, Impact of Crime, AdolescentCareer Development, Young Men's Work, Thinking Feeling Behaving, Pathways to Self Discovery or Change, and 100 Activities for Mental Health/Substance Abuse Clients. Additional treatment services provided include individual and family therapy. Program administration is comprised of a facility administrator and one assistant facility administrator. Case management services are provided by one case manager and one transitional service manager, who oversees the case management department. Mental health staff at the program includes one director of clinical services who is a licensed mental health counselor and two non-licensed therapists. Medical services are offered from 8:00 a.m. to 4:00 p.m. daily and are provided by one full-time registered nurse (RN) who is the health services administrator (HSA). The program hired a new part-time RN; both positions are contractually obligated. Educational services are provided by the Polk County School Board. The layout of the program includes one large building which houses administration, the classrooms, case management, a clinic, dorm rooms, and youth dayroom. The program has thirty-two operating security cameras providing coverage. At the time of the annual compliance review, the program had six vacant positions; three youth care worker I, two youth care worker II and one shift supervisor.

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 has a policy and procedures addressing pre-employment background screenings. Four applicable staff records and one contracted provider were reviewed. There were no new applicable volunteer records reviewed for background screenings. All five records reflected an eligible background screening from the Agency for Healthcare Administration (AHCA) Clearinghouse through the Department's Background Screening Unit (BSU). For each of the five records reviewed, background screenings were completed prior to the date of hire, criminal histories were reviewed, and four had a pre-employment assessment tool administered to direct care applicants. Each of the four direct care staff received a passing score on the pre-employment assessment tool. The program's Annual Affidavit of Compliance with Level 2 Screening Standards was completed for the program and sent to the BSU on December 6, 2019, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for education staff was completed and sent on December 19, 2019.

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 has a policy and procedures ensuring staff receive a background rescreening every five years from the initial date of employment. One staff at the program required a background rescreening during the annual compliance review period. The staff received a rescreening within twelve months of the five-year anniversary of the initial date of hire.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a policy and procedures to ensure program-related incidents, which have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff, or visitors, the security of the facility, or the reputation of the provider are reported and handled appropriately and in a timely manner. According to the written policy and procedures, abuse reporting procedures are as follows: any staff who have knowledge of, or has a reasonable suspicion a youth has been, is being, or is in danger of being abused, should immediately report it to the Florida Abuse Hotline (for youth under the age of eighteen), or the Central Communications Center (CCC) (for youth eighteen years of age or older). If a youth is requesting to contact the Florida Abuse Hotline, policy states staff are to notify the shift supervisor, who will assist the youth in making the call. The program has had no substantiated incidents of physical, psychological, or emotional abuse since the last annual compliance review. Staff adhere to a code of conduct, as indicated in the receipt of the employee handbook contained in the staff record. All five reviewed pre-service records reflected staff received training on child abuse reporting. The Florida Abuse Hotline and CCC numbers were observed posted throughout the facility. All five interviewed youth reported they feel safe in the program. All five youth reported they have never been prevented from making a call to the Florida Abuse Hotline. Four of the five youth reported staff are respectful when talking with youth, and one youth reported hearing staff use profanity. Each of the five staff interviewed were familiar with the program's abuse reporting procedures. Staff reported they have never observed a co-worker denying a youth the right to an abuse call, and all five reported they have not witnessed their co-workers using profanity or using threatening behavior when dealing with a youth. The facility administrator reported youth and staff are given instruction on abuse reporting at respective orientations, and annually thereafter for staff.

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

The program had no incidents of physical, psychological, or emotional abuse in the facility during this annual compliance review period; therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures to ensure program-related occurrences which place at risk, or have the potential to place at risk, the health, safety, or welfare of the public or of youth, staff or visitors, the security of the facility, or the reputation of the program are reported and handled appropriately and in a timely manner. The program had eight incidents reported to the Central Communications Center (CCC) during the previous six months and seven were related to COVID-19. The one applicable incident was reviewed. The incident was reported within the required two hour time frame. Reporting of the incidents to the CCC were documented in the program's logbooks. The program has not experienced an increase in the number of reportable incidents to the CCC since the last annual compliance review. A comparison of reportable incidents during the same time period last year showed a decrease of the reportable incidents from five incidents during the same time period last year, to one incident this year. Seven of the eight incident reports were COVID-19 related, leaving one total incident reported for the eleven month period. According to the facility administrator, incidents which are determined reportable are called into the CCC within two hours and documented in the program's logbook. He also reported significant incidents impacting operational safety and security are reported internally, and for qualifying incidents, to the CCC.

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

The program has had three incidents of utilizing Protective Action Response (PAR) techniques during the previous six months. All three PAR reports were reviewed. All three reports were completed by the end of the staff member's shift and included statements from all staff involved. Mechanical restraints were not utilized in any of the PAR incidents. None of the reports resulted in an allegation of abuse. All three reports reflected a review by a PAR certified instructor/supervisory staff and post-PAR interviews were completed with the youth involved within thirty minutes of the incident. All three reports were reviewed by the administrator or designee within seventy-two hours of the incident. None of three reports indicated the need for a PAR Medical Review; however, medical reviews were conducted by the on-site medical staff for all three PAR incidents. The program's PAR Plan for the 2020 year was approved by the

Department on December 9, 2020. The program's PAR rate for the previous quarter was 0, which is below the statewide residential rate of 2.10. According to the facility administrator, all PAR reports are reviewed and compared to video surveillance of the incident. The facility administrator added, the program follows up appropriately if use of PAR is unwarranted or improper.

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 a policy and procedures ensuring all newly hired staff are sufficiently prepared to meet the needs of the program and youth in their care. According to the program's written policy and procedures, staff must complete a minimum of 120 hours required training within the first 180 days of their hire date. Training documentation was available for review within the Department's Learning Management System (SkillPro) for the four applicable new hires. All four reviewed pre-service training records indicated all four staff had in excess of the required 120 hours. Each of the four staff members completed the required training prior to having any contact with youth. Contractual required training was completed as required. All instructors are qualified to deliver training provided to staff. All pre-service training was observed documented in SkillPro within the thirty day requirement. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training, which was approved on December 20, 2019.

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 has a policy and procedures ensuring all staff maintain the necessary training to meet the needs of the program and youth in their care. All five reviewed in-service staff completed the required mandatory in-service courses. All five in-service training records reflected each staff completed over twenty-four hours of annual training. The program had two applicable supervisory staff at the time of the annual compliance review. Two of the five staff had more than the required eight hours of supervisory training. None of the five staff were eligible for fiscal training. The program employs one registered nurse (RN), who had current certifications for cardiopulmonary resuscitation (CPR) with automated external defibrillators (AED). All training was observed to be documented in the Department's Learning Management System (SkillPro) within the thirty-day requirement. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training and the training plan was signed on December 20, 2019. The program has an annual training in-service calendar, which is updated as changes occur.

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 for youth to formally file complaints about conditions, treatment, services, and the actions of program staff and other youth in violation of the youth's rights and to ensure such complaints are reviewed in a fair and timely manner and resolved to the best interest of the youth, the program, and the Department. The program's grievance process includes an informal phase, including verbal dialogue and Conference Request forms, and a written or formal and appeal phase, in which youth utilize the grievance form. According to the written policy and procedures, the program has seventy-two hours to handle informal and formal grievances. The program reviews all grievances during morning management meetings and are followed-up on within twenty-four hours. The program has had one grievance filed within the previous eleven months since the last annual compliance review. The grievance was responded to and/or resolved the same day the grievance was submitted. The grievance was reviewed by the facility administrator within seventy-two hours. The program maintains copies of grievances for twelve months. Grievance forms were observed available to youth on the dorms as well as a locked grievance box. A review of four applicable pre-service records reflected all staff completed training on the program's grievance procedures. Each of the five youth interviewed were familiar with the program's grievance procedures. All youth reported they can ask for assistance in filling out grievances and forms are available to them by asking staff. All five staff interviewed were familiar with the program's grievance forms location and the procedures. According to the facility administrator, youth have a three phase grievance system; informal phase or conference request, formal phase, and appeal phase.

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

The program provides Thinking for a Change (T4C), Impact of Crime (IOC), Anger Management for Substance Abuse and Mental Health, Strategies for Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, Adolescent Career Development, and Young Men's Work, which are listed in the contract as delinquency intervention and Standardized Program Evaluation Protocol (SPEP) groups. The groups, which are required by contract, are designed to promote insight and understanding into how thought patterns and conduct impact the youth and their community. Each youth is to complete at least one delinquency group prior to the youth's release from the program. These groups are classified by the Department as evidence-based or a promising practice and provided as contractually required. There was a total of five staff who delivered the interventions during the annual compliance review period and all had the appropriate training, level of education, and numbers of years of experience in working with juvenile or adult offenders. The program considered education as well as work experience regarding which staff is to deliver the interventions. Both T4C and IOC are held twice a week for one hour, as required by contract and are evidence-based services. All staff facilitating specialized services groups have received the required training. Group sign-in sheets were

available for review and found groups were delivered, as designed. A review a five youth records found all youth have participated in either T4C or IOC. The performance plans for each of the youth addressed a priority need. The program's activity schedule reflects the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. According to the facility administrator, all facilitators are trained to facilitate the specialized service groups.

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 has a policy and procedures in place regarding life skills training provided to the youth. Services in place to address the priority needs of the youth they serve are; Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, Thinking for a Change (T4C), Adolescent Career Development, Young Men's Work (YMW), Thinking Feeling Behaving, Pathways to Self-Discovery or Change, and 100 Activities for Mental Health/Substance Abuse Clients with T4C are evidence-based services. The youth are assigned to staff/counselors/case managers and intervention groups based on comprehensive evaluation and therapist strengths. A review of three staff training records found all group facilitators were trained to deliver their respective curricula, with all facilitators having at least a master's-level education. A review of group sign-in sheets confirmed the clinical Mental Health Overlay Services groups are held seven days a week, as required. Five youth interviews indicated all participate in some type of group sessions such as Impact of Crime (IOC), Anger Management, Thinking for a Change (T4C), mental health and substance abuse counseling, SkillStreaming the Adolescent, Teen Relationship, YMW, coping skills, individual/family counseling, Alternatives to Drugs, and T4C. An interview with the clinical director confirmed the therapists follow the group schedule, and indicated weekly fidelity checks on the provided groups. A review of five youth case management and mental health records confirmed each youth received services, as outlined in their individual performance and treatment plans.

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.	

A review of the program's contract reflected the program provides Impact of Crime (IOC) to youth in the program as well as Pathways to Self-Discovery and Change. Each group is provided twice a week in the evenings. A review of the program's activity schedule reflected IOC and Pathways are conducted twice a week. Do to the COVID-19 pandemic, youth have not been able to participate in community opportunities for reparation activities intended to restore victims and communities. Youth have made cards for residents at a local retirement home. Each of the five reviewed youth records reflected all youth are currently participating in IOC. Group sign-in sheets were available for review and found groups are delivered, as designed. All five youth interviewed were able to report the current groups they are participating in and new skills or behaviors they have learned. The facility administrator indicated youth participate in IOC for restorative justice. They complete projects as a part of this curriculum. Due to the COVID-19 pandemic, youth have been restricted from going into the community.

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

The provider's contract specifies Teen Relationship Workbook and Young Men's Work (YMW) to be delivered as gender-specific treatment services, which addresses the needs of the male youth ranging from fourteen to eighteen years of age in need of mental health services. The program's activity schedule has the interventions scheduled twice a week for one hour and the group sign-in sheets indicated the service is delivered as planned. The facility administrator interview indicated YMW, recreational activities, and vocational training are used to address the needs of the targeted gender group. All five youth interviewed were able to report the current groups they are participating in and new skills or behaviors they have learned.

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

The program has a policy and procedures which addresses and determines how youth alerts are identified, documented, updated, and communicated to program staff. Five youth records were reviewed to address the program entering alerts into the Department's Juvenile Justice Information System (JJIS). All five youth records reflected alerts were entered into JJIS, as required. All alerts were verified prior to being into JJIS. Each of the five youth alerts reviewed were applicable for, and found evidence of, being documented within the program's logbook and shift reports. A review of the program's internal alerts found they were consistent with alerts entered within JJIS. All alerts requiring removal or downgrading were found to have been completed by the appropriate staff member. The facility administrator was interviewed concerning the program's internal alert process, as well as the process of entering alert information into JJIS. The facility administrator stated alerts are entered in JJIS by case management, clinical staff (mental health and substance abuse), and medical staff (medical and food allergies). Alerts are reviewed daily during management meetings and posted in the staff conference room for review by all incoming staff. He reported dietary alerts are posted in the conference room and sent to the contracted food provider by fax. Five interviewed staff reported they are briefed on youth alerts through briefings with shift supervisors, and the internal alert board located the conference room. The nurse interview indicated medical alerts are updated weekly or as needed on the alert board located in the conference room. The nurse updates the JJIS alerts as needed or as required when a change occurs.

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

The program separates the youth records into three separate records: an individual management record, individual healthcare record, and mental health and substance abuse record. All youth records are marked 'Confidential.' All records are maintained in locked cabinets within the responsible program area's office. No records were observed to be accessible to youth. In addition, office area doors are marked 'confidential.' A review of five individual management records found each record were separated by labels to include the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each record was divided into the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous.

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

The program has formal processes to promote input from youth. A review of sign-in sheets and agendas found evidence the program hosts daily meetings, community meetings, and monthly Youth Advisory Board meetings. Additionally, the program provides "Speak Out" forms for youth to submit ideas, needs, or concerns. The forms are available in various program areas. Youth may complete the forms and submit them to staff in order to speak with designated staff and administration concerning issues they may have. In addition, the program conducts regular surveys for youth and parent(s)/guardian(s.) The facility administrator was interviewed concerning the program's efforts to provide youth the opportunity to give input, which revealed this is completed through the use of daily meetings and the Youth Advisory Board. Five youth were interviewed concerning their ability to provide input into programming operations. All youth reported they an offer input about what happens at the program. The youth reported they can do this through the Youth Advisory Board, "Speak Out" forms, grievances and/or Conference Requests forms, daily meetings, community meetings, and informal discussions with administrators.

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

The program has a Community Advisory Board (CAB) which is scheduled to meet on a quarterly basis and is combined with another program in the community. This ended as of May 2020 with Polk Halfway House maintaining the board following the closure of the Bartow Youth Academy program. The program was able to provide a written agreement with the Department of Juvenile Justice to hold a combined CAB. A review of the CAB binder found the quarterly advisory board meetings to be held on December 2019, March, June, September, and December of 2020. Due to the COVID-19 pandemic, the meetings for March, June, September, and December 2020 were conducted utilizing a web-based video conferencing system. Each meeting included documentation of the attendees list to support members participation. The sign-in sheet and

agenda were reviewed. A mailed letter sent to the advisory board members was reviewed confirming the board members' invitation to the upcoming meetings. A review of meeting sign-in sheets, the board roster, and letters from the program found the facility administrator (FA) solicited involvement from a law enforcement representative, judiciary community representative, other community partners, business community representative, school board or district representative, faith community representative, Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) community representative, victim, victim advocate, or other victim services community representative, and a parent/guardian whose child was previously involved in the juvenile justice system. An interview with the FA indicated the CAB meets quarterly. Due to COVID-19, meetings are held online through a web-based video conferencing system. Members of the CAB provide suggestions about activities for youth. For example, CAB members recently dropped off a Christmas tree and decorations, and are planning a Christmas celebration for the youth. During the interview with a CAB member, the board member stated they served on the board for approximately seven years and attended fifteen or more CAB meetings. The board member stated CAB meetings are typically held quarterly, and the board has accomplished such tasks as planned youth outings, scheduled guest speakers, and have donated breakfast items for youth, holiday dinners, and holiday gifts for the youth.

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

The program provides youth and parents/guardians surveys to complete in order to utilize data for program planning. Surveys include admission surveys, discharge surveys, and quarterly surveys sent out during the youth's stay. The survey results are incorporated into the planning process through sharing of information in monthly all-staff meetings. This information was verified through a review of meeting minutes and agendas. The facility administrator (FA) uses meetings as a system of communication to keep staff informed and allow them opportunities to provide input and feedback pertaining to program operations. The program has a staff retention plan, which includes steps to minimize turnover and improve staff morale. These include recognition rewards, incentive rewards, employee referrals, and bonuses. The program has a policy and procedures for staff communication to include opportunities for providing input and feedback on the program's operations. The program communicates important information by shift briefings and daily management meetings. All five interviewed staff report staff meetings were held monthly. The five interviewed staff report meeting topics include important and valuable information such as issues with youth, safety and security, changes in policy and procedures, dress code, observations, and drills. All five staff report they were briefed on survey results and annual reports, as well as input is encouraged by staff. Four of five staff reported the communication at the program was very good and one staff reported communication was good. The FA reported staff turnover is a recurring issue in all facilities. The interview with the FA confirms the assistant facility administrator (AFA) and FA are regularly reviewing résumés and conducting interviews to fill staff vacancies. The FA stated morale among staff seems to be good. The facility does events throughout the year to improve staff morale. For example, there was a potluck dinner provided for youth and staff on Thanksgiving Day. Staff participate in TrueCore Employee of the Month to promote staff recognition. The FA stated they review the Comprehensive Accountability Report (CAR) and Monitoring and Quality Improvement (MQI) results, as well as surveys in all monthly staff meetings and work to improve services based on feedback.

1.19 Staff Performance	Satisfactory Compliance

The program ensures a system for evaluating staff, at least annually, based on established performance standards.

The program has a policy and procedures for evaluating staff, performance standards, and the frequency of evaluations. The program's policy indicates evaluations are to be completed annually, or as deemed appropriate by the supervisor. A review of five position descriptions was conducted and determined each staff member's performance standards were clearly identified. A sample of performance evaluations were reviewed and determined to be completed consistent with the program's policy. Staff are evaluated at least annually on their established performance standards. The performance standards matched job descriptions for each staff position reviewed. A review of the program's contractual agreement found all key positions were filled at the time of the annual compliance review. The facility administrator was interviewed and stated supervisors rate staff based on key performance indicators and set goals for each staff to attain beyond these. Five staff were interviewed and asked how often they receive performance evaluations. All five staff reported annually.

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

The program provides a variety of recreational and leisure activities to include basic physical fitness, team and individual sports, and teambuilding activities. The program has a posted activity schedule. The program has a policy and procedures, which describes provided activities are based on the developmental levels and needs of the youth in the program. Activities include a choice of leisure and recreation options. Youth are encouraged by staff and activity options to explore interest. Youth were observed to be engaged in constructive use of leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury, some of which is documented in the logbook (outside temperatures and conditions, physical plant issues). A review of the logbook indicated four out of five days reviewed did not have recreation documented. Video review indicated four of fourteen days was indoor recreation due to weather. The other ten days indicated recreation was held as required. A review five youth records demonstrated the therapeutic activities provided are part of each youth's performance and/or treatment plan. Five youth were interviewed. Each of the youth agreed there are physical activities and leisure activities provided for at least one hour a day. Youth described some of the activities to include football, basketball, television, kickball, watching movies, and character building games with treatment staff. Each of the five youth affirmed they are provided with varying degree of mental and physical exertion throughout the day. Five staff were interviewed, and each were able to provide an example of what types of indoor and outdoor activities are provided to the youth.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures to ensure each youth's parent/guardian, committing court, and assigned juvenile probation officer (JPO) are notified of the youth's admission to the program within the required time frames. A review of five youth case management records indicates the program notified each youth's parent/guardian by telephone within twenty-four hours of admission and in writing within forty-eight hours of admission. The reviewed records indicate each youth's committing court and assigned JPO were notified within five working days of admission. All parent/guardian, committing court, and JPO notifications were made the day of admission. Notifications to the youth's post-residential counselor were not applicable in any of the records due to the post-residential counselor not being assigned at the time of 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.	

The program has a policy and procedures stating each youth shall be provided an orientation to the program rules, procedures, schedules, and services, beginning on the day of admission. A review of five youth case management records reflect each youth received orientation on the day of their admission. Each youth's orientation included all required topics. Each youth's record contained an orientation form signed by the youth which lists all covered topics and is dated the day of admission. In addition, each record contained a signed form, dated the date of admission, outlining the program's sexual misconduct policies and procedures. Five youth interviews confirmed each youth received an orientation beginning within twenty-four hours of admission. Each interviewed youth was able to explain the orientation process and stated they received the program rules. No admissions occurred while the annual compliance review team was on-site; therefore, an orientation was not able to be observed.

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

The program has a policy and procedures which requires the program to obtain 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 any information related to the youth's physical or mental health screening, assessments, or treatment with the parent/guardian. None of the five case management records selected for review were for youth who were eighteen years of age at the time of admission or had turned eighteen since being in the program. Three additional records were requested for review. All three youth records contained a written

consent from the youth, signed and dated on their eighteenth birthday, prior to providing or discussing information related to physical or mental health screening, assessments, or treatment with the parent/guardian.

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 to address utilization of a classification system which promotes safety and security, as well as, effective delivery of treatment services, and ensures initial classification is used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. A review of five case management records showed each youth received an initial classification the day of admission. Each record contained a Classification form including all required elements. Four of the youth had a new Victimization and Sexually Aggressive Behavior (VSAB) completed and entered into the Department's Juvenile Justice Information System (JJIS) prior to the youth's room assignment. The remaining youth's VSAB was completed and entered in JJIS a day late. All five youth records revealed documentation of identified or suspected risk factors, including: suicide, medical, escape, and security risks on their classification forms. All identified alerts were entered into the program's internal alert system. All identified alerts had previously been entered in JJIS. The program's internal alert system was reviewed, and they have an alert board, listing each youth's alerts, located in the conference room. An interview with the facility administrator (FA) confirmed all factors of each youth are evaluated during intake to determine the appropriate room assignment. The FA stated case management, clinical, operations, and medical all have an opportunity to provide input and the VSAB is used to determine vulnerability. A review of five case management records showed each youth was reassessed prior to considering an increase in the youth's privileges or freedom of movement. The program completes monthly risk assessment forms on each youth, which are kept in a risk assessment binder. Each youth had a form completed monthly for consideration of an increase in program privileges. The program does not participate in work projects or off-campus activities.

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

The program has a policy and procedures for gathering information on gangs and sharing the information with law enforcement. One of the five selected youth case management records was applicable for youth gang involvement or association. The program only had one youth applicable for gang involvement or association; therefore, no additional records were reviewed. The one applicable youth record contained documentation of local law enforcement, education, and the youth's juvenile probation officer (JPO) being notified of suspected gang activity the day of admission. The youth's residential placement was not in the youth's home county. Law

enforcement in the home county of the residential facility and law enforcement in the youth's home county were notified of gang involvement or association for the youth. The youth had a gang alert in the Department's Juvenile Justice Information System which was entered prior to the youth's admission to the program.

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

The program has a policy and procedures for implementing gang prevention and intervention strategies. The program utilizes an ARISE curriculum titled, "Gangs: 50+ Stories of Fractured Lives," as their gang intervention curriculum. The program utilizes the Impact of Crime (IOC) group and social and life skills groups for gang prevention/awareness for all youth. One of the five selected youth case management records was applicable for youth gang involvement or association. The program only had one youth applicable for gang involvement or association; therefore, no additional records were reviewed. The program maintains a gang binder with the curriculum, sign-in sheets, youth's completed program activities, a copy of the youth's performance plan, and all other gang information. A review of the gang binder confirmed the youth is participating in gang interventions. The youth's performance plan includes relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. An interview with the facility administrator (FA) indicated youth who are identified as gang members upon intake are documented in their gang binder. The FA stated youth who are determined to be gang members are reported to their juvenile probation officer (JPO) and local law enforcement. The FA stated youth participate in IOC and Thinking for a Change as their prevention strategies. The program's policy and procedures indicate the youth have an opportunity to develop a plan to dis-affiliate with a criminal street gang, if they desire.

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

The program has a policy and procedures to ensure an initial assessment of each youth is conducted within thirty days of admission and a reassessment of each youth is conducted within ninety days of the initial assessment. All assessments and reassessments should be maintained in the Department's Juvenile Justice Information System (JJIS). Five youth case management records were reviewed, and each had a Residential Assessment for Youth (RAY) completed in JJIS within thirty days of admission. Four of the youth records were applicable for reassessments, as ninety days had not passed since the initial assessment for the remaining youth. Each record contained documentation showing a reassessment was completed within ninety-days after completion of the initial RAY. Two records were applicable for a second reassessment, as it had been ninety days since the initial reassessment. One record contained documentation the second reassessment was done within ninety-days of the first reassessment.

The remaining record contained documentation of a second reassessment was completed; however, it was completed four days late.

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. A review of five youth case management records indicate each youth had a YNAS completed within thirty days of admission. Each YNAS was documented in the Department's Juvenile Justice Information System.

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

The program has a policy and procedures to address performance plan development and ensure each youth's Individualized Performance Plan (IPP) is developed within thirty days of admission. Five youth case management records were reviewed, and each contained documentation showing their IPPs were completed within thirty days of admission. Each youth's IPP was developed after the initial assessment was completed. The creation of the IPP should include treatment team members including the treatment team leader, youth, administrative representative, treatment staff, educational staff, if applicable, Department of Children and Families (DCF) caseworker or Agency for Persons with Disabilities (APD) waiver support coordinator, if applicable, all parties who have significant responsibility in goal completion, and the parent/guardian. All required parties participated in the development of the IPP for each youth; however, education staff were not available for participation for two of the youth due to COVID-19, and the county school board requiring teachers to remain out of the facility. In each of these instances, the education staff provided written feedback to the treatment team on the youth's educational progress. None of the reviewed youth were applicable for DCF or APD participation. All five youth records contained correspondence of the IPP being sent to a parent/guardian with a request to sign the signature page and return it to the program. Each IPP included the required elements including individualized goals, incorporation of the three top criminogenic needs, specific delinquency interventions with measurable outcomes, target court-ordered sanctions, transition activities, youth responsibilities, staff responsibilities, target dates for completion, and the youth's recreation plan. The program is required to send a transmittal letter and copy of the IPP to the committing court, juvenile probation officer (JPO),

parent/guardian, and if applicable, the DCF caseworker within ten working days of the plan being completed. All five records included documentation of the transmittal letter and IPP being sent to the required parties in the required time frame. Five youth were interviewed, and each youth stated they participated in the development of their IPP. Each youth was able to identify their goals and stated they have a copy of their IPP.

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

The program has a policy and procedures to ensure each youth's performance plan is revised when determined necessary by the intervention and treatment team. A review of five youth case management records indicated there was no need to revise any of the youth's plans based on their Residential Assessment for Youth (RAY) results, as the top three criminogenic needs did not change. All five plans were revised based on newly acquired information and when the youth demonstrated progress or lack of progress towards completing a goal. The program's practice revealed the treatment team meets formally at least every thirty days to discuss each youth's performance plan, and any necessary revisions to the plan are made. None of the five records were applicable for youth in transition. Three additional closed records were requested for review and all indicated updates were completed on the plans to address transitional activities prior to the youth's release date.

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

The program has a policy and procedures to ensure the treatment team prepares a Performance Summary at ninety-day or less intervals following the signing of each youth's performance plan. A review of five case management records indicated four records were applicable for a Performance Summary. Ninety days had not passed since the creation of the performance plan for the remaining youth. Three of the applicable records had a Performance Summary completed at least every ninety days following the signing of their performance plan. The remaining youth's second Performance Summary was completed two days late. Each summary included the youth's status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment to the program, and any significant positive and negative events. None of the reviewed records were applicable for having a performance summary completed prior to the youth's release, discharge, or transfer from the program. Documentation on reviewed Performance Summaries reflected all four youth were given the opportunity to read and add comments prior to signing their Performance Summaries. Documentation revealed each youth was provided a copy of their Performance Summary and the original summary was placed in their case management record. Each summary was signed

and dated by the treatment team leader, staff member preparing the summary, program designee, and youth. A review of transmittal documentation in three records validated each summary was sent or provided to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian within ten working days. The remaining youth's transmittal letter was sent to the court, JPO, and parent/guardian four days late. None of the five youth were involved with the Department of Children and Families. Interviews with five youth indicated they all received a copy of their Performance Summary sent to the court.

A review of three closed youth case management records indicated the original release summary, along with justification for release was sent to the assigned JPO with the Pre-Release Notification (PRN) for each youth. All three summaries and PRNs were sent at least forty-five days prior to the planned release date and a signed copy was retained in each record. The court did not object to the release for any of the three youth. Each record contained documentation showing the program provided written notification to each youth's parent/guardian notifying them of the youth's release. Each contained documentation supporting the Residential Assessment for Youth (RAY) was completed for each youth following approval of their release. None of the reviewed youth were applicable for the Sexually Violent Predator Program (SVPP) or for victim notification.

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

The program has a policy and procedures to ensure they are encouraging and facilitating the involvement of the youth's parent/guardian in the case management process, to the extent possible and reasonable. Each youth's parent/guardian participates in the case management process, including the assessment process, development of the performance plan, progress reviews, formal treatment team meetings, and transition planning. If unable to attend, the parent/guardian can participate by telephone. Reviewed documentation indicates a telephone call is made to the parent/guardian, on the day of admission, to inform them the youth has been admitted and to obtain information on the youth. An admission letter is sent to the parent/guardian, along with a parent/guardian handbook. A parent/guardian input form is also sent out to gather additional information on the youth and family to assist in the case management process. Letters are mailed to the parent/guardian informing them of the dates and times of youth treatment team meetings, the transition meeting, and the Exit Conference inviting them to participate. A review of documentation in five youth case management records revealed the parent(s)/guardian(s) were invited to all formal treatment team meetings and were able to provide feedback. Two treatment team meetings were observed during the annual compliance review, and the parent/guardian was contacted by telephone in each instance. The first parent/guardian stated they were at work and unable to participate. The second parent/guardian participated by telephone. An interview was conducted with the facility administrator (FA) who verified parent(s)/guardian(s) are encouraged to participate in the treatment team process by telephone. The FA indicates the case manager maintains contact with parent(s)/guardian(s) as necessary. Five youth were interviewed, and all indicated their parent/guardian is involved in their case management services.

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

The program has a policy and procedures ensuring each youth's treatment 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. A review of five youth case management records and two observed treatment team meetings during the annual compliance review verified each youth's treatment team includes a treatment team leader, the youth, an administrative representative, treatment staff, educational staff, juvenile probation officer (JPO), parent/guardian, living unit representative, and the transition services manager. In addition, a representative from medical was present at each treatment team meeting. Documentation reviewed in each case management record indicated each youth's JPO, parent/guardian, and other pertinent parties were encouraged to participate through advanced notification and were able to provide input if unable to participate in person. Each record contained letters to the JPO and parent/guardian informing them of the date and time for each treatment team meeting and inviting them to participate. All reviewed records contained documentation showing all required participants attended each treatment team meeting. During the annual compliance review, an observation of two treatment team meetings revealed active participation by all required parties. None of the youth reviewed were involved with the Department of Children and Families.

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

The program has a written policy and procedures to ensure each youth's performance plan references or incorporates their treatment or care plan. A review of five youth case management records reflect each youth had an additional plan addressing academics, medical, mental health, and/or substance abuse. All five reviewed records contain documentation verifying each youth's performance plan references or incorporates their treatment plans. There were no applicable youth at the program involved in the Department and Children and Families (DCF) or receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a policy and procedures to address informal and formal treatment team meetings. The meetings are to take place bi-weekly, formally and informally, to review each youth's performance. A review of five youth case management records indicated each youth received a formal treatment team review at least every thirty days. A review of five youth case management records indicated each youth received an informal treatment team review once bi-weekly each month. All formal and informal reviews were documented in the youth's case

record and included the youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress, any performance plan revisions, progress on goals, positive and negative behaviors, behaviors resulting in physical interventions, an opportunity for the youth to demonstrate skills, and treatment progress. Four of the records were applicable for Residential Assessment for Youth (RAY) Reassessment results being reviewed and documented on during formal reviews. The remaining youth had not been in the program long enough for a RAY Reassessment to be completed. The RAY Reassessment results were reviewed and documented in one of the youth's case management records. The remaining three records did not include documentation of RAY Reassessment results being reviewed during their formal reviews following a RAY Reassessment. The program acknowledged the reviews of RAY Reassessments were not documented; however, they stated they did review the reassessments during the formal reviews and attached them to the review forms. Two formal treatment team meetings were observed during the annual compliance review. All required staff were present and participated, and all required information was discussed. Education was not present but provided information in writing prior to the meetings. Each youth's treatment plan stated the youth's anticipated release date. A review of the Department's Juvenile Justice Information System (JJIS) indicated JJIS was updated to reflect each youth's anticipated release date. Five youth were interviewed, and each stated staff review their performance to include progress on treatment plan goals, positive and negative behavior, and treatment progress. Each youth indicated they are provided an opportunity to demonstrate skills they learned in the program during treatment team meetings.

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

The program provides for a Type 2 vocational competency program for all youth, which incorporates the use of My Career Shines. This curriculum includes communication, interpersonal, and decision-making skills, as well as offering career interest surveys, résumé preparation and experience in completing job applications. A review of the interview with both the lead educator and the facility administrator disclosed the program provides certificates in Safe Staff and Occupational Safety Health Administration (OSHA), which is appropriate for both the age of the youth served and their length of stay. Three closed records were reviewed. All three records contained an individual résumé, samples of completed job applications, and a calendar of post commitment appointments including the telephone number and location of each youth's local Career Source Center. None of the three youth had a Department of Highway Safety and Motor Vehicle state-issued identification (ID) card, but all records included a statement, in their transition plan, indicating due to the COVID-19 pandemic restrictions, the youth would not be able to be taken off campus to be able to obtain an ID card. In addition, the statement mentions the parent(s)/guardian(s) would follow up with the ID process once the youth is released from the program. There was paperwork included outlining the process for obtaining documentation necessary to attain an ID for the youth.

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.	

Polk County School District provides educational instruction on a 250-day calendar to youth in the program. The district approved calendar was reviewed and incorporates ten-days of in-

service training for the teachers. The daily class schedule was provided and there are six periods a day providing the minimum required twenty-five hours of instruction a week. The youth receive credits for the education and training received while at the program. A review of the daily logbooks, provided by an on-site reviewer, ensured classes are taking place as scheduled. The lead teacher interview confirmed the class schedule is appropriate, career education is being provided, and there are minimal interferences of the educational program. Five interviewed youth indicate there are no classroom interruptions.

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

The program has a policy and procedures to address the provision of education transition. Three youth closed case management records were reviewed, and all included an Education Transition Plan. All plans were developed based on the youth's post-release goals, beginning at admission, to include all key personnel related to transition activities, including responsibility requirements, and post-release needs. The three closed records included a copy of the youth's Electronic Educational Exit Plan (EEEP), a notification of the Community Re-Entry Team (CRT) meeting, and a calendar of appointments which included the location of the youth's local Career Source Center. According to the youth interviews, all five youth responded they were involved in the development of their Education Transition Plan and all believe they had been well prepared, while at the program, for employment or their next educational placement.

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

The program has a policy and procedures to ensure the treatment team is planning for each youth's successful transition to the community upon release from the program, when developing the youth's performance plan and throughout its implementation during the youth's stay. A review of three closed case management records verified the program held a Transition Conference for each youth at least sixty-days prior to their targeted release date. Documentation in all three records confirmed the program invited each youth's parent/guardian, juvenile probation officer (JPO), educational staff, and other pertinent parties to the Transition Conference. All required parties participated either in person or by telephone. Documentation in all three records verified the attendees signed and dated the transition plan and a copy of the plan was sent by mail to the parent(s)/guardian(s) and JPOs who participated by telephone, with

a request they sign the plan and return it to the program. Documentation indicated the Transition Conference included a review of transition activities, a revision of performance plan, identification of additional transition activities as needed, identification of target completion dates, and persons responsible for completion. Reviewed documentation confirmed each youth participated in a Community Re-Entry Team (CRT) meeting with their case manager prior to their release from the program. Evidence in all three case records indicated an invitation to participate in the CRT was received and maintained in the record.

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

The program has a policy and procedures for assembling an Exit Portfolio for each youth to assist the youth once they are released back into the community. A review of three closed case management records confirmed an Exit Portfolio was discussed and initiated for two youth at the Transition Conference. The additional youth was not applicable as their Transition Conference was held at a different program prior to transferring to the program. All three youth's portfolios were completed by the program, verified at the Exit Conference, and given to the youth upon release. Each record contained a copy of the youth's Exit Portfolio including a copy of the youth's transition plan, a calendar with all upcoming community appointments, education or vocational certificates, education records, school transcripts, a résumé, and sample job applications. None of the three records contained a Department of Highway and Safety Motor Vehicles state-issued identification (ID) card and one of the records did not contain a birth certificate or Social Security card. The program was unable to obtain state ID cards, Social Security cards, or birth certificates for the youth due to COVID-19 restrictions. Each Exit Portfolio included instructions for getting a state ID card, birth certificate, and Social Security card, along with a plan for each youth to obtain the needed documents. There was documentation in each record showing the Exit Portfolio information was forwarded to the youth's juvenile probation officer (JPO). The program's contract was reviewed, and no additional requirements were noted.

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

The program has a policy and procedures to make certain an Exit Conference is conducted for each youth, 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 youth case management records were reviewed. Documentation indicated each reviewed youth had an Exit Conference, which was held after the program notified the juvenile probation officer (JPO) of release, and at least fourteen days prior to the youth's release date. Each Exit Conference was documented in the case management record and included a summary of pending transition goals, the date of the conference, and names/signatures of participants. The status of transition activities established at the Transition Conference and finalized plans for the youth's release were reviewed for each youth. Participants included the treatment team leader, parent/guardian, an education representative, JPO, and youth. Each youth's Exit Conference was separate from their transition and Community Re-Entry Team meetings. No Exit Conferences took place during the annual compliance review; therefore, the process was not able to be observed. Each

youth's date of admission and date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS).

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

The program has an on-going safety planning process for each youth, which is designed to identify stimuli which have both positive and negative effects on the youth. The program maintains a safety plan binder which contains the most recent safety plans and is kept in the conference room, accessible to all staff. Older safety plans are maintained in the youth's mental health records. Dates of updates are documented on the program's alert board every time a safety plan is updated for each youth. Any changes in youth safety plans are discussed in shift briefings. Each youth's safety plan includes warning signs, baseline behaviors, crisis recognition, coping strategies, intervention strategies, and debriefing preferences.

A review of five mental health records found each youth had a safety plan developed within fourteen days of admission. Each plan was jointly prepared by the youth, parent/guardian, and clinical staff. Telephone calls were made to parent(s)/guardian(s) on the day of admission, and input forms were mailed out to gather information for the safety plans. Each safety plan was mailed to the parent/guardian to sign and return to the program. Four of the youth's safety plans incorporated recommendations from assessments and/or screening instruments and incorporated trauma responsive practices. The remaining youth's safety plan did not incorporate these things. Documentation in all five youth records found each youth's safety plan was updated every thirty days, with the exception of one update for one youth, which was completed four days late. Five youth were interviewed, and each youth stated they were involved in the development of their safety plan. Five staff were interviewed, and they all were aware of the location of the youth safety plans. Each staff stated safety plans are reviewed monthly. Three staff stated they last reviewed safety plans a week prior to the annual compliance review and the remaining two staff stated they reviewed safety plans two days prior to the annual compliance review. An interview with the facility administrator indicated safety plans are updated every thirty days during treatment team, and as necessary in the event of a qualifying incident.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA). The LMHC is licensed under Chapter 491, Florida Statute with a clear and active license expiring on March 31, 2021. The LMHC is employed with the program as a full-time employee, on-site a minimum of forty hours a week; and provides coordination and implementation of mental health and substance abuse treatment services. In addition, the DMHCA provides clinical supervision of the non-licensed therapists. The LMHC position description was available for review while the annual compliance team was on-site. All mental health and substance abuse staff licensures and position descriptions were available on-site for review with no issues. An interview with the DMHCA revealed she understands her role in the coordination and implementation of mental health and substance abuse services at the program. In addition to being on-site full-time, the DMCHA is on-call and available by phone twenty-four hours a day, seven days a week. If back-up coverage is needed, the DMHCA stated the company would be informed and another DMHCA from another program would provide back-up. Additionally, the program is considering using the newly licensed therapist at the program, as a backup, but the decision is pending a change in the position description for the newly licensed therapist's position. The program has a licensed psychiatrist who visits the program and meets with the youth bi-weekly. The program provides specialized Mental Health Overlay Services (MHOS) for twenty-four slots, serving male youth between the ages of fourteen to eighteen years old. The program provides evidence-based groups, bi-weekly individual sessions, and monthly family sessions.

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 reviewed records confirmed the program's mental health and substance abuse staffing is in accordance with the program's contract and Florida Administrative Code. The program has one licensed mental health counselor (LMHC) on-site, who serves as the designated mental health clinician authority (DMHCA). A review of the DMHCA's license confirmed it is clear and active and expires March 31, 2021. The licensures for all qualified mental health and substance abuse professionals were available for review on-site. The program is licensed under Chapter 397, Florida Statutes to provide substance abuse treatment services as certified by the Department of Children and Families (DCF), which expires on April 7, 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.	

A review of the records confirmed the non-licensed mental health and substance abuse clinical staffing at the program is in accordance with the current contract and Florida Administrative Code. The program has one full-time non-licensed clinical staff, who provides mental health and substance abuse services within the program. A review of the records confirmed the non-licensed clinical staff holds the appropriate level of education necessary, is in accordance with Florida Administrative Code and the contract between the provider and the Department. The non-licensed clinical staff holds a master's-level degree from an accredited university in an appropriate field of study. The non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training was documented on the appropriate Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. A review of the last six months of direct supervision logs for mental health clinical staff indicated the non-licensed clinician received direct supervision by the designated mental health clinician authority every week they provided services at the facility.

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

The program maintains a policy and procedures addressing the implementation of a standardized admission/intake mental health and substance abuse screening process which includes all required elements. The program has a comprehensive plan for mental health and substance abuse services which defines the standardized admission/intake mental health and substance abuse screening process. The program's mental health clinician conducts a comprehensive screening process to address the mental health and substance abuse needs of the youth. Referrals are made when the youth's mental health (MH) or substance abuse (SA) needs are identified as possible suicide risk or other vulnerabilities. Immediately upon the youth's arrival to the program, an initial MH/SA screening process is initiated by multidisciplinary treatment staff to ensure the identification of MH/SA issues requiring immediate attention. The screening process is designed to gather information on the youth prior entering the general population. A Facility Entry Physical Health Screening is conducted by the nursing staff to assess the youth's medical needs. Mental health substance abuse screening is conducted by the assigned therapist or clinical director. All consents are obtained. A Massachusetts Youth Screening Instrument Second Version (MAYSI-2) shall be administered and scored using the Department's Juvenile Justice Information System (JJIS). In addition, an Assessment of Suicide Risk (ASR) is conducted to assess the youth's suicide risk. A review of the youth's commitment information packet information is conducted to assess past history, existing problems and risk factors.

A screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) is administered and scored using the JJIS form. An Admission Classification Meeting Process is conducted to assist in the determination of appropriate placement needs, safety and security issues, sleeping arrangements and the identification of youth in need of mental health and substance abuse assessment and treatment. Five youth records were reviewed for a mental health and substance abuse admission screening. Documentation indicated the staff conducted a comprehensive review of all five youth's commitment packet information, reports, and records referencing existing mental health and/or substance abuse problems. In addition, the Department's Juvenile Justice Information System (JJIS) alerts were reviewed and corresponded with the reviewed documentation. Each of the five youth had MAYSI-2 screenings completed on date of the youth's admission to the program and were conducted by staff who completed the appropriate training. The MAYSI-2 screenings were administered in the Department's JJIS. None of the five youth records had indications where staff believed a youth had a mental health or substance abuse problem, was a suicide risk or had indications where staff determined a referral for further evaluation was needed. Two of the five youth MAYSI-2 conducted screenings indicated further assessments were required; however, the MAYSI-2 did not indicate a referral was necessary; the staff entered the information, observations, events, or concerns leading to the determination into JJIS. All five youth were referred for an ASR. Each ASR was completed within twenty-four hours of the referral. All five of the youth were referred for a comprehensive evaluation. Each of the youth had a reason for a referral documented but only two required further assessments.

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.	

Five youth records were reviewed for a comprehensive mental health and substance abuse evaluation. All five youth records reviewed had a new comprehensive mental health and substance abuse evaluation completed within thirty calendar days of admission. Three of the five new comprehensive mental health and substance abuse evaluations were conducted by a non-licensed mental health clinical staff and two were completed by the program's licensed mental health counselor (LMHC). All three comprehensive mental health and substance abuse evaluations completed by a non-licensed mental health clinical staff, were reviewed and signed within the required ten days by the LMHC. Each of the five comprehensive mental health and substance abuse evaluations contained all the required elements and recommendations.

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.*	

Five reviewed youth records confirmed the program is providing mental health and substance abuse treatment planning addressing intervention and treatment for every youth entering the program. Documentation indicated in all reviewed records, the youth were assigned to a mental

health and substance abuse treatment team during entry into the program. In four of the five records documentation indicated the treatment teams were comprised of representatives from administration, education, vocational training, medical, mental health and substance abuse staff, youth, residential living unit staff and when possible, the youth's parent/guardian. In the remaining one youth record documentation indicating participation of all required treatment team members were found except for the treatment plans on September 17, 2020 and October 12, 2020, where documentation for the living unit representative was not found.

All five reviewed youth were determined to be in need of mental health and substance abuse treatment. Reviewed documentation for all five revealed the treatment plans required daily group counseling sessions, bi-weekly individual counseling sessions, and monthly family counseling sessions. The review of progress notes and other supporting documentation confirmed each of the youth were in receipt of individual, group, family counseling, and/or psychiatric medication management, as required. The substance abuse treatment provided was conducted by a licensed qualified professional or a non-licensed substance abuse clinical staff working under the direct supervision of a licensed mental health professional. Each of the five youth records reviewed for substance abuse treatment had a signed Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records form. Mental health and/or substance abuse treatment notes were documented on the provider's form, which contained all the required information from the Department's Counseling/Therapy Progress Note form.

All five youth records reviewed were applicable for mental health treatment. The program has a contract to provide Mental Health Overlay Services (MHOS) to twenty-four youth. Youth sign-in sheets for MHOS groups were reviewed. Documentation reviewed and video observations during the annual compliance review confirmed the MHOS group therapy did not exceed ten youth in any session. Youth sign-in sheets for substance abuse treatment groups documented the groups were limited to fifteen or less. A review of the five youth records contained documentation youth were involved in individual psychotherapy or counseling. Youth were engaged in therapeutic activities designed specifically to address skill deficits or maladaptive behaviors. The program utilizes the following curricula for psychosocial skills training such as Anger Management/Strategies for Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, Adolescent Career Development, Young Men's Work, Thinking Feeling Behaving, Pathways to Self-Discovery or Change, and 100 Activities for Mental Health/Substance Abuse Clients. Substance abuse treatment is provided by qualified staff under the program's Chapter 397 license. Each of the five youth had a properly executed Authority for Evaluation and Treatment (AET) form on file. All five staff interviews indicated they do not facilitate or aware of other direct care staff facilitating any mental health or substance groups. The designated mental health clinician authority (DMHCA) was interviewed and stated mental health and substance abuse treatment services are available on-site through the provisions of MHOS all available services at the program are designed to serve youth with mental health and substance abuse issues. Additionally, the DMCHA stated all mental health and substance abuse treatment services at the program are provided by or under the supervision of the licensed mental health professional. At a minimum mental health and substance abuse treatment services will include individual therapy sessions on a bi-weekly basis by the primary therapist, family therapy sessions monthly through telephone and daily group counseling sessions. The DMHCA is responsible for the oversight of all mental health services. Five of five youth interviews indicated youth are participating in family and individual counseling. All five staff interviews indicated they do not facilitate mental health or substance abuse groups.

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

The program maintains a policy and procedures for the provisions of mental health and substance abuse treatment and discharge planning. Five youth records were reviewed for an Initial Mental Health and Substance Abuse Treatment Plan. Each plan included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Documentation indicated all five Initial Mental Health and Substance Abuse Treatment Plans were developed on the date of admission and were completed by a non-licensed mental health clinical staff which were subsequently reviewed and signed by the licensed clinical supervisor within ten days of completion or developed by a licensed clinician. Reviewed documentation reflected each plan was signed by all treatment team members except the living unit representative in two instances.

A review three additional closed records indicated all three youth had a Mental Health and Substance Abuse Treatment Discharge Summary completed prior to the discharge date and reviewed with the youth and parent/guardian upon release. None of the three youth required notification of suicide risk at the time of discharge. All three Mental Health and Substance Abuse Treatment Discharge Summaries addressed the needs of the youth once released from the program. All three closed youth records contained a Discharge Plan which addressed the continued services the youth and family will need after the youth is released from the program. The three Discharge Plans included contact information for service providers. All three plans were discussed with the youth, juvenile probation officer (JPO), parent/guardian and the youth during the Exit Conference. All three youth closed records contained the Acceptance of Custody for Release form which verifies the parent/guardian received the Mental Health and Substance Abuse Treatment Discharge Summary during the youth's release 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.".	

The program has a contract to provide Mental Health Overlay Services (MHOS). The scope of the MHOS treatment service delivery is outlined within the contract between the program and the Department. The program provides up to twenty-four MHOS beds for male youth, between the ages of fourteen and eighteen years old. The program provides daily group therapy, bi-monthly individual therapy, and monthly family therapy, when indicated. The program provides daily group therapy, which utilizes mental health, substance abuse, and psychosocial skills training curriculum. The psychiatrist is on-site bi-weekly. Youth with identified substance use disorders receive substance use services twice a week through group therapy and have at least

one substance abuse goal on their Individualized Treatment Plan. There is one licensed mental health professional employed at the program, who is on-site at least five days a week. The program has a contract with a licensed psychologist to provide services, as needed. The program reports psychological services were not needed during the scope of the annual compliance review. Each of the two non-licensed full-time mental health therapists generally has a caseload of ten youth and the designated mental health clinician authority (DMHCA) has a caseload of four youth. An interview with the program director and the DMHCA confirmed the program is contracted to provide MHOS.

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

The program maintains a policy and procedures for the provisions of psychiatric services. The provider contracts with a licensed psychiatrist to deliver services to the youth in the facility. The psychiatrist, who is licensed under Chapter 459, Florida Statutes, meets all requirements outlined within the Florida Administrative Code with a clear and active license expiring on January 31, 2022. A copy of the contract between the provider and the psychiatrist was available for review while the annual compliance review team was on-site. The psychiatrist is available for on-call and emergency consultation twenty-four hours a day, seven days a week. The psychiatrist provides a briefing to a representative of the treatment team on the psychiatric status of each youth receiving psychiatric services who is scheduled for a treatment team review. The briefing is accomplished through face-to-face interaction or telephonic communication.

The psychiatrist's evaluation and recommendations for the youth is incorporated into the mental health clinical staff's evaluations of the youth and the youth's Individualized Mental Health or Substance Abuse Treatment Plan, as noted within the three applicable youth records reviewed. The program does not have a psychiatric advanced practice registered nurse (APRN). A review of the program's psychiatric sign-in and sign-out logs confirmed the visits during the past six months, validating the psychiatrist was on-site every two weeks for a minimum of two hours as specified in their contract. The designated mental health clinician authority (DMHCA) had a backup agreement with a psychiatrist to cover during vacations. Each youth on prescribed psychotropic medication receives monitoring and review at a minimum of every thirty days. A review of five youth records confirmed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. There were no indications the program has any standing orders or emergency treatment orders for psychotropic medications. Five youth records were reviewed for the inclusion of psychiatric services. Four of the five records revealed the youth entered the program on prescribed psychotropic medications. Each of the youth records reviewed were applicable for referral of psychiatric services. Each of the initial diagnostic psychiatric interviews included a youth history, Mental Status Examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations if applicable, prescribed medications if applicable, explanation of the need for psychotropic medication, and frequency of medication monitoring. Youth referred for the initial diagnostic psychiatric interview were seen within fourteen days of

the referral. All five initial diagnostic interviews were documented on the Clinical Psychotropic Progress Notes (CPPN) and clearly identified as initial psychiatric diagnostic interview. Three of the five initial psychiatric diagnostic interviews resulted in the prescription of psychotropic medication or changes to youth's existing psychotropic medication regimen. Page three of the CPPN was used to document the prescribing or changes of prescriptions for each of the three youth. Documentation indicated all applicable youth on prescribed psychotropic medication were seen for medication monitoring review by the psychiatrist every thirty-days.

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

The program has a written suicide prevention plan which details suicide prevention procedures. The program's written suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The program's written suicide prevention plan is reviewed annually. The plan was reviewed and signed by both the designated mental health clinician authority (DMHCA) and the facility administrator on April 28, 2020.

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

The program maintains a policy and procedures regarding the provisions of suicide prevention services which addresses Secure Observation not being used as a suicide precaution within the program. A review of five records found documentation each youth received a referral for an Assessment of Suicide Risk (ASR) and was administered upon admission of the youth to the program. Each of the youth remained on standard supervision based on the results of the ASR. Four of the five ASRs were completed and conducted by a non-licensed mental health clinical staff, which were subsequently reviewed by the program's licensed mental health professional within twenty-four hours. The remaining ASR was completed by the program's licensed mental health professional. None of the five youth assessed were determined to be in any kind of crisis and none of the ASRs were conducted outside of the program.

One of the five sampled youth reviewed was placed on Precautionary Observation (PO). The program was able to provide one additional record of a youth placed on PO since the last annual compliance review. Both reviewed records indicated the youth were placed on (PO) and placed under staff supervision until completion of the ASR. All ASRs were completed within twenty-four hours using the Department's ASR form. The youth on PO were screened and

subsequently maintained on PO. The required Suicide Precaution Observation Log was used to document the supervision of the youth while on PO. The precautionary placements were authorized by the facility administrator (FA)/designee. Mental health staff provided supportive services, and conferences between the licensed mental health professional and FA were documented to reduce the level of supervision. When each of the youth's Follow-Up ASRs indicated suicide precautions may be discontinued, each youth were stepped down to close supervision prior to transition to standard supervision. The Follow-Up ASRs on each of the youth records included all required elements and the discontinuation of close supervision were documented as required. Each of the youth maintained on PO were allowed to participate in select activities with other youth in designated areas of the program. Each of the youth were not limited to an individual cell or restricted to their sleeping room. The parent/guardian and juvenile probation officer (JPO) were notified of each youth's potential suicide risk and the alerts were entered and updated as required in the Department's Juvenile Justice Information System (JJIS), as well as in the facility's logbook.

The program has two suicide response kits in the front office and in the laundry room which is located on the youth dormitory. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. The program's written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan addresses the facility administrator (FA) review process for every serious suicide attempt or serious self-inflicted injury and mortality review for a completed suicide. All five interviewed staff responded they would notify mental health staff should youth express suicidal thoughts. All five stated they would contact either the FA and/or someone within the chain of command. All five interviewed staff were able to identify the location of the program's suicide response kits.

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

The program maintains a policy and procedures regarding the provisions of suicide prevention services. Four of the five records reviewed were not applicable. The program provided one additional applicable record for the annual compliance review period for completion of suicide Precautionary Observation (PO). A combined total of thirty-one mental health alerts, PO, and Close Observation (CO) Logs were reviewed. Each of the logs documented the appropriate level of supervision and observations of the youth's behavior. Staff recorded observations of each youth's behaviors in real time, at a minimum of thirty-minute intervals with no noted warning signs. Twenty of the thirty-one logs were reviewed and signed by each shift supervisor and the mental health clinical staff with all required elements documented. The remaining eleven logs had the following exceptions: five incidents when the Yes box for identified safe housing for youth was not checked on the Mental Health Alert Observation form; one incident of the Mental Health Alert Observation form was missing staff initials; three incidents when the Suicide Precautionary Observation form's back page was missing a staff signature; and two incidents when staff was late by five minutes on the Close Supervision Observation form. There were two youth who had previously been on suicide precautions upon admission to the program and each reported staff were with them at all times and 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 three operating shifts. The program conducted a total of fifteen mock suicide drills and three make-up drills for staff not present during regular drills. The program has a process in place which allows staff not present during a mock suicide drill to review each drill scenario and procedures. All twenty-one drills included action to be taken by staff; a method for contacting other program staff by radio or for back-up support to include emergency medical services 9-1-1. In addition, each of the mock suicide drills, included life saving measures such as cardiopulmonary resuscitation (CPR) and/or the use of the suicide response kit. Staff with direct contact, on a day-to-day basis with youth, participated in at least one quarterly mock drill semi-annually. Two of the three shifts had at a minimum of one drill completed for each of the quarters reviewed. The remaining shift, third shift, had one drill completed for first, third, and fourth quarters; however, third shift did not have documentation of a completed drill during the second quarter.

Twelve staff training records were reviewed for suicide prevention training. Each staff completed required six hours annual suicide training. An informal interview with the facility administrator confirms mental health emergency drills, including suicide drills, are completed regularly by the clinical department. Five staff were interviewed and four staff stated medical emergency and suicide drills are conducted once a quarter on each shift, while the last staff indicated drills are conducted once each shift on a monthly basis.

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 comprehensive Mental Health Crisis Intervention Plan which utilizes the least restrictive means possible to protect the safety of youth and others. The plan includes verbal de-escalation and Protective Action Response, notification, alert system, and means of referral include youth self-referral, communication, supervision, documentation, and review of the crisis. The plan was reviewed and signed by both the designated mental health clinician authority and the facility administrator on January 2, 2020.

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

Documentation confirmed the program has a comprehensive crisis intervention plan which outlines the procedures used to efficiently respond to youth experiencing psychological distress. None of the five records reviewed were applicable. The program was only able to provide one additional record with a Crisis Assessment conducted since the last annual compliance review. The assessment was completed on the Department's Crisis Assessment form. The Crisis Assessment documented the date the youth was determined to be in crisis, reason for assessment, a Mental Status Examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up, or further evaluation. The assessment was completed by a non-licensed clinician within twenty-four hours of the identified need and reviewed by the licensed clinician within the required time frame. The alert was placed into the Department's Juvenile Justice Information System (JJIS) once the assessment was completed.

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.	

Documentation indicated the program has an Emergency Mental Health and Substance Abuse Services Plan to respond to youth determined to be in imminent danger to themselves. The plan is comprised of immediate staff response, notifications, communication, and supervision. In addition, the plan includes authorization to transport for emergency mental health services or substance abuse services, transport for Baker Act and Marchman Act, as well as documentation, training, and a review process. The plan was reviewed and signed by both the designated mental health clinician authority on and by the facility administrator on January 2, 2020.

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

The program did not utilize a Baker Act or Marchman Act procedure during this 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 contract with a licensed physician who holds a clear and active in the State of Florida, with an expiration date of March 31, 2022, and has specialty training in internal medicine. Reviewed documentation confirmed the designated health authority (DHA) is a licensed internal medicine physician who has an unrestricted license meeting all requirements for independent and unsupervised practice in Florida. Reviewed documentation revealed for the previous six months, the DHA was on-site for two hours a week, as required by program's contract with one exception. The DHA did not sign in or sign out for their visit on September 24, 2020. Additionally, DHA coverage has been arranged with another doctor of equal licensure, in the event of DHA is on vacation or a scheduled absence. Since the last annual compliance review, the backup doctor's services were not required. The DHA is responsible for evaluating youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. A interview with the DHA confirms their primary duties at the program consist of completing Comprehensive Physical Assessments (CPA) within seven days of admission, completing periodic evaluations, conducting sick calls, being involved in policy and procedure development, and providing on-call services twenty-four hours a day seven-days a week, including holidays.

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.	

Documentation confirmed the designated health authority (DHA) and facility administrator have signed and dated all respective treatment protocols and medical Facility Operating Procedures (FOP) on June 18, 2020. On October 27, 2020, nursing staff reviewed, signed and dated a cover page which contained all medical FOP, treatment protocols, and other procedures listed. A review of two new healthcare personnel records reflected orientation has been provided by a registered nurse (RN) and is on-going as each of the healthcare personnel are still within their 180-days of being hired. Approval of treatment protocols or standing procedures were written and authorized by the DHA and were not delegated to any other person. The review and development of FOP, or other protocols related to psychiatric services and psychotropic medication management is only performed by the program's psychiatrist. The psychiatrist reviewed and signed FOP related to psychiatric services and psychotropic medication management on June 19, 2020.

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 to address parent/guardian consent which requires a signed Authority for Evaluation and Treatment (AET) by the youth's parent/guardian. Five youth Individual Healthcare Records (IHCR) were reviewed and four included a legible copy of the AET with the word "COPY" stamped on the forms. One youth IHCR contained an original AET.

There were no applicable youth being served by the Department of Children and Families where the parental rights have been terminated since the last annual compliance review. All youth consents were valid, as the youth remained in the custody of the Department since the document was signed.

None of five youth records in the sample contained youth who were eighteen years of age, so the annual compliance review team requested a sample of three additional records of youth over the age of eighteen. All three records of the eighteen year old youth reflected the medical staff gained consents for release of information, as required. The nursing staff interview indicated, the program's policy for obtaining a new or current AET, is to review the Department's Juvenile Justice Information System (JJIS). Medical and case management staff coordinate to ensure youth in the admission process have a valid AET prior to the youth arriving at the facility. If needed, the juvenile probation officer (JPO) would be contacted by case management staff to obtain a new AET prior to the youth's arrival at the program. The medical staff must attain a Release of Information form for youth who are eighteen years of age or turn eighteen while in 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 which require notifications to the youth's parent/guardian for any new medications, off-site referrals, and medical emergencies. The policy also requires additional informed consent for special circumstances such as hospitalizations, surgeries, or other invasive procedures. The program maintains a list of over-the-counter (OTC) medications which were approved by the designated health authority (DHA). The list is sent to all parent(s)/guardian(s) with instructions to sign and return the OTC list to the program which provides their consent for the medications. Five youth Individual Healthcare Records (IHCR) were reviewed for parental notifications including instances of OTC medications and vaccinations/immunizations not consented for on the Authority for Evaluation and Treatment (AET), significant changes to existing medications, off-site emergency care and medical treatment, and discontinuation of medication prescribed prior to youth entering the custody of the Department, and for new medications. Two youth had written notifications sent to their parent/guardian for all required instances, as required. The reviewed documentation validated written notification were sent to the parent/guardian, in each instance, regardless of conducting telephone notifications. A second staff member witnessed all telephone call attempts and conversations during all telephone notifications. Each applicable record contained documentation of the program obtaining consent prior to administering psychotropic medications, as required.

Three of the five youth were applicable for off-site care. The reviewed documentation supported parental notifications were made for all off-site care. Two youth were seen for off-site dental procedures and one youth was seen for orthopedic purposes. All three youth had parental notification conducted by telephone and later in writing when they received off-site care. Three youth IHCRs reflected a psychotropic medication drug was prescribed or a change in dosage of medication. In each instance, a parent/guardian verbal consent was documented on page three of the Clinical Psychotropic Progress Note (CPPN), as well as written consent documented on the Acknowledgment of Receipt of the CPPN. Review of the five IHCRs validated vaccinations were verified within thirty days of the youth's admission. All youth were determined to be current on immunizations, as required. There were no youth applicable regarding religious or medical

exemption. The nursing staff interview indicated parent/guardian notifications are required for OTC medications not covered by the AET, vaccines, significant changes or discontinuation of medication, new prescriptions not covered by the AET, invasive consents, x-rays, emergency care, non-routine dental work, and any off-site or on-site physician encounters. The interview indicated parent(s)/guardian(s) are contacted by telephone and written notification are mailed within twenty-four hours.

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

The program has a policy and procedures addressing healthcare admission screening which requires the completion of a Facility Entry Physical Health Screening (FEPHS). The policy requires the FEPHS to be completed by a registered nurse on the youth's date of admission to the program. All five reviewed youth Individual Healthcare Records contained a FEPHS form completed on the date of admission by a registered nurse (RN). No youth were applicable for a change in physical custody for greater than twenty-four hours, while in 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 the provisions of healthcare orientation to the youth. The program has a comprehensive orientation to their medical services. The orientation is provided by a nurse on the day of the youth's admission to the program. The provision of the orientation is documented by the signature of the youth and the nurse providing the orientation on the orientation form. All five reviewed youth Individual Healthcare Records confirmed the youth received a general care orientation upon admission to the program which included detailed topics of access to medical care, sick call, what constitutes an emergency, and when to notify staff. In addition, the orientation topics consist of the medication process to include side-effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers. A signed and dated receipt of healthcare orientation was observed in all five reviewed youth IHCRs and the Health Education form was populated for each youth, as required.

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

The program has a policy and procedures requiring notification to the designated health authority (DHA) upon the youth's admission to the program, regardless of the youth's medical condition. All five reviewed youth Individual Healthcare Records contained documentation reflecting the DHA was notified by telephone, or in person, for each youth upon admission to the program. Additionally, the DHA notification was documented in the Chronological Progress Notes in the youth IHCRs, as required. The nurse interview indicated they notifiy the DHA of all youth being admitted to the facility and the youth's health condition.

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 to address the completion of a Health-Related History (HRH). The policy requires a new or updated HRH to be completed prior to the youth participating in any strenuous activity. Five youth Individual Healthcare Records (IHCR)were reviewed, and each contained a new HRH form which was completed by a registered nurse (RN) within seven days of admission. In the five reviewed youth IHCRs, the Department's HRH form was completed before completion of the Comprehensive Physical Assessment (CPA), as required. Review of the five youth IHCRs validated the designated health authority documented review of each youth's HRH on the CPA, as required. The nursing staff interview indicated the RN is responsible for completing the HRH on the day of each youth admission which takes place prior to the completion of the CPA.

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 which require the designated health authority (DHA) must complete a new Comprehensive Physical Assessment (CPA) for each youth within seven days of admission and annually for each year following. Five youth Individual Healthcare Records (IHCR) were reviewed. In all youth IHCRs reviewed, the program utilized the Department's CPA form. The CPA was completed within the first seven days of the youth's admission by the designated health authority (DHA) and the medical grade was documented on the form for all five youth. All CPAs were completed in accordance with the Department's rule requirements and all sections were marked with an "O" or an "X". Any section of the exam which was refused was marked appropriately and "youth refused" was documented with the youth's signature next to the statement. The Department's Problem List was updated for the five applicable youth.

The program has a written policy and procedures which govern the tuberculosis screening and rescreening processes which were reviewed at the time of the annual compliance review. All five 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. Each youth was assessed prior to being placed in the general population. An interview with the health service administrator confirmed each youth is screened for tuberculosis at admission and the CPA form is completed within seven days of admission by the DHA and annually.

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

The program maintains a policy and procedures which ensure all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The nurse completes the Department's Sexually Transmitted Infections Screening form to clinically assess

the youth. Additionally, the designated health authority (DHA) must decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of five youth Individual Healthcare Records (IHCR) indicated each youth was screened and evaluated for STIs. Documentation reflected all youth received a STI screening upon admission to the program. Testing, screening, results, clinical evaluation, and diagnosis were documented on the Infectious and Communicable Disease (ICD) form. All five IHCRs indicated the youth objected to further testing and each record contained the appropriate refusal form, as required. Upon request, the program provided one applicable record, since the last six-months, in which a youth received human immunodeficiency virus infection (HIV) testing. Review of the one applicable IHCR reflected the youth was offered HIV screening upon admission, pre/post counseling, and testing, as required. The DHA conducts all HIV testing on-site and pre/post counseling. None of the five youth reviewed were out of the Department's custody; therefore, none of the youth required a re-screen. Five interviewed youth reported they could request a HIV test. The youth's HIV test results were maintained in the youth's medical record, marked "Confidential", and kept within a sealed envelope. Nursing interview indicated HIV testing and pre and post-test counseling is conducted on-site by the DHA.

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 which outlines the provision of sick call to include procedures for when licensed healthcare staff are not on-site. Five youth Individual Healthcare Records (IHCR) were reviewed, none of which, presented with similar sick call complaints three or more times within a two-week period or complained of any severe pain with which the staff was unfamiliar. All five youth completed Sick Call Request forms which were placed in a locked box, retrieved by the nursing staff and properly filed in each youth's IHCR in reverse chronological order. Reviewed documentation supported the registered nurse (RN) completed the sick call with the youth within twenty-four hours of the youth submitting the sick call. No youth were applicable for being placed in restricted housing. In all five youth IHCR, the Sick Call Request form or progress notes were documented in accordance with the Health Services Rule 63M-2, and each sick call was documented on the Sick Call Index and the Sick Call Referral Log, as required.

The program conducts sick call daily as indicated in the contract and the hours are posted in each of the youth's modules, above the sick call box, and reflected on the master schedule which is posted throughout the facility. Sick call is conducted by a licensed nurse. A sick call was scheduled during the annual compliance review and verbal consent was provided by the youth for the team member to observe the process. The youth was escorted by a youth care supervisor to the clinic where the medical services were provided by an RN. A youth care supervisor remained outside of the exam room which ensured confidentiality. The nurse addressed the reason for why the youth was being evaluated as it was written on the youth's Sick Call Request form. The nurse interviewed, examined, and obtained vitals of the youth. After the examination, the youth was given a follow-up plan, signed the Sick Call Request form and the RN filed the form in the youth's IHCR. Five staff were interviewed, and all indicated the nurse conducts sick call. Five interviewed youth indicated they can see a nurse immediately once they submit a Sick Call Request.

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 to address episodic and first aid care for the youth. The program utilizes an Episodic Care Log to document youth requiring episodic care or first aid treatment. Five youth Individual Healthcare Records (IHCR) were reviewed and two youth required on-site first aid or episodic care for a total of three instances. On two occasions, youth received on-site care by a licensed healthcare staff which was documented in problem oriented subjective, observation, assessment, and plan (SOAP) or standard narrative charting format. One non-health care staff provided on-site health care for a youth, the Department's Report of On-Site Health Care by Non-Licensed Care Staff form was completed by staff and over-the-counter (OTC) medications were offered in compliance with nursing protocols, as required. All events were documented on the Episodic Care Log. The program posts emergency numbers within the clinic in the nurse's office and master control which are inaccessible to the youth.

The program has five first aid kits which all are maintained in master control, a classroom, and the laundry room allowing for quick response capability. There were two designated first aid kits used for transports. The transport staff select the appropriate kit in master control prior to conducting transports. The designated health authority (DHA) approved the inventory list of items to be placed in the first aid kits. During the annual compliance review, the contents of three sealed first aid kits were observed. Each inspected kit was filled with the DHA required items. None of the reviewed kits contained any expired items. After breaking the seals on the first aid kit, staff are instructed to take the first aid kits to the medical clinic for replenishment. There were weekly first aid inspection kit inspection logs which validated a nurse completed a weekly check of each first aid kit for the past six months.

The program has two centrally located suicide response kits which included a knife-for-life, needle nose pliers, and wire cutters located in the lobby area and utility room. The suicide response kits are inspected monthly by a nurse which was documented on the Emergency Equipment Inspection Log, as required. The program has one automated external defibrillator (AED) which is located in the administration hallway. The medical staff checked the AED during the annual compliance review, and confirmed it was in working order. The last six months of AED documentation indicated the nurses conducted weekly checks, as required. The AED pads were installed on November 10, 2020 and expires on January 20, 2022. The AED battery was installed on July 26, 2017 and expires July 26, 2020. A review of the last four quarters of medical drills was conducted which validated the program completed at least one quarterly drill on each shift to include first aid care, cardiopulmonary resuscitation (CPR) and/or AED demonstration, annually.

Five pre-service and five in-service training records were reviewed and indicated each staff had the CPR, AED, first aid, and epinephrine auto-injector training. A current CPR with AED certification was found for all licensed healthcare staff. Five staff were interviewed and indicated they are permitted to call 9-1-1 when a youth is identified with a medical emergency. All five interviewed youth reported being able to see a doctor or dentist, if requested.

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 address emergency care for the youth which includes the provisions of off-site care. The policy includes notification requirements and the completion of the Summary of Off-Site Care form. Five youth Individual Healthcare Records (IHCR) were reviewed, three of which, were applicable regarding off-site care events during the annual compliance review period. Parent/guardian notifications were made in all three instances, as required. The Department's Summary of Off-Site Care Consultation Report was utilized to document each event, filed in the youth's IHCR, accompanied with the youth's discharge instructions. The designated health authority reviewed and signed all off-site care findings, instructions, and information for each occurrence. All youth received the required follow-up testing, referral, and care as appropriate.

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 to address monitoring youth with a chronic condition which requires any youth with a chronic condition to receive a periodic evaluation at least every two months by a physician. Two of the five youth Individual Healthcare Records (IHCR) were applicable for chronic conditions. Each of the applicable youth IHCRs reflected the youth as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the two youth reviewed had a communicable disease. Each of the applicable youth were taking prescribed medication on an on-going basis. Both youth properly reflected having a chronic illness on the program's internal alert roster. The Chronic Physical Health Conditions Roster includes the scheduled due dates for each youth's next periodic evaluation. Documentation reflected each of the two youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. The Department's Problem List for each youth was updated in accordance with the Health Service Rule 63M-2.0048, as required. All periodic evaluations were conducted on-site. Evaluations are conducted prior to the renewal of a prescription medication. Treatment orders were observed to be detailed and legible for clinical staff. In an interview, the designated health authority (DHA) reported the health services administrator tracks all youth with chronic conditions using the sixty-day medical tracker and periodic evaluations for youth with chronic conditions are conducted every sixty days not to exceed ninety days. An interview with the health services administrator confirmed the practice. A nurse stated in an interview, when youth are identified upon intake or by the DHA to have a chronic condition they are placed on the Chronic Physical Health Conditions Roster for monitoring and tracking. An interview with the facility administrator indicated he meets with healthcare staff daily during the morning management meeting to discuss medical and healthcare issues of the youth.

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

Five youth Individual Healthcare Records (IHCR) were reviewed for youth taking prescribed medication upon entry to the program. All reviewed IHCRs contained validation of prescription verifications for youth taking medication upon entry to the program which was documented in each youth's Chronological Progress Notes. All reviewed IHCRs reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. Four youth were admitted on psychotropic medications and were continued on the prescribed medications. One youth was admitted on a non-psychotropic medication and was continued. All medications were observed to have a current, valid order, and were given pursuant to a current prescription. Three of the five youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). All OTC medications were administered in accordance with approved protocols. The program utilizes a pharmacy Medication Administration Record (MAR) to track the issuing of medications. Reviewed documentation reflected both staff and youth initialed each administered medication and there were no undocumented explanations for lapses or errors in medication administration. Nursing staff document daily side-effect monitoring on the MAR, as required.

The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. There were two instances of medication refusals and in each of the cases the youth confirmed the refusal by initialing the MAR and a signed Refusal of Treatment form was placed in the youth's IHCR. All medications were observed to be stored in separate, secure areas which are inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is only used for medication. Syringes and sharps are secured in the medical cart and locked cabinet. The medication cart was observed to be clean, organized, and stock items are stored separate from youth specific medications. Expired medication is destroyed using Medication Disposal Container once a month according to the agreement with the pharmacist. Medication pass was able to be observed during the annual compliance review which was compliant with policy and procedures. Four of the five youth interviewed reported the nurses administer medication. One youth stated he does not take medication. Four of the five interviewed staff indicated the nurse dispenses medications to youth and one staff stated medical technicians dispense medication. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site.

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 which govern the appropriate storage of all medication and equipment classified as sharps. Medical equipment classified as sharps were securely stored and inventoried daily with the utilization of a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were separated. A shift-to-shift

inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record on all three shifts. The program has a process in place for disposal or destruction of expired and discontinued medications. The daily perpetual inventory of all sharps and medications were reviewed for a six-month period, and all items were accounted for and the forms were observed to be completed as required. The annual compliance reviewer observed the registered nurse (RN) conduct an inventory of a sample of three controlled medications, over-the-counter (OTC) medications, and sharps. All inventoried medications and sharps matched the inventory counts. The program has procedures in place in the event of inventory discrepancies. According to the RN, medication inventory is completed both daily and weekly. The RN explained medication is secured in a locked medication cart located in medical, secured behind a locked door where OTC medications are located and in a locked cabinet and in the medical cart. Medications are inventoried daily and weekly basis on a perpetual inventory. Sharps are stored in the medical cart or the locked cabinet within the medical clinic. The RN indicates controlled substances are stored within a locked box, within a locked drawer, and are locked within the medical office.

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 an infection control procedure in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, written in accordance with the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control (CDC) guidelines. The procedures include common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, Tuberculosis, Hepatitis A, B, and C, as well as human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. Other outbreaks or epidemics caused by any other infectious agent whether spread directly or indirectly, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms are included as well as food-borne illnesses, bio-terrorist agents, chemical exposures in the workplace, providing Hepatitis B immunizations for staff, staff having access to protective equipment, staff following standard universal precautions and a comprehensive process for needle stick post-exposure evaluation. In the event of a facility/occupational exposure, the facility administrator (FA) will establish a separate file containing all documents for youth and staff. The program did not have any instances in which the local county health department, CDC and/or the Department's Central Communications Center (CCC) had to be notified regarding infectious diseases, any quarantining, or hospitalization. The program's Exposure Control Plan is combined with the infection control procedure and is available to all staff. The plan was observed to be signed and approved on January 2, 2020 by the FA and designated health authority (DHA) of the program and included risk assessment and methods of compliance. A newly contracted DHA reviewed and signed the plan on October 27, 2020 during their orientation to the program.

All five reviewed Individual Healthcare Records (IHCR) contained documentation of training which included the prevention of blood borne pathogens and communicable disease to include

handwashing which was provided within seven days of admission into the program. A review of the five staff pre-service training records indicated all received the infection control and exposure control training. An interview with the nurse revealed the registered nurse (RN) provides infection control training for staff on-site during orientation and to youth during the admission process. Additionally, the RN provides Exposure Control Plan training twice a year, as well as, upon new employee orientation. The FA interview reflected the Exposure Control Plan in a binder in the administrative hallway and is reviewed annually with staff.

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

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

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

The program utilizes a registered nurse (RN), whose license is clear and active, as the health services administrator (HSA) with a license expiration date of April 30, 2021 and a licensed practical nurse (LPN) pro-re-nata (PRN) with a licensed expiration date of July 31, 2021. The nurses are responsible for the delivery of health services, supervision of personnel, and liaison services within the program. The HSA is to ensure the designated health authority signs-in/signs-out when on-site for required visits. The HSA is responsible for daily communication to program administration on important medical issues pertaining to youth at the program. Each of the nurses have current certifications in cardiopulmonary resuscitation. The program is in compliance with specific duties outlined in the contract.

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 procedure addressing the supervision of youth. The program's staff to youth ratio is one to eight during awake hours and one to twelve during sleeping hours. Ratios for youth transports, off-site activities, visitation, when youth are separated from the population, and work details are one to five. These ratios were adhered to throughout the annual compliance review period. A review of the program's logbooks revealed ratios were maintained throughout the last six months. Logbooks also revealed staff documented headcounts, line movements, transports, disruptions, incidents, and staff assignments/duties during each shift. The program's policy requires staff to conduct a minimum of six headcounts within a twenty-four-hour time frame. A review of documentation and observations throughout the week of the annual compliance review, revealed staff exceeded policy expectations and conducted headcounts hourly and randomly throughout each shift while maintaining and positively interacting with youth while engaging in a full schedule of constructive activities. The activity schedule was posted throughout the facility, including in the youth dayroom and dorm areas. The annual compliance review team witnessed staff providing proper supervision during school, lunch, breaks, recreation, and line movements. Program staff were interviewed throughout the week and were always aware of their current headcounts and the whereabouts of youth who were not in their presence in addition to the procedures taken when a count cannot be reconciled.

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 for the training and implementation of the program's behavioral management system (BMS). The program utilizes a positive performance system (PPS) as the BMS. It is a multi-level point system designed to enhance the youth treatment, to increase healthy pro-social behavior using positive reinforcement and to decrease unhealthy behaviors through natural consequences. The system is clearly written in the youth handbook. In the handbook, each level of the PPS is explained with goals to accomplish on each level and the rewards a youth will earn once achieving the level. All five reviewed youth case management records contained documentation to support the youth received an orientation to the program which included the explanation of the BMS, an explanation of youth expectations, responsibilities and consequences. A list was observed posted on the white board in the large group room which included each youth and the level of the PPS they were currently on. This list is used to assist the staff in knowing which youth will participate in daily incentive and weekly

incentives. Observations made during the annual compliance review week found staff interacted with the youth in a way which supports the use of the PPS. The reviewed youth case management records contained documentation to support special treatment teams were used consistently to address negative behaviors demonstrated by the youth.

A review of five staff training records for in-service and pre-service training found all staff completed training on the BMS. A review of training documentation verified the educational staff were trained in the implementation of the BMS on December 3, 2020. Staff received an additional training on the BMS on November 17, 2020. Both trainings were facilitated by the transitional services manager. The program has an agreement with the school addressing the PPS. The teachers report violations of the PPS to the program administration staff. Special treatment teams are conducted with the youth when there are major violations. The teachers have an incentive Friday in addition to the weekly incentive offered by the school.

An interview with the facility administrator (FA) indicated the program utilizes a daily point-based incentive program and the total daily points earned determines the youth's incentive levels. The use of rewards is monitored by the assistant facility administrator. Consequences assigned to the youth are monitored by the management team. The FA indicated consequences are discussed and decided upon as a group during special treatment team meetings. The FA reported staff's implementation of the BMS is addressed in annual performance evaluations. Five youth were interviewed and explained the consequences used in the program included level freezes and having incentive privileges suspended. The youth were able to explain the difference between the levels, how to move from one level to the next, and about the rewards earned. All five youth indicated they felt staff were consistent in the use of rewards. All five youth indicated youth are not allowed to punish other youth. Four of the five youth rated the BMS as good and one youth rated the system as fair. Five staff were interviewed and were able to explain the program's BMS to include addressing the point and level system, and rewards and consequences. All five staff indicated the BMS is posted throughout the facility and included in the handbook. All five staff indicated things cannot be taken away from youth as a consequence. All five staff indicated youth are informed of the consequences through special treatment teams or informal meetings. All interviewed staff indicated the supervisors provide feedback about the use of the BMS when needed.

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

The program maintains a policy and procedure addressing the behavior management system (BMS) infractions and system monitoring. The program's BMS includes a process where staff provide feedback to the youth regarding the implementation of the BMS prior to the end of the staff's workday, youth are given an opportunity to explain their behavior, staff discuss with the youth the behavior's impact on others, reasonable reparations for harm caused to others, and

alternative acceptable behavior. This process occurs at the time the sanction is given and during daily meetings. A review of the program's contract ensured all required parties were involved in the development, implementation, and on-going maintenance of the applicable BMS. The program does not utilize room restriction as a part of the BMS.

An interview with five youth and five staff confirmed all understood the process which allows youth and staff to discuss sanctions imposed, consequences, and alternative acceptable behaviors. All four interviewed youth indicated staff are fair and consistent when issuing rewards, examples of how they are rewarded, the differences between each level, how they move from level to level, and youth are not allowed to punish each other. An interview with five staff confirmed they receive feedback on their application of the BMS on their annual performance evaluations, receive coaching, and feedback from both supervisory staff and administration, as needed. Staff report the program has an open-door policy and everyone provides input about the implementation of the BMS. A review of five staff's training records confirmed the required completion of BMS training, and each were trained in the jointly combined BMS plan for use during school. The facility administrator (FA) interview indicated the implementation of the BMS is monitored to ensure it is administered fairly and consistently among all staff through annual BMS training and the assistant facility administrator monitors the rewards provided to the youth. The FA confirmed the transitional service manager trained the education staff in the jointly combined BMS plan for use during school.

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

The program has a policy and procedures addressing ten-minute checks. The policy requires staff to conduct visual checks at least every ten-minutes when youth are in their sleeping quarters. Staff are to document the time room checks are conducted on the Dorm Verification and Headcount Sheet. The program has thirty-two recording video cameras located throughout the building from which video recordings are maintained for at least thirty days. A comparison of three hours documented on the Dorm Verification and Headcount Sheets from three randomly selected dates, times and shifts were reviewed with the corresponding video footage recordings. A total of thirty-six ten-minute checks were reviewed on video. The annual compliance review team members found staff were conducting visual checks of the youth every eight minutes. Staff were observed pausing at each bedroom door and used flashlights to ensure they physically saw each youth. The checks were consistently conducted and coincided with the information on the Dorm Verification and Headcount Sheets. A review of Dorm Verification and Headcount Sheet for the last six months found visual checks of the youth occurred as required. Five staff were interviewed and asked how often room checks are completed when a youth is placed in their room and all five indicated room checks are completed every eight minutes. An interview with the facility administrator indicated all cameras are operational and video recording is maintained for thirty days. Videos of incidents are copied and saved in an archive indefinitely.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program maintains a policy and procedure addressing census, counts, and tracking of youth. The program's policy indicates headcounts will occur and shall be documented at a minimum of six times within a twenty-four-hour period. The master logbook is utilized by the program to document youth census, counts, and movements. The logbook is utilized to maintain a chronological record of events as they occur. Headcounts are conducted by the program's supervisory staff at the beginning of each shift to verify accuracy and all other counts are conducted and documented at least hourly in the master logbook. Counts are conducted at the beginning and end of each shift, after outdoor activities, and emergency situations. The logbook tracks youth intakes, releases, and movement outside of the facility. The program utilizes an alert board, located in the program's conference room, to track the daily count of all youth in and out of the program. During the annual compliance review period, counts were observed being conducted, as required. Staff were always aware of all youth within the facility and were able to provide the proper counts to the annual compliance review team members during the review week. Five staff were interviewed, and each were aware of count procedures, as required by program policy, including what to do in the event an unsuccessful count.

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 addressing logbooks. The program uses a permanently bound logbook with pre-printed, sequentially numbered pages. It is the responsibility of the shift supervisor to document emergency situations, incidents, special instructions for the supervision and monitoring of youth, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), and the Florida Abuse Hotline. A review of logbooks from the previous six months found entries were documented in ink with no erasures or white-out areas. There were little corrections made to the entries and entries were consistently documented in chronological order with minimal late entries. Information related to incidents, perimeter checks and transports were consistently documented. Each logbook entry included

the date and time of the event and a brief description of the event to include the names of youth and staff involved. The name of the staff making the entry was consistently documented in the logbook. Population counts were documented at the beginning and end of each shift. Calls to the CCC and the Florida Abuse Hotline were found documented as required. Special instructions for the supervision and monitoring of youth was also documented as required. Supervisors conduct staff briefings prior to the beginning of each shift, where incoming staff are briefed on the previous shift. Observations made during the annual compliance review week found shift briefings were occurring as required. The review of logbook documentation found staff consistently signed the logbook during their shift to indicate they reviewed the previous two shifts logbook documentation except on November 18, 2020 where one staff did not sign.

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

The program maintains a policy and procedure addressing key control. The policy addresses 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, and reporting and replacement of damaged keys. Staff keys are locked in a locked key box, located in master control, at the front of the facility by the facility administrator's (FA) office. Keys are secured in a lock box when not in use and staff have limited access to the boxes. Only the FA, assistant facility administrator (AFA), plant manager, and shift supervisors have access to key lock boxes. All keys are counted daily and documented in the program's daily key log binder. All visitors and volunteers' keys are collected and secured by program staff when entering the facility.

During the week of the annual compliance review, observations by a member of the review team confirmed the collection and securing of staff shift and visitors' keys. The key collection and distribution were conducted by the shift supervisor. All staff keys were collected and locked in the staff key box. Staff signed the key log acknowledging they received a set of program keys and included their printed name, date, time, key type, and key number. The shift supervisor/designee signature was observed in the key log, ensuring the information is accurate. Program keys are inventoried when staff return program keys and issued their personal keys. An observation of restricted keys confirmed the program's practice. Three random key rings were collected for observation and all keys matched the key information on the tab, the key inventory list, and all keys were secured on a tamper-proof key ring. Observations of the key storage area confirmed the keys were properly secured when not in use. A random check of staff keys during the annual compliance review period, revealed no staff had personal keys on the secure floor and all staff's personal keys were secured in the key lock box. Interviews with the AFA and shift supervisor were conducted regarding key control procedures and both staff were knowledgeable about the program's policy on key control. An interview with five staff validated the process for restricting usage of keys for medical, mental health, case management, and the transport vehicle. All five interviewed staff revealed each understood the proper procedures taken daily, as well, procedures if a key is lost, stolen, missing, or damaged.

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 to address contraband control and searches. A review of the program's policy, youth handbook and written rules for visitation confirmed the list of unauthorized and contraband items was included. The policy addresses any staff who is found in possession of contraband will be subjected to disciplinary action up to and including dismissal. The youth handbook addresses the consequences of possessing contraband. A review of five youth case management records confirmed youth received an orientation upon admission which included the review of the youth handbook. A review of room search and contraband tracking logs for the previous six months confirmed room searches were conducted at least once a week, at times, twice a week. Contraband found during room searches consisted of pencils. No illegal contraband was discovered during room searches.

A review of the Department's Central Communications Center (CCC) reports for the past six months indicated there was no illegal contraband found. A review of the program logbooks for the previous six months found perimeter searches were conducted and documented in the logbook. Reviewed documentation during visitation confirmed visitation areas and youth were searched at the conclusion of visitation. Observations during the annual compliance review week confirmed staff searched youth after every movement which included participating in recreation time outside and after participating in agriculture classes. During the COVID pandemic, the youth have not been participating in off-campus activities. An interview with the transitional services manager (TSM) confirmed incoming and outgoing correspondence is searched to control the introduction of contraband into the program. The TSM explained all outgoing mail from the youth are searched by the shift supervisor prior to sealing the envelope. Incoming mail is opened by the TSM in front of the youth and the TSM reviews the mail prior to giving it to the youth. All incoming mail is documented on a tracking sheet. If the mail is inappropriate, the TSM will store the item with the youth's personal belongings to be received at the time of discharge or the TSM will return the item to the original sender. All five interviewed youth and staff indicated searches are conducted after every movement. An interview with the facility administrator indicated items confiscated and not considered illegal will be discarded, returned to the original owner, mailed to the youth's home or stored and returned to the youth

upon release. Items considered illegal would be turned over to law enforcement and a criminal report would be filed.

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

The program maintains a policy and procedure addressing searches and full body visual searches. The program performs searches as a method to prevent the introduction of contraband and unauthorized items into the facility. A review of the facility operating procedures confirmed searches of youth are conducted before and after groups, transports, admission, visitation, off-campus activities, education/vocation instruction, outdoor activities when moving youth from an outside area into the building and moving youth from the building to an outside area. During the annual compliance review period, the review team observed several youth searches and video observations of searches. No observations were able to be conducted for any off-site transports or activities which would allow the youth to have access to tools during the annual compliance review period because the program did not have any. Searches were conducted with each movement of youth from each area of the building such as the classroom, dining hall, and dorm. Search procedures and expectations were properly explained to all youth before searches were conducted. Searches were conducted by staff of the same gender as the youth, while a second staff member assisted with supervision of the youth. Searches were thorough and completed in a manner to allow the youth to be treated with dignity and respect to minimize the youth's stress and embarrassment. All searches were documented in the program's shift logbook. A full body visual search could not be observed during the week of the annual compliance review period. Interviews with youth and staff revealed all parties were aware of proper search procedures and when the searches take place.

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 had one operable van used to transport youth during the annual compliance review period. The annual inspection of the vehicle was completed August 4, 2020 by a properly certified mechanic. Annual compliance review team members found the vehicle equipped with a fully-charged fire extinguisher, a seatbelt cutter, window punch, and operable seatbelts for each passenger. The vehicle has a safety screen and child locks are activated on the passenger doors when transporting the youth so the doors cannot be opened from the inside of the vehicle. The first aid kit for the vehicle is maintained in the administration area of the building and is obtained at the same time staff receive the keys for the vehicle. The vehicle was found to be locked while parked in the parking lot throughout the week of the annual compliance review. There were no transports during the week of the annual compliance review. Annual compliance review team members conducted random checks of personal vehicles parked in the parking lot to ensure the vehicles were locked throughout the annual compliance review week. One vehicle

was found to be unsecured during one of the random checks. This observation was found right before shift change and prior to the perimeter check being completed.

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

The program maintains a policy and procedure addressing transportation of youth and includes staff to youth ratio during transports as one to five, in the event there are five or less youth, a minimum of two staff are needed to perform all transports. The program has a total of two transport vehicles; however, one of the transport vehicles was given to the program upon closure of Bartow Youth Academy on September 30, 2020 and has not been used by the program since receiving; therefore, the program only has one transport vehicle for use. The transport vehicle was inspected by an annual compliance review team member and the transport vehicle is equipped with a safety gate separating the driver from the passenger's compartment. The transport vehicle has a fire extinguisher, knife-for-life, window punch, and a first aid kit which is taken on each transport. A review of the first aid kit used for youth transports confirmed the first aid kit contained all required items with no expired contents.

The program has an approved transport list, updated monthly to ensure staff driver's licenses are valid. The approved driver's list is located in master control, on the key lock box. An annual compliance review team member observed a shift supervisor conduct a routine check of all personal vehicles in the parking lot including the program's transport vehicle. All vehicles were found locked and secured. Members of the annual compliance review team conducted several vehicles checks throughout the annual compliance review period and found all vehicles to be secured and locked. No transports were scheduled during the week of the annual compliance review; however, interviews conducted with five staff validated the program's transport process. Staff confirmed they are issued a cellular telephone before transport, both youth and staff wear seat belts during transport, youth are not left unattended during transportation, staff do not conduct transports in personal vehicles, and in the event of an emergency staff will contact the program's administration. Interviews with five youth confirmed they have never seen anyone place contraband in the transport vehicle and feel staff are safely operating the transport vehicle.

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 addressing weekly safety and security audits. The policy identifies the physical plant manager for being responsible to conduct the weekly security audits and safety inspections. A random sample of documented weekly safety and security audits were reviewed for the past six months. Documentation supported the weekly inspections were completed as required. Documentation supported when issues were identified and when they were corrected. An interview with the facility administrator indicated safety and security issues are discussed daily in the morning management meeting. Deficiencies are immediately addressed through a work order system, staffing adjustments, or any other means necessary to correct the deficiency.

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

The program maintains a policy and procedure addressing tool inventory and management. The policy addresses the issuance, inventory, and control of equipment and tools. The program has identified the plant manager as the program's tool control manager. The policy classifies tools into two categories as Class A tools and Class B tools. Class A tools are hazardous with sharp edges or points, with a high potential to be used as a weapon to inflict serious bodily harm. Class B tools do not have sharp edges or points such as brooms, mops, and scrub brushes. All Class A tools are secured in the plant manager's office. All tools are secured behind the locked door with restricted access. The tools are placed on the wall with an outline of each individual tool with an identifying tool number for proper placement and all were in their respective place with no tools being unaccounted for. The plant manager maintains a binder with a photo and corresponding tool number which matched the wall of tools and inventory list and aids in the ease of identifying each Class A tool. Observation of the plant manager's office was neat, clean, and very organized. All program's Class A tools are inventoried daily by the plant manager except on days when the maintenance office is not accessed during the weekends and holidays which was confirmed with observation of the Daily Inventory Log. Class B tools are inventoried daily by program staff. All program tools are signed out by staff before use and signed back in once they are returned to their proper location.

A random selection of three tools were properly identified during inspection, in the respective location, and in good repair. The five pre-service and five in-service training records indicated all staff were trained on the safe use of tools. Five youth records were reviewed, and all indicated youth have been trained on the proper usage of tools during their orientation process and the youth signed an acknowledgement of tool training. An interview with the program's plant manager validated he is was aware of the proper procedures to follow if tools are missing or damaged. The plant manager stated there were no tools which were currently damaged/dysfunctional, missing/lost, or out of use. Interviews with five staff and five youth confirmed youth are only allowed to use a mop, broom, and scrub brush. An interview with the educational staff indicated youth are allowed to use other tools after being screened and under supervision such as a screwdriver, hammer, and saw for purposes of the agriculture curricula the program utilizes.

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 addressing youth tool handling and supervision. The policy indicates youth are not permitted to handle any tools unless a risk assessment has been completed. Youth placed on security alert are not permitted to handle any tools. The policy identifies the staff to youth ratio of one to five required when completing activities involving tool use, activities involving vocational training, and disciplinary work projects. A review of five youth case management records confirmed risk assessments were completed and identified if the youth was eligible to use tools. An interview with the vocational teacher confirmed youth receive verbal training on the use and safety of tools prior to engaging in vocational projects. There were no vocational work projects taking place the week of the annual compliance review. Youth were observed using mops and a dust sweeper during the week of the annual compliance

review. Observations confirmed the staff-to-youth ratio was met while the youth were using these Class B tools. Youth observed using the tools were not deemed a security risk and had a current risk assessment allowing them to use tools. All five interviewed staff indicated the only tools youth are permitted to use are mops and brooms. Four of the five interviewed youth indicated they are allowed to use mops and brooms. One youth indicated they are not permitted to use any tools.

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 maintains a policy and procedure addressing outside contractors, which includes information about tool control and restrictions. The program utilizes a form signed by outside contractors which addresses how tools will be checked upon arrival to and departure from the program, restrictions to youth work area access, immediate reporting of missing tools, restriction of personal cellular telephones, and/or equipment capable of taking pictures and/or recording audio/video in secure areas. The form requires contractors to list each tool brought into the facility. The list is reviewed by the plant manager/designee before the contractor has access to a secure area. The list is reviewed again prior to the contractor exiting the program. The contractor's failure to sign this form prohibits access to work within the program. Outside contractors are escorted and supervised by the plant manager/designee any time they are within the facility. Although no outside contractors were scheduled during the annual review week, an interview with the program's plant manager revealed this practice is followed for each outside contractor. The program had a total of twenty-six invoices for outside contractors. A review of the invoices compared to the written notification and guidelines form confirmed nine of the forms for outside contractors were not completed; however, the program provided documentation the outside contractors did sign the vendor sign-in log.

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 Continuity of Operations Plan (COOP) which was approved by the Department on January 2, 2020. Reviewed documentation of drills for the past six months confirmed the program completed drills in accordance with the COOP. Monthly drills were conducted on each of the three shifts and included drills to address; fire, escape, chemical spill, flood evacuation, and program disturbances. Documentation of the drills included the type of drill, date and time of the drill, participants, brief scenario of the drill, and the findings and recommendations. Egress plans with marked evacuation routes were posted throughout the facility. Documentation supported the fire extinguishers and the buildings fire safety system were inspected annually. An interview with the facility administrator indicated drills are completed monthly on each shift. All five interviewed youth indicated they had been instructed on what to do in the case of a fire. Four of the five youth indicated fire drills are conducted monthly. One youth did not remember how often fire drills are conducted. Five staff were interviewed and were asked what drills they participated in within the last twelve months. Three staff indicated they participated in weather, major disturbance, and flooding drills. All five staff indicated they participated in fire, medical, and mental health drills.

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

The program maintains a policy and procedure addressing the Continuity of Operations Planning (COOP). The program has a COOP which ensures basic care and custody of youth in the event of an emergency or disaster. The COOP was submitted to the Department and was approved on January 2, 2020. The plan addresses all required topics. A copy of the COOP is available in the facility administrator's (FA) office and the facility's conference room for staff access. Each youth has a hard copy record located in the transition specialist office within the master control area. It was observed each record contained all the required elements. The FA interview indicated the COOP is maintained in the FA's office as well as the conference room.

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

The program has a policy and procedures addressing the control of hazardous materials. Observations made throughout the annual compliance review week supported the flammable, poisonous, and toxic items were secured at all times and not accessible to the youth. Chemicals are stored in two locations within the facility. Most flammable, poisonous, and toxic items are maintained in the maintenance office in a locked metal cabinet. A bottle of bleach and a bottle of disinfectant cleaning liquid is stored in a locked cabinet located in the staff office. Binders with the Safety Data Sheets (SDS) were located with the chemicals. The program maintains a list of approved staff positions who are permitted to have access to the stored chemicals. There is a separate list of approved staff positions who are permitted to draw chemicals. A random review of the Class B Tools and Chemical Supply Sign out and In Log Sheet supported the use of chemicals was documented on every shift for the last six months. Each shift maintained a perpetual inventory of the chemicals located in the staff office. A separate chemical inventory sheet was completed daily by the physical plant manager. Annual compliance review team members compared the actual stored chemicals with the chemical inventories in both locations of the facility. The inventory matched the actual items in each storage area. The chemicals in both locked metal cabinets were well-organized and neatly maintained.

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

The program maintains a policy and procedure addressing youth handling and supervision of flammable, poisonous, and toxic materials. The policy prohibits youth from using flammable, poisonous, and toxic items and materials. The flammable, poisonous, and toxic materials are stored in a locked room with restricted access in a file cabinet located on the youth dorm hall in addition to the plant manager's office. Youth do not have access to these items and are supervised by staff during daily cleaning. The youth did not participate in facility clean-up during the week of the annual compliance review; therefore, no observations were able to be conducted. A review of five youth interviews indicated they are prohibited from using chemicals/cleaning products.

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

The program has a policy and procedures addressing the disposal of all flammable, toxic, caustic, and poisonous items. The program has designated the physical plant manager as the staff authorized to dispose of unused flammable, poisonous, and toxic materials. An interview with the physical plant manager indicated the program has not had the need to dispose of unused chemicals during the annual compliance review period; however, if the need arose, the chemicals would be taken to Polk County Waste Management for the disposal. An interview with the facility administrator confirmed this practice. The program does not have a kitchen; therefore, there is no kitchen liquid waste to dispose. Documentation supported the program has not had any chemical spills; however, there is a process in place to address chemical spills.

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 rated 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 addressing visitation and communication. A review of five youth case management records verified each record contained an approved correspondence, visitation, and telephone log. Visitation is conducted on the weekends in the cafeteria area and large group room. Special visitations are provided for those parent(s)/guardian(s) who are unable to participate in the regularly scheduled visitation day. Youth receive weekly telephone calls. The length of the telephone call correlates to the behavior management system. Youth are provided writing materials, and a self-addressed stamped envelope to send letters to approved family members. An interview with the transitional services manager (TSM) confirmed incoming and outgoing correspondence is searched to control the introduction of contraband into the program. The TSM explained all outgoing mail from the youth are searched by the shift supervisor prior to sealing the envelope. Incoming mail is opened by the TSM in front of the youth and the TSM reviews the mail prior to giving it to the youth. All

incoming mail is documented on a tracking sheet. All five interviewed youth indicated they are able to call their parent/guardian and mail letters.

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

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

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

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

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

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