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): January 28 – 31, 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:

Tamara Mahl-Adkins, Office of Program Accountability, Lead Reviewer (Standard 1)
Kara Brown, Office of Program Accountability, Regional Monitor (Standard 4)
Johnnie Downing, Charles Britt Academy, Facility Administrator (Standard 5)
Felicia Goldstein, Office of Program Accountability, Regional Monitor (Standard 4)
Gregory Mahoum-Nassar, Office of Program Accountability, Regional Monitor (Standard 3)
Rowena Rose, Department of Juvenile Justice, Education Coordinator (Standard 2)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 3)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Polk Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Bartow County / Circuit 10
Review Date(s): January 28 – 31, 2020

MQI Program Code: 1049
Contract Number: 10359
Number of Beds: 24
Lead Reviewer Code: 156

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 Initial Background Screening *	4.15 Medication Management
2.04 Classification Factors, Procedures, and Reassessment for Activities	
2.09 Performance Plan Development, Goals and Transmittal *	
2.14 Incorporation of Other Plans Into Performance Plan	
3.12 Suicide Precaution Observation Logs *	
4.16 Medication/Sharps Inventory and Storage Process	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The 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 practice as well as the following groups. Anger Management/Strategies for Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, Thinking for Change, Impact of Crime, 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. Additional treatment services provided includes 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. 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 starting February 3, 2020; 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 three vacant positions; two youth care workers and one part-time RN.

Strengths and Innovative Approaches

- The program operates an aquaculture/horticulture program. In the program, the youth grow tilapia in a large tank. The waste from the fish is used as a nutritive fertilizer for the attached horticulture program. The program also has a beekeeping program in conjunction with the local school district. The bees are kept in hive stacks in the back corner of the property. Between the two programs, youth are educated on various biology and earth science topics. Both programs are managed by the youth under staff supervision.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Limited 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.	

A total of eleven newly hired staff personnel records were reviewed for initial background screening. All eleven records had a background screening conducted prior to hire or within the time frame the employee was going through training and the orientation process with no access to youth. In all records, the criminal history report was reviewed, all other requirements were met, no exemption was needed, and the staff was added to the Clearinghouse employment roster. Eight of the eleven staff were direct care staff. Six of the eligible eight staff did not have a pre-employment assessment tool administered prior to the hire date. All reviewed personnel records maintained the pre-employment assessment tool passing score. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit (BSU) on December 6, 2019, meeting the annual requirement. The annual background screening for the teachers who are paid by the school board, was received on December 6, 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 did not have any staff eligible for a five-year rescreening; however, the program has a policy and procedures for conducting five-year rescreening.

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

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

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

The program maintains a policy and procedures for staff to immediately report any knowledge or suspicion regarding an incident of abuse or harassment having occurred in the program. The staff shall also verbally notify the on-duty supervisor once the call to the Florida Abuse Hotline or the Department's Central Communications Center (CCC) have been made, as well as the reason why the call was placed. Furthermore, the staff is to complete an Internal Incident Report form and forward the completed form to their assigned supervisor once the call has been made to the Florida Abuse Hotline. These steps are not required if the person has made an anonymous report. A total of five CCC reports were reviewed which occurred since the last annual compliance review. In all five instances, allegations included physical, psychological, or emotional abuse with two substantiated incidents. A review of eleven personnel records indicated staff sign documentation indicating they will adhere to a code of conduct which includes the provision of an abuse free environment, as well as being mandatory reporters. The Florida Abuse Hotline and the CCC telephone numbers were posted throughout the facility for youth and staff access.
The program conducted TRACE self-assessments in October, November and December 2019.

Five youth interviews indicated all feel safe at the program and none ever had to call the Florida Abuse Hotline or the CCC. All five indicated staff are respectful when talking with them or other youth and none had ever heard staff use profanity when speaking to any youth.

Five staff interviews indicated all staff and youth can make a call to the Florida Abuse Hotline or the CCC if they wanted to, three would notify the supervisor and the facility administrator, and two would let their supervisor make the call. The staff also stated the supervisors have a telephone from which calls can be made as well as providing the youth with access to a telephone to place the call confidentially, with supervision. One staff added, depending on the nature of the allegations, staff will notify mental health and case management staff. Staff can

make anonymous calls. All five staff indicated they have never observed a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with a youth, nor telling a youth they could not call the Florida Abuse Hotline.

The facility administrator (FA) interview indicated the program's staff code of conduct includes no abuse of any type, falsification, contraband, foul language, threats, or weapons. Write ups, suspension, and/or termination are actions taken if physical abuse, threats, or profanity towards youth is used. The program's incident reporting process is for all CCC reportable incidents to be called in within two hours and to provide unimpeded access to the CCC and the Florida Abuse Hotline for the youth. If an abuse allegation is accepted, the CCC will be called.

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

The program had five instances in which staff were accused of physical, psychological, and/or emotional abuse since the last annual compliance review. In all five instances, management took immediate action to investigate the allegations of abuse and applied corrective action. In two of the five instances, the allegations were substantiated and the staff were terminated/dismissed. A total of four staff were terminated in the two instances.

The facility administrator (FA) interview indicated staff are notified during staff meetings, annual in-service training, and pre-service training on what to do regarding contact with the Florida Abuse Hotline or Central Communications Center (CCC). All CCC and abuse reports are reviewed and discussed in the morning management meetings. The FA interview indicated three staff were terminated due to allegations of abuse towards a youth since the last annual compliance review.

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

The program had five Department's Central Communications Center (CCC) reports in the last six months. One CCC was called in by an outside source. In the four remaining reports, the incident was called into the CCC hotline within the required two-hour time frame and the call was documented in the logbook. In two of the four instances, it was documented as a late entry and in one other instance, there was no time documented when the call was made. A review of the internal incidents/grievances indicated no other reports were warranted. The program has seen a decrease in the number of reportable incidents to the CCC.
The facility administrator (FA) interview indicated all CCC and abuse reports are reviewed and discussed in the morning management meetings.

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 had a total of sixteen Protective Action Response (PAR) reports in the last six months. Five PAR reports were reviewed and all five reports were completed by the end of the staff member's workday and included a statement of all staff involved. No mechanical restraints were used and no PAR resulted in an injury to the youth or staff or an abuse call being made. All five were reviewed by a PAR certified instructor or supervisory staff, a PAR medical review was conducted no matter what the post-PAR interview indicated, and the post-PAR interview was conducted with the youth by an administrator or designee within thirty minutes of the incident as well as a review by the administrator or designee within seventy-two hours. A copy of all PAR reports was placed in a centralized file within forty-eight hours of being signed by the administrator. The program's PAR plan was approved on March 28, 2019 by the Department. The program has experienced an increase in PAR reports since the last annual compliance review from six to sixteen reports. The program's PAR rate during the annual compliance review period was 3.02, which is higher than the state Residential PAR rate of 2.35. The program staff indicated since the last annual compliance review, the program experienced a slight increase in PAR reports with a spike occurring in the month of September 2019 resulting in five PAR incidents. During September 2019, the program experienced an influx of new staff as well as a change in some veteran supervisory staff which upset some youth and the program milieu. Program administration focused their attention on this area and PAR numbers returned to normal after this month.

The facility administrator (FA) interview indicated the process for monitoring PAR incidents and use of force is for all PAR incidents to be reviewed in the morning management meeting the next day, as well as video being reviewed after the PAR intervention to ensure the techniques were appropriate and not abusive.

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.	

Three pre-service training records were reviewed. In all three records, the staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention/intervention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), active shooter training, as well as grievance process, infection control, exposure control plan, behavior management system, intended and safe use of tools, and mental health/substance abuse training. The program's contract required training was also completed by all staff. The staff was certified within 180 days of hire completing the minimum required hours of training respectively and documented in the Department's Learning Management System (SkillPro). All instructors providing PAR, first aid, and CPR training had the proper certifications. The program submitted in writing on April 12, 2019, a list of pre-service training to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training based on the required topics.

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.*	

Three in-service training records were reviewed. Each of the staff completed the required cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, suicide prevention/intervention, active shooter, grievance process, emergency response, emergency drills, infection control, blood-borne pathogens, exposure control plan, behavior management system, stress management, as well as training in mental health and substance abuse topics. Two of the staff were supervisors and completed fourteen and fifteen hours, respectively, in the areas of management, leadership, employee relations, and communication skills. Two of the three staff had four hours each of training completed which was not documented in the Department's Learning Management System (SkillPro) but was added at the time of the annual compliance review. All other training were documented in SkillPro. All the instructors providing PAR, first aid, and CPR training had the proper certifications. All licensed nursing staff had current certifications in CPR with AED. The program submitted in writing on April 12, 2019, a list of in-service training to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training based on the required topics. The program provided the annual in-service training 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 maintains a policy and procedures addressing the grievance process including the training requirements. The grievance process included the informal, formal, and appeal phase. All three phases included time frames the staff must adhere to which includes: informal within twenty-four hours, formal within seventy-two hours, and the appeal phase within another seventy-two hours. The program maintains a binder with the last twelve months of grievances. A total of five grievances were reviewed. All were resolved in the formal phase within twenty-four hours of the grievance being made, well within the program's policy time frame. In the three pre-service and three in-service training records reviewed, all staff were trained in the program's grievance process and procedures.

Five staff interviews indicated they all were aware the grievance forms are placed throughout the program with four stating the grievance process has different time frames and they are reviewed by a supervisor. Three stated the facility administrator reviews grievances and youth can request assistance in filling out the form. One staff was able to indicate the grievance process has different phases such as informal and formal, as well as an appeal phase. Five youth interviews indicated they were aware the grievance forms are placed throughout the

program. One youth stated staff will provide writing utensils to fill out the form. Three stated they would fill out the form and staff will address the issue, and one youth indicated they could speak to staff first to resolve the issue but could take it further by speaking to the facility administrator (FA).

The facility administrator (FA) interview indicated the program's grievance process has an informal phase. Youth should speak with the person with whom they have the grievance. A formal phase is addressed at the next step by the assistant FA and an appeal phase, which is the final step, is addressed by the FA. Youth can also utilize an informal grievance called a “Speak Out” form where the youth can request a conference.

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

The program is required to deliver Impact of Crime (IOC) as well as Thinking for a Change (T4C). IOC is to be delivered by a trained case manager and T4C delivered by a trained therapist. 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 in regard to which staff is to deliver the interventions. Both interventions are held twice a week for one hour, as required by contract and are evidence-based services. A review of the program’s activity schedule, as well as the program’s contract, demonstrated the program is providing structured and planned activities at least eighty percent of the youth’s awake hours. A review of three youth records indicated all youth were involved in a delinquency intervention which was evidence-based, as well as numerous other interventions addressing an identified priority need. Two of the three youth did not have a goal identifying an intervention to address a priority need. The third record included an intervention goal which addresses a priority need.

The facility administrator (FA) interview indicated the program is providing services to address the priority needs of the youth they serve by delivering Anger Management, Skillstreaming the Adolescent, Teen Relationship Workbook, T4C, IOC, 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 with T4C and IOC being evidence-based services. The youth are matched to staff/counselors/case managers and intervention groups based on comprehensive evaluation and therapist strengths.

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.	

Neither the provider’s contract nor the facility operating procedures requires a specific intervention to be delivered to address life and social skills. The program provides youth with interventions such as Young Men’s Work (YMW), Anger Management, and Skillstreaming the

Adolescent to address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, critical thinking, including problem-solving, and decision-making skills. All the youth participate in YMW, Anger Management, and SkillStreaming the Adolescent. A review of the sign-in sheets confirmed the program's activity schedule has the interventions scheduled three times a week. The clinical director interview indicated the program offers mental health overlay services (MHOS) with regular clinical supervision and fidelity checks to ensure contractual requirements are adhered to.

Five youth interviews indicated they 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, Teen Relationship, YMW, coping skills, individual/family counseling, Alternatives to Drugs, and Thinking before acting.

1.12 Restorative Justice Awareness for Youth	**Satisfactory Compliance**
The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths' criminal actions and harm to others.	

The provider's contract specifies Impact of Crime (IOC) to be delivered as a restorative justice intervention and the program has added Pathways to Self Discovery and Change as part of the curriculum to assist youth in accepting responsibility for harm they have caused by their past criminal actions, challenging them to recognize and modify their irresponsible thinking, such as denying, minimizing, rationalizing, and blaming victims. These interventions also teach youth about the impact of crime on victims, their families, and their communities. The program provided minimal opportunities for youth to plan and participate in reparation activities intended to restore victims and communities. The youth crafted cards to provide to residents at a retirement home. The program has not exposed the youth to any victim speakers or victim impact statements since the last annual compliance review, other than through IOC. The program's activity schedule has staff deliver one intervention on the weekend and another twice a week. A review of documentation indicated the groups are delivered as scheduled and the staff delivering the intervention have been trained. The annual compliance review team observed an IOC group which was delivered by the recreational therapist. The staff was doing an amazing job keeping the youth focused and engaged. Three youth records were reviewed and all three received services to increase youth accountability for criminal actions and harm to others.

The facility administrator interview indicated the program utilizes IOC as a restorative justice group for youth. IOC also exposes the youth to victim's perspective through victim speakers, as well as completing community service type projects intended to restore victim and communities.

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.

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

The program maintains a policy and procedures addressing how alerts are identified, documented, updated, and communicated to staff. Three youth records were reviewed. In one of the records, the youth was to be on a medical alert but never entered into the Department's Juvenile Justice Information System (JJIS). The same youth had another medical alert which was closed in JJIS over one month after the doctor discontinued the youth regarding the medical condition. Any alerts which were entered, removed, or downgraded were completed by the appropriate staff.

The facility administrator interview indicated the formalized procedure in place for healthcare staff is for the staff to review the important medical issues pertaining to the youth at the program with the management team in the daily morning management meeting. The program's internal alert process is to document the alerts on the alert board in the conference room, as well as the medical alert binder. The mental health and medical department complete their respective alerts, and gang alerts are completed by case management.

The five staff interviews indicated the alert board in the conference room is how staff are made aware of youth alerts. Four staff stated they are informed during morning meetings/shift briefings and two stated the allergies are also posted in the cafeteria area. The staff also indicated mental health will notify of youth alerts, as well as being informed during the admission classification meeting, and through a supervisor or administration staff.

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 record into three separate binders such as an individual healthcare record, a mental healthcare record, and an individual case management record. The individual case management record contained a file tab with the youth's name, the Department

of Juvenile Justice Identification number, date of birth, county of residence and committing offense, as well as being separated into legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous sections. All records are stored in the locked cabinet and are labeled as "confidential."

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

The program utilizes a youth advisory board, "Speak Out" forms, grievances, and meetings with the facility administrator (FA) and assistant facility administrator (AFA) to seek input from the youth. A review of the youth advisory board indicated the board met monthly to discuss various issues. The youth serving on the advisory board were chosen depending on the program's level system. Five youth interviews indicated the process for allowing youth to provide input about what happened at the program is to speak to the recreational therapist. One youth stated they would speak to the FA and AFA, and another youth stated to the supervisor. One youth indicated youth bi-weekly community groups are held to where youth can provide input. The FA interview indicated the formal process to solicit input from youth on systemic issues impacting the residential community is the youth advisory board, "Speak Outs" where the youth can request a conference., grievances, meetings with FA and AFA, as well as youth completing quarterly satisfaction surveys.

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's community advisory board meets on a quarterly basis. The community advisory board is conducted for the program and another sister program in the same circuit. A review of the meeting minutes indicated the meetings were held as required and during each meeting the two programs were separately addressed. The facility administrator (FA) actively solicited involvement from law enforcement, judiciary, business, faith and lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) communities, as well as the school board and other community partners. Each of the meetings reviewed, other than the meeting in the last quarter had several community partners participating in the meeting. The FA has made recruitment efforts with victims, victim advocates, as well as parent/guardian of a child previously involved with the Department, as indicated by letters reviewed.

The FA interview indicated the community advisory board is held quarterly and the members are involved in family days, holiday celebrations, and weekly church services provided on Sundays and Tuesdays, as well as the pastor being the community service liaison for the program, connecting youth with different churches in the area. The board members also provide input and suggestions for additional community resources.

An interview with a board member indicated the board member has been a member of the advisory board for the last six years as a school board partner. The board member stated the meetings were extremely informative and everyone gets a chance to provide input as well as

discuss issues. The meetings discuss problems with the program, positive matters, anything related to the youth, as well as future planned events. Meetings are documented on an agenda and meeting minutes. Meetings are held once a quarter and the board member receive notification either by email, text, or verbally beforehand.

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

The program has a policy and procedures addressing communication with staff regarding the program. The program has monthly all-staff meetings and daily management meetings where staff are made aware of results from youth surveys, annual Department reports, and program planning; however, it was unclear if the Comprehensive Accountability Report (CAR) was reviewed with staff after review of meeting minutes. The youth and staff surveys request input about safety, treatment, and conditions in the program. The program has provided documentation of opportunities to minimize staff turnover and build staff morale. The program held two cooking/baking contest, safe employee raffle, and recognizing work anniversaries in the newsletter.

Five staff were interviewed and reported discussions during staff meetings include alerts, daily operations, drills, safety plans, and any issues in regard to youth in the program. Each of the interviewed staff confirmed they are briefed on annual reports and youth/parent surveys. Four interviewed staff indicated communication is very good and one reported good. During the interviews, the staff indicated they are able to provide input/feedback during monthly meetings, suggestion box, and can talk to administration about concerns.

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

The program maintains a policy and procedures ensuring staff receive a performance evaluation annually. A review of three staff evaluations confirmed each staff received an annual evaluation. The evaluations were reviewed with both the supervisor and staff. The evaluations rate the staff's basic knowledge of the program policies, quality of their work, modeling appropriate behavior, employee's use of motivational interviewing techniques, and their use of positive reinforcement. The program has a job description for each job position. Five staff were interviewed if they received a performance evaluation. Two indicated receiving a formal evaluation yearly, one indicated once or twice, another staff stated receiving weekly and monthly evaluations, and the remaining staff stated daily, weekly, and during staff meetings.

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

The program maintains a policy and procedures ensuring youth receive recreation and leisure activities. The program has a recreational therapist with a Bachelor of Science Degree in exercise science. The program has a daily activity schedule which includes activities with

various degrees of mental and physical exertion for the youth. A review of logbooks for the last six months for recreation revealed the youth received large muscle exercise daily for an hour. Five staff interviews indicated youth participate in at least one hour of recreation which includes youth participation in basketball, football, pull ups, sit ups, and jumping jacks. Five youth were interviewed and reported they receive one hour of large muscle recreation and they participate in basketball, football, frisbee, push-ups, jumping jacks, and individual workouts. Each youth reported being provided mental and physical exertion throughout the day.

Standard 2: Assessment and Performance Plan

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

The program maintains a policy and procedures ensuring youth admission to the program includes notification to the parent/guardian and court. A review of three youth records had documentation the parent/guardian was notified by the program within twenty-four hours of admission for each youth telephonically. The program notified the parent/guardian in writing within forty-eight hours and the committing court within five working days of admission for each youth.

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

The program maintains a policy and procedures ensuring each youth admitted to the program is provided an orientation on the day of admission. A review of three youth records had documentation the youth received an orientation on the day of their admission. The orientation included each of the required elements and the youth signed a form acknowledging receipt of the orientation which also comprised of receiving a copy of the behavior management system and youth handbook. During the annual compliance review, the program did not have any admissions; therefore, observations could not be conducted.

Five youth were interviewed and reported receiving their orientation on the day of their admission to the program. Each of the youth reported introduction to staff and were informed about program rules and expectations.

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

The program maintains a policy and procedures ensuring youth eighteen years of age or older provide written consent prior to release of information. None of the youth selected for the review were applicable, the program could only provide two additional youth records for review. Both youth records included signed written consents.

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

The program maintains a policy and procedures ensuring the program conducts the classification process for each youth admitted to the program. The program conducts a classification meeting to review each youth's information/documentation. Documents include initial interviews, records, observations, and screening finding. The meeting is attended by the case manager, assistant facility administrator, therapist and health services administrator/nurse, youth, and parent/guardian (if available). The program had documentation the alerts are updated continually. A review of three youth records reviewed included the initial classification form which encompassed each of the required elements and identified or suspected risk factors. None of the three youth had a Victimization and Sexual Aggressive Behavior (VSAB) entered in the Department's Juvenile Justice Information System (JJIS) upon admission. Each youth had a VSAB completed on the program's VSAB form on the date of admission and were maintained in each record. The program completed two VSABs in JJIS on January 15, 2020 and one on January 24, 2020. The youth were admitted into the program in July, August, and October 2019, respectively. The program completed reassessments monthly for each youth due to increase of privileges/freedom of movement, participation in work projects, or off-campus activities.

The facility administrator interview indicated factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a living unit/sleeping room by means of a review during the admission classification meeting. Youth having special needs or alerts such as an escape are placed in the rooms which are near to the staff. Younger youth are typically housed with similar ages which also depends on the youth size. Determination of which room is the safest for the youth are based on size, maturity, age, victimization, and risk.

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

The program maintains a policy and procedures ensuring notification of law enforcement of gang activities. None of the three youth records selected for review were applicable for gang identification. The program was only able to provide one additional youth applicable for review since the last annual compliance review. The one applicable record included documentation local law enforcement was notified by the program upon identification of the youth's gang involvement, as well as the youth's home county law enforcement agency of placement in the program. The program entered the gang alert in the Department's Juvenile Justice Information System (JJIS) upon identification and notified the educational provider serving the program and the juvenile probation officer (JPO). The post residential counselor was not applicable.

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

The program maintains a policy and procedures ensuring gang identified youth are provided prevention and intervention activities. None of the youth selected for review were applicable for gang identification. The program was only able to provide one additional youth record applicable for review since the last annual compliance review. In the one applicable record, the youth was identified as a gang member or affiliated gang member. The youth participated in gang prevention and intervention strategies and the youth's performance plan included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program provides a gang intervention/prevention curriculum called "ARISE: Gangs: Fifty plus Stories of Fractured Lives" to youth who have gang involvement. There is documentation of worksheets and sign-in sheets of the one youth participating in monthly activities. The youth participated in intervention/prevention activities for the duration of their stay in the program.

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

The program maintains a policy and procedures ensuring youth in the program have the Residential Assessment for Youth (RAY) and reassessments completed. A review of three youth records had a completed RAY within thirty days of their admission and was maintained in the Department's Juvenile Justice Information System (JJIS). In two of the three youth records, the RAY re-assessment was completed two days after the required ninety-day period; the other was completed on time. Each initial assessment and the reassessments were maintained in the three youth records reviewed.

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

The program maintains a policy and procedures ensuring the completion of a Youth Needs Assessment Summary (YNAS) for each youth entering the program. Two of the three youth records reviewed had a completed YNAS within thirty days of their admission. The remaining

one youth's YNAS was initiated 63 days after the admission date and completed in the Department's Juvenile Justice Information System (JJIS) 175 days after admission.

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

The program maintains a policy and procedures regarding the development of performance plans and transmittals. Two of the three reviewed youth records had an individualized performance plan (IPP) completed within thirty days of their admission. The remaining one youth plan was completed 146 days late. The program indicated the IPP was due on August 31, 2019 and completed by the case manager on August 26, 2019. Due to human error, the original copy of the signed IPP was mailed to the juvenile probation officer (JPO) but upon review of the case management record this error was identified. Once identified, a new IPP was printed and signed for the day the error was discovered. In each of the three records, the IPP was completed after the initial assessment. The youth, treatment leader (case manager), administrative representative, living unit representative, treatment staff, education, and parent/guardian participated in the development of the plan. The Department of Children and Families representative were not applicable for any of the youth reviewed. Each of the three performance plans were signed by the youth, intervention/treatment team leader, and all parties who had significant responsibility.

None of the three performance plans included transition activities for the last sixty days, one did not include youth responsibilities, and another did not contain staff responsibilities. The remaining elements were included in each of the three performance plans reviewed. In all three records, the plans were mailed within ten working days of completion to the youth, parent/guardian, court, and JPO. None of the plans were returned with signature by the parent/guardian. Five youth were interviewed and able to explain the treatment progress which includes the development of performance plans, treatment team meetings, and current goals they are working on. All five were able to provide the correct information. Three of the five interviewed youth reported receiving a copy of their performance plan. The remaining two stated they did not receive a copy; however, they are able to request a copy.

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

The program maintains a policy and procedures about the process of revising performance plans. Two of the three youth records reviewed had a performance plan revision in their records. The revisions were for correcting missing information such as youth and staff responsibilities, transition activities, and incorporating other treatment plans.

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

The program maintains a policy and procedures regarding performance summaries and transmittal. Two of the three youth records reviewed had a completed summary in their records. The third youth was not applicable due to the plan having been completed late and the summary not due at the time of the annual compliance review. One of the two applicable records had the summary completed on January 24, 2020; however, it was due on October 31, 2019. The program reported the performance summary was originally completed late on November 11, 2019 and mailed to the juvenile probation officer (JPO). Upon review of the record on January 24, 2020, the error was identified and a new printed performance plan was sent to the parent/guardian and JPO for their signature. The second youth had a summary completed within ninety days of the plan. The two summaries included youth status, overall treatment progress, academic status, youth's behavior, interaction with peers and staff, overall behavior adjustment, and, significant positive and negative events. One of the two summaries did not include the level of motivation/readiness to change. The remaining summary did. In the two applicable records, the youth was provided a copy of the performance summary and the original was maintained in each youth record. In one of the two summaries, the youth did not provide a comment to signify having read the summary. The remaining youth had a comment. In the two records the treatment team leader, facility administrator/designee, and youth signed the summary and a copy was mailed within ten working days to the committing court, JPO, youth, and parent/guardian.

Three closed youth records were reviewed for evidence of a release summary. Each of the three records contained the signed original release summary and a Pre-Release Notification (PRN), which was submitted at least forty-five days prior to the youth's release date. The committing court did not object to the release in each case. There was documentation in each of the three records the program mailed a letter to the parent/guardian of the youth's planned release. In two of the three closed records, the exit Residential Assessment for Youth (RAY) was completed upon approval by the court. In the remaining closed record, the exit RAY was

completed ten days after release. None of the youth were applicable for sexually violent predator program (SVPP) and victim notification. Four of the five interviewed youth were not applicable for receipt of a summary and one reported they did not receive a copy.

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 maintains a policy and procedures ensuring parent/guardian involvement in case management services.

In each of the three records reviewed, there was evidence the program encouraged the parent/guardian through different methods. The three records had documentation letters were mailed to the parent/guardian in regard to providing input in the assessment process, development of plans, and treatment team meetings, as well as communicating through telephone contact to invite and remind about pending meetings. If the parent/guardian is not able to participate in scheduled meetings, they are provided the opportunity to deliver written/verbal input prior to the meeting. In addition, the program schedules family days to encourage positive family reunification. During the annual compliance review, the program had one youth scheduled for treatment team. During the meeting, it was observed the parent/guardian called in to participate in the meeting, providing input and encouragement for the youth.

Each of the five youth interviews indicated their parent/guardian is involved in the case management process. The facility administrator interview indicated the program encourages parental involvement in the case management process through admission calls, treatment team, treatment and performance planning, family days, contact with parent/guardian for behavioral purposes, or special incentives such as birthdays.

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 maintains a policy and procedures identifying the members of the treatment team. Treatment team consists of the youth, parent/guardian, juvenile probation officer (JPO), facility administrator or director of clinical services, living unit representative such as the assistant facility administrator (AFA), shift manager and youth care worker, and others directly responsible for providing services such as the case manager, recreation therapist and therapist, education. The program invites each youth's JPO, parent/guardian, and other pertinent parties through email, letter, and telephone correspondence.

A review of three youth treatment team notes for a total of seventeen meetings was conducted. As evident of signatures or written input, the youth, representative from the living unit and administration, case management, mental health, parent/guardian, JPO, and education participated in all treatment team meetings. The medical staff attended thirteen of the seventeen meetings and the recreation therapist participated in seven of the seventeen meetings. The AFA is the gang prevention specialist and participated in all treatment team meetings.

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

The program maintains a policy and procedures in regard to the incorporation of other treatment plans into the performance plan. A review of three youth performance plans revealed two performance plans did not include academic plans, safety plans, delinquency interventions, or their treatment plans such as mental health/substance abuse. None of the three youth were applicable to include a Department of Children and Families case plan.

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

The program maintains a policy and procedures ensuring youth participate in both formal and informal treatment team meetings bi-weekly for informal and at least every thirty days for formal. A review of three youth records revealed formal and informal treatment teams were held as required. The formal and informal reviews documented the youth's name, date of review, comments from attendees, brief synopsis of progress, performance plan revisions, progress on performance plan goals, positive/negative behaviors, behaviors resulting in physical interventions, treatment progress, and Residential Assessment for Youth (RAY) reassessment results. The youth were provided an opportunity to demonstrate a skill acquired in the program.

Each of the five youth interviews indicated they are given the opportunity to demonstrate skills learned during treatment team, as well as staff reviewing their performance progress. During the annual compliance review, the program had one treatment team meeting. During the treatment team, it was observed all required staff were present and each provided input into the youth's treatment as well as discussing the youth's goals, behaviors, participation in treatment groups and individuals, and the team encouraging the youth to work on goals.

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

The program offers Type 2 career education programming appropriate for the age of the youth, the length of stay, including teaching personal accountability skills and behaviors leading to appropriate work habits for employment and living standards and an orientation to the broad scope of career choices, based upon personal abilities, aptitudes, and interest, as well as communication, interpersonal, and decision-making skills. Three open and two closed youth records were reviewed. All five records contained a sample employment application and a résumé. Three of the five youth were applicable and had documentation of location and business hours for a local Career Source Center and appropriate documents to obtain employment. In the two closed records, the youth's parent/guardian and juvenile probation officer (JPO) were made aware of the vocational plan for the youth. This was not applicable to

the three open records. The lead educator interview indicated Polk County Schools provides the career programming which includes My Career Shines Inventory, courses in career research, employability skills, digital technology, and assessment tools for youth to determine their educational abilities and career goals. Horticulture classes are taught at the program and youth are trained and earn certificates for Safe Staff Food Handler, Occupational Safety Health Administration (OSHA) safety, Food Manager, and Ready to Work. Speakers are invited from various occupations sharing work habits for employment or prerequisites needed for entry into a specific occupation.

The facility administrator (FA) interview indicated the youth are provided vocational services through résumé writing, mock interviews, completing job applications, as well as providing horticulture and agriculture classes.

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

The school district has approved the instructional schedule which is a three-block class schedule using an A/B Alternating-day schedule. The program provides 250 days of instruction, distributed over twelve months; at a minimum of twenty-five hours weekly. The reviewed documentation indicated ten days or less are utilized for teacher planning and/or training. The daily schedule of educational classes from 7:30 a.m. to 2:10 p.m. are adhered to, with minimal interference.

Five youth interviews indicated all confirmed little to no interruptions in educational instruction. The lead educator interview confirmed there are no deviations from the education schedule.

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

A review of three open and two closed youth records indicated each youth had an individual education transition plan developed which was based on youth's post-release goals, beginning at admission. The youth, parent/guardian, personnel from the post-release school district, as well as the educational personnel from the program, Department personnel, a registrar or designee from program's district with access to management information system, and school counselor were included in the development of the education transition plan. In the two closed records, the transition plan was developed with the youth, the program, education, and aftercare staff with specific plans for continuation of education and/or employment. This was not applicable to the three open youth records. In all five records, the transition plans addressed services and intervention based on student assessed educational needs and post-release education plans. The plans included specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services, as well as the recommended educational placement for post release based on the individual needs and performance. In the two closed records, the plan included provisions for continuation of education and/or employment, a valid Florida Identification card, documentation indicating the location and hours of a local Career Source Center, evidence of the youth's case management

and parent/guardian being aware of the plan, documents, and post-release discharge plans. The three open records were not applicable. In all five records, the plan included a sample employment application, a résumé, and appropriate documents essential to obtaining employment upon leaving the program. Youth's transition plans are continually processed daily.

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 maintains a policy and procedures ensuring youth pending discharge have a transition/exit conference and community re-entry team meeting (CRT). Two of the three closed records reviewed had a transition conference held at least sixty days prior to pending release date. The remaining closed record transition conference was one day late. The program invited the juvenile probation officer (JPO), parent/guardian, education, and pertinent parties to participate either by providing written or verbal input. None of the youth were in the Department of Children and Families custody. In all three records, the transition conference was attended by the youth, treatment team leader, facility administrator, and other members as evident by signatures on the form. During the transition meeting, the youth transition activities on the performance plan, additional transition activities, identified target completion dates, and persons responsible for completion were discussed. For those who could not attend, the program mailed the transition conference form to review and sign. In each of the three closed records, the CRT meeting was held prior to the youth's release. The youth and case manager participated in the meeting telephonically and the email invite was 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 maintains a policy and procedures ensuring youth pending release have an exit portfolio.

Three closed records were reviewed which each youth was over fifteen years of age. During the transition conference, the exit portfolio was initiated. One of three youth had a State issued identification card and birth certificate. The program attempted to obtain both for the remaining two youth; however, the parent/guardian did not provide the necessary information. Each of the three closed records included a copy of the transition plan, calendar with all upcoming

appointments, education documents, résumé, and sample employment application. In all three records, the program attempted to assist the youth with obtaining a social security card but the parent/guardian did not provide the necessary documents. In all three records, the exit portfolio was verified during the exit conference. The youth received the documents upon release from the program and there was documentation the program forwarded the exit portfolio to the juvenile probation officer.

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

The program maintains policy and procedures in regard to the exit conference being held for youth scheduled for release from the program. Three closed records were reviewed for exit conferences. Each had an exit conference held separate from the transition and community re-entry team (CRT) at least fourteen days prior to release after the program notified the juvenile probation officer (JPO) of release, it was documented in the case record. All three records confirmed the treatment team leader, parent/guardian, education, JPO, youth, and other team members attended the exit conference. The team reviewed the youth’s status of transition activities and finalized plans for release. In all three records, it was confirmed the date of admission and date of discharge in the program documents matched the Department’s Juvenile Justice Information System (JJIS).

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 reviewed records indicated the facility administrator (FA) has administered oversight and management of mental health and substance abuse services in the program. Due to the program operating capacity of fewer than 100 youth, 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 Statutes. A review of the LMHC's license was conducted and revealed the license number is clear and active with an expiration date March 31, 2021. The LMHC is a full-time employee of the program and is on-site a minimum of forty hours a week. As a result, the DMHCA is able to ensure appropriate coordination and implementation of mental health and substance abuse treatment services. The LMHC has been the DMHCA since August 19, 2019. A copy of the LMHC's licensure and position description was available for review while on-site. The program provides specialized treatment services such as mental health overlay services (MHOS) for twenty-four slots, serving male youth between the ages of fourteen to eighteen years old. All mental health and substance abuse staff licensures and position descriptions were available on-site for review. During an informal interview, the DMHCA described their role as ensuring clinical coverage needs and services are being provided. In addition, the DMHCA provides clinical supervision of the non-licensed therapists. 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. Documentation confirmed both the facility administrator (FA) and licensed metal health counselor (LMHC) have ensured all individuals who are providing mental health and substance abuse services have the appropriate qualifications to include education, training, and experience. Each of the therapists were master's-level and qualified to conduct the program's therapeutic groups. A review of the Department of Health, Medical Quality Assurance website found the LMHC license expires on

March 31, 2021 and is clear and active. The LMHC assist in the absence of the DMHCA. The LMHC license expires on March 3, 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 two full-time non-licensed clinical staff, who provide mental health and substance abuse services within the program. One of the non-licensed clinical staff have been providing services at the program since September 6, 2016, the remaining one since February 2, 2019. A review of the records confirmed each of the non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with Florida Administrative Code and the contract between the provider and the Department. The non-licensed clinical staff each hold a master's-level degree from an accredited university in an appropriate field of study. 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 4, 2020.

Each of 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. The clinical supervisor provided supervision through weekly on-site, face-to-face interaction with each of the non-licensed clinical staff, lasting at least one hour for each contact. A review of the last six months of direct supervision logs for mental health clinical staff indicated both non-licensed clinicians received direct supervision by the designated mental health clinician authority every week they provided services at the facility. The program has a Chapter 397 license to provide substance abuse services to youth 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. Documentation indicated the staff conducted a comprehensive review of the three youth's commitment packet information, reports, and records on existing paperwork on mental health and/or substance abuse problems. In addition, the Department's Juvenile Justice Information System (JJIS) alerts were reviewed according to their documentation review form.

Three youth records were reviewed for a mental health and substance abuse admission screening. Each reviewed record had a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) conducted upon the youth's admission to the program. During the admission process, available information was reviewed to include the commitment packet, reports, and records from existing documentation of mental health and/or substance abuse issues. Each of the three MAYSI-2 screenings were completed on date of the youth's admission to the program in a confidential manner and by non-licensed clinical staff who completed the required training. In all three records, staff followed the standardized process for the referral of youth identified for further mental health and/or substance abuse evaluation. Each of the MAYSI-2 screenings were administered in the Department's JJIS. All three MAYSI-2 screenings indicated further assessment was required. All three youth received a referral for further evaluation based on results of the MAYSI-2. None of the youth were found to be at risk of suicide during the screening process.

Based on the program's comprehensive plan for mental health and substance abuse services, each youth was subsequently referred for an Assessment of Suicide Risk (ASR), which was completed within twenty-four hours of the referral. All three youth who were administered the MAYSI-2, were referred for a comprehensive evaluation. Each of the youth referred had a reason for referral documented. During an interview with the facility administrator, it was stated all youth are administered the MAYSI-2 assessment, assessment of suicide risk, and Vulnerability to Victimization and/or Sexually Aggressive Behavior at admission.

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

A review of three records confirmed the youth identified by screening, staff observation, or behavior in need of further mental health and substance abuse evaluation received a comprehensive mental health evaluation. The assessments completed during the evaluation process were the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), the Vulnerability to Victimization and/or Sexually Aggressive Behavior (VSAB) form, an Assessment of Suicide Risk (ASR), and if warranted and based on hits on the MAYSI-2; the program would administer the Trauma System Checklist for Children (TSCC), the Substance Abuse Screening Inventory form (SASSI), and/or Reynolds Adolescent Depression Scale (RADS-2). Based on the clinical judgement of the therapist, the TSCC, SASSI and/or RADS-2 could be administered to gain additional insight at any point in the youth's treatment. Youth also meet with the psychiatrist within fourteen days of admission for an evaluation. Once the psychological intervention and evaluations are completed, an individualized treatment plan is developed. The treatment plan is developed based on information from both evaluations and input provided from the youth and parent/guardian.

The three youth records reviewed, had a new mental health evaluation completed within thirty calendar days of admission by a non-licensed mental health clinician. Two of the three evaluations were reviewed and signed within the required ten days by the licensed mental health counselor (LMHC). The third mental health evaluation was reviewed and signed by the LMHC 143 days late. All three records contained a comprehensive mental health and substance abuse bio-psychosocial evaluation which included demographics, reason for evaluation,

relevant background information, behavioral observation, methods of assessment, patterns of alcohol and other drug abuse, impact of alcohol and drug abuse, risk factors of continued alcohol and other drug abuse, mental status examination, discussion of findings, diagnostic impression, and recommendations. Each of the new evaluations addressed the original referral reason. Additionally, each of the three youth records contained a signed Youth Consent for Substance Abuse Treatment form.

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

Three reviewed 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 the three records reviewed the youth were assigned to a mental health and substance abuse treatment team during entry into the program. 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. All three reviewed youth were determined to be in need of mental health and substance abuse treatment. Reviewed documentation for all three revealed the treatment plans called for 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, with one minor exception. One youth missed group sessions on November 30, 2019 and December 1, 2019.

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 three youth records reviewed for substance abuse treatment signed both a 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.

Youth sign-in sheets for mental health overlay services (MHOS) were reviewed. Documentation reviewed and 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 fewer youth. A review of the three youth records contained documentation youth were involved in individual psychotherapy or counseling. Youth were also 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.

All three youth records reviewed were applicable for mental health treatment. The program has a contract to provide MHOS to twenty-four youth. Each of the three youth had a properly executed Authority to 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 articulated the program offers MHOS and for youth dual-diagnosed are provided with group, individual, and/or family therapy. All five youth interviews indicated they participate in group and specialized counseling.

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. Three 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 three 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. One youth was applicable to include psychiatric needs but this was not included in the initial treatment plan.

The review of three youth mental health records confirmed each youth had an individualized treatment plan which was completed within thirty days of admission, on a form which contained all elements found on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Documentation indicated two of three youth individualized treatment plans were completed by a non-licensed mental health clinical staff and were subsequently reviewed and signed by the licensed clinical supervisor within ten days of completion. The third youth record was developed by a licensed clinician. In two of the three records, the individualized treatment plan was signed by all treatment team members who participated in the development of the plan. One of the youth's initial treatment plan was missing signatures from the living unit and administration stakeholders. One record was applicable regarding psychiatric services and contained the psychiatrist signature. Documentation indicated the youth on psychotropic medication had the required input by the psychiatrist. The treatment plan included psychotropic

medication and frequency monitoring by the psychiatrist. Documentation indicated treatment plan reviews conducted were documented on a form which contained all the elements of the Department's Individualized Mental Health Treatment Plan Review form. All three individualized treatment plans reviewed had documentation regarding on-going prescribed services, individual, group, family, and/or psychiatric services, as required. Two of three records were completed within the thirty-day time frame and one review was completed four days late.

In the three records reviewed, the discharge plans were documented on the Department's Mental Health and Substance Abuse Treatment Discharge Summary form. Reviewed documentation reflected two of three were completed by a non-licensed mental health clinical staff and were subsequently reviewed and signed by the licensed clinical supervisor within ten days of completion. The third youth record was developed by a licensed clinician. There was no indication of the three youth requiring any type of notification for suicide risk or precautions. Each of the three mental health and substance treatment discharge summaries documented the services required for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. Each discharge plan were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during an exit conference and a copy was provided to each youth, JPO, and parent/guardian.

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."	

A review of documentation revealed the program provides specialized treatment and mental health overlay services (MHOS) through a contract between the provider and the Department, which outlines the scope of the services provided. The program offers twenty-four MHOS beds for male youth between the ages of fourteen to eighteen years old, including bi-monthly individual therapy and monthly family therapy, when indicated as well as daily group therapy which utilizes mental health, substance abuse, and psychosocial skills training curricula. The program has a contract with a licensed psychiatrist who 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 currently one licensed mental health professional employed at the program who is on-site at least five days a week and serves as the designated mental health clinician authority (DMHCA). If licensed mental health professional coverage is needed, the providers regional clinical director can be on-site to provide backup coverage, as needed. The program has a contract with a licensed psychologist to provide services, as needed. Each full-time therapist which are non-licensed mental health clinical staff generally carries a caseload of twelve youth if the program is at full capacity. An interview with the facility administrator (FA) and DMHCA revealed 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 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. Each youth on prescribed psychotropic medication receives monitoring and review at a minimum of every thirty days. A review of three youth records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication service within the program. There were no indications of the program having any standing orders and emergency treatment orders for psychotropic medications.

Three records were reviewed in which one youth entered the program on prescribed psychotropic medications. The program was able to provide two additional examples. A referral for psychiatric services were needed in all five records reviewed. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnosis, treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication (where applicable), and frequency of medication monitoring (where applicable). The youth were seen within fourteen days of the referral. The program's practice for all youth to be referred to the psychiatrist regardless of medical status. All five initial diagnostic interviews were documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as "initial diagnostic psychiatric 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 utilized 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.

An informal interview with the psychiatrist stated meets with members of the treatment team and is on-site every two weeks. The psychiatrist meets with the program's designated mental health clinician authority (DMHCA) and facility administrator (FA) bi-weekly to discuss youth receiving psychiatric services while on-site. The psychiatrist is available to conduct face-to-face or

telephonic communication with a representative from the treatment team. The psychiatrist does not have any concerns with the healthcare at the program.

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'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 the designated mental health clinician authority (DMHCA) on September 13, 2019 and by the facility administrator on April 23, 2019.

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 three records found documentation each youth received a referral for an Assessment of Suicide Risk (ASR) and one 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. The program was able to provide one additional record of a youth placed on precautionary observation (PO) since the last annual compliance review. The reviewed record indicated the youth was placed on precautionary observation (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 was screened and subsequently maintained on PO. Supervision was maintained on a Mental Health - Alert Log instead of the required Suicide Precaution Observation Log. The precautionary placement was authorized by the facility administrator (FA)/designee, mental health staff provided supportive services, and a conference between the licensed mental health professional and FA was documented to reduce the level of supervision. When the youth's follow-up ASR indicated suicide precautions may be discontinued, the youth was stepped down to close supervision prior to transition to normal routine/standard supervision. The follow-up ASR included all required elements and the discontinuation of close supervision was documented as mandatory. The parent/guardian and juvenile probation officer (JPO) were notified of the youth's potential suicide risk and an alert was entered and updated as required in the Department's Juvenile Justice Information System (JJIS), as well as in the facility's logbook.

Three of the four 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. The one youth maintained on PO was allowed to participate in select activities with other youth in designated areas of the program. The youth was not limited to an individual cell or restricted to their sleeping room.
None of the four youth assessed were determined to be in any kind of crisis and none of the ASRs were conducted outside of the program.

The program has two suicide response kits in the front office and in the laundry room which is located on the youth dormitory. The kit in the laundry room could not be unlocked as a result, the lock was replaced by the program during the annual compliance review. 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 FA review process for every serious suicide attempt or serious self-inflicted injury and mortality review for a completed suicide. A multidisciplinary review includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

All five interviewed staff responded they would notify mental health staff should youth express suicidal thoughts. One staff stated they would place the youth on alert. 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)	**Limited 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. The three records reviewed were not applicable. The program was able to provide one additional applicable record for the annual compliance review period for completion of suicide precautionary observation. In the one applicable record, the supervision was not documented on the Suicide Precautionary Observation Log. The program mistakenly used the Mental Health Alert - Observation Log. The incorrect form was used for all three days the youth was on supervision. Each of the logs documented the appropriate level of supervision and observations of the youth's behavior. Staff recorded observations of the youth behaviors in real time, at a minimum of thirty-minute intervals with no noted warning signs. The logs were reviewed and signed by each shift supervisor and the mental health clinical staff. The Mental Health Alert - Observation Log which the program utilized in error, does not include specific language documenting safe housing areas for the youth within the program. There were no youth currently in the program who had been on suicide precaution.

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.	

A review of six staff records representing the direct care, supervisory, and nursing staff found documentation all completed the suicide prevention training course in the Department's Learning Management System (SkillPro). Documentation revealed the program operates on three shifts in which the program conducted mock suicide drills at a minimum quarterly on each shift, for all staff in contact with youth. All twenty-six reviewed drills included action to be taken by staff with 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 the use of the suicide response kit or automated external defibrillator (AED). The review of drills found cardiopulmonary resuscitation (CPR) was being administrated in the medical drills. Staff with direct contact on a day-to-day basis with youth, participated in at least one quarterly mock drill semi-annually. The program has a process in place which allows staff not present during a mock drill to review each drill scenario and procedures.

Four of five interviewed staff indicated they had participated in a mental health drill in the last twelve months.

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 (PAR), 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 the designated mental health clinician authority (DMHCA) on September 13, 2019 and the facility administrator on April 23, 2019.

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 three records reviewed were applicable. The program was able to provide only one additional 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.

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 employs an emergency mental health and substance abuse 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 the designated mental health clinician authority (DMHCA) on September 13, 2019 and by the facility administrator on April 23, 2019.

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

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

Standard 4: Health Services

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

The program contracts with a medical doctor to serve as the designated health authority (DHA). The DHA is an osteopathic physician with a specialty in internal medicine and experience in adolescent health. The DHA's license is clear and active in the State of Florida expiring on March 31, 2020. The program does not utilize the services of a physician's assistant or an advanced practiced registered nurse (APRN) for medical services. The provider employs a medical doctor who is available as a back-up if needed. The provider's doctor has a current and active license in the State of Florida which expires on January 31, 2021. It was verified, through weekly physician clinic lists for the last six months, the DHA was on-site weekly every Thursday, for a minimum of two hours, with two exceptions. On August 15, 2019, the DHA was on-site one hour and forty minutes and on September 26, 2019 one hour and thirty-five minutes. An interview with the DHA validated they are on-site once a week to complete initial physical exams, periodic evaluations/exams, and referrals to specialists, as needed. The DHA confirmed notification of each youth's admission electronically and by telephone. The DHA indicated the provider's licensed medical director would provide back-up services as needed and confirmed being available twenty-four hours a day, seven days a week for emergency care and consultation.

The program is contracted to have one full-time and one part-time registered nurse (RN). Currently, the full-time RN, who serves as the health services administrator (HSA), is on medical leave and the part-time RN officially starts on February 3, 2020. The program's part-time RN position has been vacant since March 2019 and the HSA has been on medical leave since December 24, 2019. Three RNs from other programs come in daily, or as needed, to provide seven days a week coverage. During the week of the annual compliance review, the provider indicated they will start utilizing nurses, as needed, from Maxim Healthcare. The provider had an active contract signed in April 2019 with Maxim to provide nursing staff, as needed. There were no nurses hired since the last annual compliance review. The program does not utilize the services of licensed practical nurses. A copy of all licenses for clinical staff were reviewed and verified to be clear and active in the State of Florida. Expiration dates for all four nurses are July 31, 2020 and April 30, 2020, respectively.

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.	

A review of the facility operating policy and procedures (FOPs) validated the facility administrator (FA) signed all policies on April 23, 2019, upon being hired to work at the facility. Each of the FOPs were signed by the designated health authority (DHA) in July 2018 and updated on June 20, 2019. Several FOPs were updated after June 20, 2019 and each policy was signed by the FA and DHA. The FOPs outline the program's provision of healthcare and psychopharmacological services. The DHA and the FA approved and signed the nursing protocols on June 20, 2019. The protocols are written and authorized by the DHA and are not delegated to any other person. The nursing staff including visiting nursing staff, completed an

annual review of all policies and protocols after June 20, 2019, which was documented on a signature page. The DHA creates and approves all treatment protocols and standing orders. All psychiatric related services and psychiatric medication management is performed by the program's contracted psychiatrist. A review of all psychiatric FOPs validated they were reviewed by the psychiatrist on February 26, 2019. Newly hired medical staff are required to participate in on-the-job training and orientation with the use of a comprehensive training plan. Training for new nursing staff could not be verified during the annual compliance review since the program has not hired any nurses since the program's last annual compliance review. The program hired a part-time registered nurse (RN) who will begin training on February 3, 2020. In an interview, the DHA verified their involvement with policy and protocol development.

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.	

Three youth medical records were reviewed for a valid Authority for Evaluation and Treatment (AET) forms. The AET is valid as long as the youth is under any type of supervision by the Department or until their eighteenth birthday. The program did not have any youth in the care of the Department of Children and Families (DCF) and all three were under the age of eighteen. A review of the three youth records indicated each contained a valid AET. All three AETs were copies, with the word "copy" stamped on them, signed by a parent/guardian and witnessed by a Department representative. In all three records, the completed parental notifications were maintained behind the AET. In an interview with the regional health services administrator (HSA), it was indicated the HSA is responsible to review each AET prior to or upon admission of a youth for validity. If the AET is not valid, the juvenile probation officer (JPO) or commitment manager is contacted to gain access to a valid AET. If a youth turns eighteen years of age while in the program, a release of information is signed by the youth.

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

The program maintains a policy and procedures to address parental notification when there is a significant change in the youth's condition and obtain consent when new medications and treatments are provided to the youth. A review of three youth records revealed each were applicable for parental consent/notification. None of the youth were involved with the Department of Children and Families (DCF). There were a total of fifteen consents/notifications reviewed. All records contained the appropriate Department forms mailed to the parent/guardian regardless of verbal consent, with three minor exceptions. One youth had an on-site x-ray on November 27, 2019;although, the record indicated the parent/guardian was notified of the scheduled x-ray both verbally and in writing, there was no documented notification to the parent/guardian of the x-ray's negative results. The second youth came into the program on an antibiotic and there was no general notification provided to the parent/guardian to notify them of when the antibiotic was discontinued. There was no documented notification in the third youth's record to the parent/guardian of the doctor prescribing the youth an over-the-counter (OTC) medication amount beyond those covered by the Authority for Evaluation and Treatment (AET). None of the youth needed invasive dental care or had changes to their chronic condition.

One of the three youth were applicable for surgery/invasive procedure and the parent/guardian was notified in advance of the procedure and signed the consent form on the day of surgery. Two of the three youth had a psychotropic medication prescribed or discontinued post admission and verbal consent was obtained by the parent/guardian in both instances. Each verbal consent was witnessed by another nurse or program staff. In both records, written notification along with a copy of page three of the Clinical Psychotropic Progress Note (CPPN) was mailed to the parent/guardian.

Each of the three youth's records contained a copy of their required immunizations obtained through the Florida Shots system. None of the youth required additional vaccinations. If a youth is exempt from immunizations, the program requires parent/guardians to provide the appropriate form from the Department of Health. An interview with the regional health services administrator (HSA) confirmed the program's practice and indicated verbal consents are obtained as soon as possible after an order is written by a physician and written notification to parent/guardians is mailed within twenty-four hours. If a youth has an illness or injury which requires emergency medical services, all attempts are made verbally to contact the parent/guardian prior to the youth leaving the program and a call is made upon the youth's return with results of the emergency visit.

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

The program maintains a policy and procedures to ensure youth are screened for healthcare concerns upon admission and readmission to the program. The procedures indicate each youth is screened on the day of admission or readmission when a youth has been out of the physical custody of the program.

Three youth medical records were reviewed and each contained a completed Facility Entry Physical Health Screening (FEPHS) form. All three forms were completed by a registered nurse (RN) on the day of admission. None of the youth experienced a change in physical custody nor did the program have any records including examples of a youth who had a change of custody. There were no FEPHS forms completed by direct care staff nor did the program have any records to provide as an example of the practice. An interview with the regional health services administrator (HSA) reflected youth are seen the day of admission and an RN or the HSA completes the FEPHS form. If an additional FEPHS form is needed upon a youth returning to the facility, the shift supervisor can complete the form which will be reviewed by a nurse when they arrive at the program.

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

The program maintains a policy and procedures to ensure all youth receive an orientation regarding general healthcare upon admission. A review of three youth medical records reflected each youth received an orientation to healthcare services at the program on the day of admission. Each youth's orientation included information on access to medical care, sick call,

what constitutes as an “emergency” and when to notify staff, medication process to include side effect 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. This information was documented on the health education form and all three youth signed the form. A review of the program’s healthcare contacts validated their accuracy.

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

The program maintains a policy and procedures to ensure the designated health authority (DHA) is informed of each admitted youth on the day of admission, regardless of any chronic medical conditions. A review of three youth medical records revealed one youth was admitted with a chronic condition. Each record documented the DHA was notified by telephone upon admission, which was documented on the admission form. An interview with the regional health services administrator (HSA) indicated the DHA is notified by the registered nurse (RN) or the HSA on-site or by telephone on the day of admission if a youth has a serious or chronic 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.	

Three youth medical records were reviewed and each record included a new Health-Related History (HRH) form completed on the day of admission, by a registered nurse (RN). The program utilized the Department’s most recent HRH form. The designated health authority (DHA) reviewed each of the completed HRH forms and documented this review on each of the youth’s Comprehensive Physical Assessment (CPA) form. The HRH was completed before or at the same time as the CPA for all three youth. The regional health services administrator (HSA) verified this process in an interview and stated the medical department completes the HRH form on the day of admission.

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

The program maintains a policy and procedures including appropriate documentation when any part of the exam is not conducted and/or is refused by the youth, as well as tuberculosis (TB) screening. The policy is in compliance with the Centers for Disease Control (CDC) and Prevention new 2006 recommendations and Occupational Safety and Health Administration (OSHA) standards.

Three youth medical records were reviewed and each contained a Comprehensive Physical Assessment (CPA) completed on a form which contained all of the elements of the Department’s CPA form. None of the youth had a current CPA on file at the time of admission. All three CPAs were completed by the designated health authority (DHA) within seven calendar days of the youth’s admission. All fields on the three reviewed CPAs were completed by the DHA and included, but were not limited to, the medical grade, body mass index, visual acuity

field, Tanner stage, scalp/head, cardiovascular, and the most recent tuberculosis skin test (TST). None of the youth presented with symptoms suggestive of active tuberculosis. None of the three CPAs indicated the youth refused examination. In all three records, two parts of the examination were not completed because they were deferred by the clinician due to negative history. All sections of the CPAs were completed in full utilizing "O" or "X", except for one item on one CPA form which was left blank. Three reviewed records indicated the Department's Problem List form was updated for each youth, as required. The Infectious and Communicable Disease (ICD) forms in each of the three reviewed records documented TST results. An interview with the regional health services administrator (HSA) indicated TB screening is conducted upon each youth's admission. The CPAs are completed upon admission and yearly, if the youth is still in the program.

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

The program screens each youth for sexually transmitted infections (STI) upon admission by utilizing the Department's STI Screening form. Each of three reviewed youth medical records contained an STI Screening form completed on the day of admission. None were referred for STI testing. One of the three STI screening forms did not have a check for question number six on the form and did not have the "yes" or "no" box checked indicating the need for further testing. All three forms were signed by the designated health authority (DHA), regardless if testing was ordered. An interview with the regional health services administrator (HSA) indicated youth are screened upon admission and if symptoms arise while in the program. If a screening indicates a need for further evaluation, the DHA is notified and an order will be written. STI information is documented on the Infectious and Communicable Disease (ICD) form.

The HSA and registered nurse (RN) from another program are certified 500/501 counselors and provide all human immunodeficiency virus (HIV) infection testing and counseling at the program. A review of three youth medical records validated each youth was offered an HIV test. Each youth's record contained a signed consent form refusing testing. The program did not have any examples of youth medical records for youth who consented to testing. During an interview with the regional HSA, it was indicated youth can request an HIV test upon admission if they would like testing and are able to request testing and HIV counseling at any time. Testing is documented on a nursing chronological note, results are placed in a sealed envelope with the youth's name and marked 'confidential', pre-counseling and post- counseling is documented on the Health Education Record. Five youth were interviewed and all indicated they could request an HIV test.

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

The program maintains a policy and procedures to address the provision of sick call. The procedures indicate all youth are able to make a sick call request and have complaints treated

appropriately through an established sick call system. Each youth is oriented to the program's sick call process upon admission. Sick call care is provided by a registered nurse (RN), pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The policy requires a referral to the DHA when a youth presents a serious health issue or complains of the same issue three times during a two-week period. Sick call hours are posted outside the clinic door and throughout the facility; noting the daily hours of 12:00 p.m. to 12:40 p.m. The program has an RN on duty Monday through Sunday from 8:00 a.m. to 4:00 p.m. According to the program's policy and procedures, when there is not a licensed nurse on-site, the shift manager is to review all sick call requests as soon as possible and determine if the sick call requires immediate attention. The health services administrator (HSA), the regional HSA, and the DHA and/or designee are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity of, shall be treated as emergencies. Youth can obtain a blank sick call form from a staff member or from the hanging folder outside of the clinic in the multipurpose room.

A review of three youth records reflected two youth completed a Sick Call Request form at least once during their stay. An additional third youth record was provided by the program. Each of the three applicable records contained one Sick Call Request form. In each instance, the RN documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. None of the youth submitted a complaint which warranted a referral to the DHA. Reviewed records indicated all sick call complaints were documented on the Sick Call Index and Sick Call Referral Log. All completed Sick Call Request forms are filed in reverse chronological order in the progress note section of the youth's medical record with exceptions. The nurse enters all information from the youth's Sick Call Request form into the electronic health record and prints out the final version to sign. In two of the three reviewed records, the youth's original handwritten Sick Call Request form was not in the youth's health record chronological notes attached to the electronic form as policy requires. Room restriction/controlled observation is not utilized at this program according to policy and procedures. There were no Sick Call Request forms submitted during the week of the annual compliance review; therefore, observations of the sick call process could not be made by the review team.

Five interviewed staff indicated nursing staff conduct sick call. Five youth were interviewed on how quickly they can see a nurse after making a sick call request. Three youth stated they can be seen immediately or within one day and two stated they never submitted 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 maintains a policy and procedures to detail the process for the provision of episodic and first aid care. Procedures indicate emergency medical and dental care are available twenty-four hours a day.

A review of three pre-service and three in-service staff training records revealed staff are certified in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED) training. The program provided documentation to confirm nursing staff facilitated an annual training for all program staff in the use of an epinephrine auto-injector. There are no program youth currently requiring an epinephrine auto-injector.

The program has one AED which was observed with procedures located in the AED box. The program's AED is stored on the wall in the administration area and is accessible to all staff. The AED was operational upon observation. The battery and pad checks were completed. The batteries expire on July 26, 2021 and the pads expire on November 30, 2020. The batteries were installed on July 26, 2017 and the pads in November 2019. The program has four first-aid kits in administration, in the laundry/property room, in a classroom, and one for the van. During the annual compliance review, all four sealed first aid kits were opened and found to be fully stocked. Documentation indicated the AED is inspected monthly and first aid kits weekly by a registered nurse (RN). The program maintains two suicide response kits; one in administration and another in the laundry/property room. A review of logbooks revealed direct care staff check first aid kits every shift on a walkthrough to ensure the kits are sealed. All emergency drills and trainings for direct care staff were reviewed for the past year and found to be completed, as required. An emergency drill was conducted every month for every shift over the last year, except for a third shift drill in December 2019. At least once a quarter, the emergency drill included CPR/AED demonstration. One drill on each shift included the use of an epinephrine auto-injector. Emergency numbers are inaccessible to youth and are stored in administration.

A review of three youth medical records indicated none of the youth were seen by non-licensed staff. The health care staff member who rendered care was a RN, who completed and documented the episodic care in SOAP (subjective, objective, assessment, and plan) format. In the three records the youth were seen for a total of five episodic and/or first aid care events. Each event was documented in the nursing chronological progress notes and included all required elements. Two of the three youth required an alert in the Department's Juvenile Justice Information System (JJIS). One youth was placed on sports restriction; however, an alert was not placed in JJIS. One event required off-site care. Documentation was completed and filed in the youth's record. Parental notification was made prior to the youth receiving an x-ray but the program did not complete a follow-up with the parent/guardian. All episodic care is documented on Episodic Care and Referral Logs, utilizing one form for each month documenting all episodic and emergency care. Logs for the last six months were reviewed and there were no exceptions were noted.

An interview of five youth indicated each youth can see a doctor or dentist, if needed. An interview of five staff indicated they all were aware they have the right to personally call 9-1-1 at any time.

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.	

A review of three youth medical records found two youth needed referrals for off-site treatment and/or required off-site emergency care or first-aid. An additional example record was requested

from the program; however, the program reported there were no other records applicable to off-site care/referrals. There was a total of seven examples of off-site care reviewed. None of the youth were over the age of eighteen or in the custody of the Department of Children and Families. None of the youth required off-site dental care. Both records contained the Department's Summary of Off-Site Care Consultation Report forms, which were reviewed and signed by the designated health authority (DHA) upon the youth's return from off-site care. All records contained documentation of physician orders completed by the DHA upon their review of the discharge paperwork from the off-site visit. Follow-ups, referrals, and additional appointments were tracked and completed, as documented in the youth's medical record when applicable. In one instance, the parent/guardian was notified of the youth's visit to the hospital but not notified of an over-the-counter (OTC) medication which was prescribed at the hospital. An interview with the regional health services administrator (HSA) nursing staff reported the registered nurse (RN) calls the DHA after all off-site visits are completed and received telephone orders, if applicable. All off-site care documentation is flagged in the youth's medical record and provided to the DHA to review at the next weekly visit. Follow-up appointments are tracked through an internal calendar/tracker.

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

The program maintains a policy and procedures to provide guidance in the areas of chronic illness monitoring and periodic evaluation time frame requirements.

A review of three youth medical records and Facility Entry Physical Health Screening (FEPHS) forms indicated two were identified with a chronic condition. An additional record was requested from the program to meet the sample size of three. All three youth were classified with a medical grade of two through five. None of the youth had a communicable disease nor were they taking prescribed medication on an ongoing basis. Two of the three youth were undergoing treatment for a physical health condition which included a body mass index greater than thirty. Each of the records documented updating of the Department's Problem List as changes occurred.

One of the three youth entered the program within the last thirty days and was not applicable for a periodic evaluation. A review of the remaining two records supported both youth received periodic evaluations within the required ninety-days on-site. There was no indication of lapse in care or evaluations for any of the youth. The two applicable youth received a specialized treatment plan, the periodic evaluations were tracked, and documentation was maintained in each record. Treatment orders were written where staff could clearly distinguish them.

In an interview, the regional health services administrator (HSA) indicated the designated health authority (DHA) is notified upon each youth's admission, regardless of having a chronic condition. Additionally, the regional administrator indicated youth with chronic conditions are tracked through the program's medical tracker and the Chronic Conditions Log. The facility administrator (FA) was interviewed and supported the program's practice. In an interview, the psychiatrist confirmed all youth on psychotropic medication are evaluated every thirty days.

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

The program maintains a policy and procedures to address medication verification and management, including trained non-licensed staff must verify medications when the youth are admitted to the program and licensed healthcare staff are not on duty. The program may obtain emergency prescriptions from a local pharmacy, when necessary.

A review of three youth medical records revealed two were admitted into the program on prescribed medications. A third additional record was provided by the program for review. Upon admission, all three applicable youth were transferred from a detention center. Each of the three records contained documentation indicating medications were verified in detention; however, the program did not document their confirmed verification of medication. The program's procedure indicates nursing staff are to document the verification of medication in the chronological progress note or on the Department's Prescription Medication Verification Checklist. In an interview, the program's regional health services administrator (HSA) confirmed this procedure and expected practice.

In each youth's record, the nursing admission chronological notes and Facility Entry Physical Health Screenings (FEPHS) documented the medications for each youth. Each of the records documented the designated health authority (DHA) and psychiatrist, when applicable were verbally notified by telephone on the day of admission and orders to continue medication were received. Each youth's order was current, valid and documented on a physician's order form. Documentation in all three records revealed the DHA or psychiatrist resumed the prescribed medication for each youth. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. When applicable, notification was made to the youth's parent/guardian and documented in the progress notes. Reviewed Medication Administration Records (MARs) validated the continuation of medications.

One of the three records were applicable for the youth having a change or discontinued medication. In all three records, each youth had a MAR outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. One of the three youth was administered OTC medications not listed on the AET. In each instance, the medications were administered in accordance with the approved protocols and physician's order.

A review of each of the MARs revealed the program utilizes the standard MAR provided by the program's pharmacy. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, and medical grade. A current picture of the youth is maintained in a binder with the current MAR to be utilized daily by the nursing staff. The MAR clearly indicated medication start and stop dates and nursing staff documenting side effect monitoring daily. Licensed staff initialed the MAR for each administered medication entry. The medications are maintained in blister packs documenting the number of pills in each prescription order. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. A review of all but one MAR verified there were no lapses in youth's medication regimen. The medical record for one of the youth

was missing the MAR for December which should have documented the prescribed administration of two psychotropic medications daily from December 18-31, 2019.

The program has a list indicating eight staff are currently authorized and trained to access and assist in the delivery of medications when licensed staff are not on-site. Training documentation provided to the review team revealed six of the eight staff were trained on January 22, 2020 by the regional HSA. Training for the remaining two staff was not provided. The program provided a list of approved staff for each month since August 2019. A review of this documentation revealed some months listed more than eight staff; however, training documentation was only provided for three of the staff. In one of the three records reviewed, the January MAR indicated psychotropic medication was administered on two separate dates by two non-licensed staff; however, the program did not have documentation to confirm the two staff were trained prior to January 22, 2020.

Two of the three records were applicable for medication/treatment refusals. All refusals were clearly documented on each MAR. One of the three records documented refusal of foot soaks on at least three occasions; however, there were no refusal forms present in the medical record. A second record contained refusal forms each time the youth refused a meal.

Observation of two medication administrations by nursing staff during the annual compliance review, validated the nursing staff followed procedures and the Six Rights of Medication Delivery/Administration. All youth were escorted to the medical clinic by a direct care staff member. Each youth was required to pull up their sleeves and allow staff to check their mouth after administration of medication. During an interview, the regional HSA confirmed the program does not have standing or pro re nata (PRN) orders for psychotropic medications nor do they have emergency treatment orders for psychotropic medication. Five staff were interviewed regarding the administration of medication at the program and all reported the nurse administer the medications. Four of the five staff also indicated a supervisor or trained staff member can administer medication when a nurse is not on-site. Five youth were interviewed on who gives them their medication. Three of the five youth indicated they do not take medication, two youth stated a nurse administers the medication, and one youth stated a supervisor provides medication.

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

The program maintains a policy and procedures to ensure the process for inventory and storage of all medications and sharps, as well as inventory discrepancy. All medications are secured in a locked medication cart. Additional, unopened over-the-counter (OTC) medication is in a locked cabinet within the locked medical clinic, which is inaccessible to youth. The program maintains a perpetual shift-to-shift inventory for all controlled medications which is outlined in the program's policy and procedures for medication management. All controlled medications are to be maintained in a locked box within the locked medication cart locked in the medical clinic. The locked box was observed in the cart. All medications are obtained through the pharmacy and are in blister packs documenting the number of pills in each prescription order. Each youth's individual controlled medication inventory record is to be updated after each

administration and inventory is to be conducted on each shift by two staff; either the medical staff and/or a shift supervisor.

There were no youth in the program on controlled medications at the time of the annual compliance review; however, one youth had previously been prescribed a controlled medication. The youth was admitted into the program on the controlled medication on August 1, 2019. The medication was discontinued by the doctor and returned to the pharmacy on August 21, 2019. A review of the controlled medications perpetual inventory sheet for this youth revealed, the daily shift-to-shift inventories were only completed by one nurse and there were no witness every day on the first to second shift, at least ten days on the second to third shift, and at least three days for the third to first shift.

The regional health services administrator (HSA) explained the process for disposal of expired or discontinued medications. Discontinued narcotics are destroyed monthly on-site by the pharmacy consultant. After medications are destroyed, the pharmacy consultant and a witness sign off on the controlled substance form. For non-controlled medications, the medications are placed on a quarantine list and returned to the pharmacy once a month. The program maintains a medication disposal binder for all medications destroyed on-site.
All medications, sharps, and OTC medications are counted/verified weekly, as well as utilizing a perpetual inventory. Sharps are stored in the locked medication cart. The program does not have any syringes. An inventory of three sharps, three OTC medications, and two youth medications were conducted with the nursing staff and all counts matched the inventory. A review of the program's perpetual inventories of medications and sharps from the past six months were reviewed and no discrepancies were noted. Observations found all medications were securely stored within the medical clinic. Oral medications are not stored with injectable or topical medications. The medical department has a secured refrigerator for the storage of medication only.

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 infection control procedures and an exposure control plan in place, written in accordance with the Occupational Safety and Health Administration (OSHA) standards. Review of the plan validated it was reviewed and signed annually by the facility administrator (FA). The infection control procedures include prevention, containment, treatment, and reporting requirements related to: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, Tuberculosis, Hepatitis A, B, C, and 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 (lice) and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses such as those caused by Escherichia Coli, bio-terrorist agents, such as Anthrax or Small Pox, and chemical exposures in the work place. The plan describes the process for needle stick post-exposure evaluation. It is indicated the FA had a separate file for all documents for youth and

staff who have experienced a facility/occupational exposure; although, there were no applicable events at the program since the last annual compliance review. The policy indicates staff have access to Hepatitis B immunizations and protective equipment and there are standard universal precautions followed by all staff. A review of the plan validated all required elements were included. An interview with the regional health services administrator (HSA) indicated, youth receive infection control training upon admission and one time annually as needed. There were no instances where the local health department, Centers for Disease Control and Prevention (CDC), and/or Central Communications Center (CCC) should have been notified for an infectious disease.

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

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

Standard 5: Safety and Security

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

The program maintains a policy and procedures addressing youth supervision.
The program's contracted staff to youth ratio is one to eight during awake hours and one to twelve during sleeping hours. Ratios for youth transports and work details are one to five and any disciplinary work detail would be reduced to a one to three ratio. These ratios were adhered to throughout the annual compliance review period. The program's headcount was at nine youth throughout the annual review period and at no point were less than four staff present and providing active supervision. 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 revealed staff exceeded policy expectations and conducted headcounts hourly and randomly throughout each shift. During the annual compliance review period, staff were witnessed maintaining active supervision of youth including interacting positively 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.
All five interviewed staff were aware of the program's procedures to reconcile a headcount if a youth is missing or unaccounted for.

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 maintains a policy and procedures addressing the comprehensive and consistent implementation of the behavior management system (BMS) to include staff training. The program has a detailed written description of the BMS and it is explained to each youth during their orientation process. A copy of the BMS is in each youth handbook which is provided during orientation and posted throughout the program including the youth dorm area and dayroom. Each youth signs an acknowledgement form after receiving the handbook and training on the BMS and a copy of the signed form is maintained in each youth's case management record. The BMS is a four-tier level system labeled as Rookie, Pro, All-Star, and Hall of Fame. This system utilizes daily point cards, level applications, special treatment team referrals, and a

monthly calendar of daily incentives for positive behaviors. According to the policy and an interview with the assistant facility administrator (AFA), each youth can earn up to two points for each activity throughout the day. Youth must earn a percentage of their daily points to earn a positive day towards completing levels of the BMS. As youth earn higher levels, the percentage of points the youth need to earn for a positive day increases. Daily, weekly, and monthly incentives encourage youth to earn their points throughout the day, week, and month. The system's rewards and consequences extend to the classroom as well. A representative from the program's educational department is invited to daily management meetings to discuss any issues with the BMS. Educational staff assist the management team with youth expectations, incentives, rewards, and consequences for classroom behaviors. Youth can earn or fail to earn points on their daily point cards for behavior in classrooms. A review of three pre-service and three in-service staff training records revealed all staff were trained in the program's BMS upon being hired and annually thereafter. Every day the recreation therapist review point cards with each youth. During this time, each youth has an opportunity to express any concerns with their daily points. If a youth earns a zero for any activity on their point card; the youth must sign acknowledging they are aware of the zero and staff review the reason why they earned a zero.

Interviews with five youth and five staff revealed all understood the BMS and could identify rewards and consequences for positive and negative behaviors, in addition to the requirements to advance to a higher level. The five interviewed youth revealed various feelings regarding the program's BMS ranging from poor to good.; One youth rated the program's BMS as poor. Five interviewed staff were able to explain all elements of the BMS including levels and point sheets., One staff were able to provide the location of the BMS postings. All staff were able to explain how point sheets are reviewed daily by the recreation therapist. All interviewed staff and youth acknowledged youth are not permitted to impose consequences on other youth. The program provides a variety of rewards/incentives to encourage youth participation in the program. These incentives range from daily incentives including edible rewards and video games to monthly incentives such as off-campus outings, additional telephone time, and movie parties. An interview with the recreation therapist validated the daily review of point cards with each youth. In an interview with the facility administrator (FA) and recreation therapist, it was confirmed rewards are implemented daily, weekly, and monthly. Staff are encouraged to praise youth informally throughout the day, youth displaying positive actions names are acknowledged during daily meetings and put into a drawing for an additional incentive. The drawing occurs on Fridays. The FA indicated the assistant facility administrator (AFA) monitors the point cards and the shift supervisor reviews point cards daily, as well as during special treatment team the consequences are reviewed. All five interviewed youth were aware and confirmed the incentives for the program's BMS.

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 procedures addressing the behavior management system (BMS) infractions and system monitoring.

The program's BMS includes a process wherein staff explain to the youth the reason for any sanction imposed. This process occurs at the time the sanction is given and during daily meetings. For major infractions, a youth will receive a referral for special treatment team (STT). STT meetings occur within twenty-four hours of the infraction/behavior(excluding weekends and holidays. At the STT meeting, youth are given an opportunity to explain their behaviors to the treatment team. Youth are also given an opportunity to explain their behaviors daily with the recreation therapist or shift supervisor when the recreation therapist is not on-site. STT referrals are discussed during the program's daily management meeting with all department heads and administration staff. After the details of the incident are discussed with the management team members, the team meets with the youth who committed the infraction to allow an opportunity to explain their behavior and to participate in creating a plan to help promote positive behaviors. The program's recreational therapist is responsible for reviewing STT referrals and point sheets at the end of each day to ensure points and referrals are completed appropriately and fairly. Any discrepancies found on point sheets or referrals are presented to the management team for correction prior to the STT. The program does not utilize room restriction as a part of their BMS. The training the three pre-service and three in-service staff received on the BMS included the use of the BMS during school hours.

Interviews with five youth and five staff revealed all understood the process which allows youth and staff to discuss sanctions imposed, consequences, and alternative acceptable behaviors. All five interviewed youth indicated staff are fair when issuing nightly rewards. Staff receive feedback on their application of the BMS on an annual basis but also receive coaching and feedback from both supervisory staff and administration, as needed. 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, the assistant facility administrator (AFA) meeting with the youth, and during annual staff evaluations.

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 maintains a policy and procedures which address ten-minute checks for youth housed in their sleeping quarters.

The program utilizes a thirty-two camera digital video recorder (DVR) system which is housed in the facility administrator's (FA) office. At the time of the annual compliance review, all thirty-two cameras were operational and the DVR system had a thirty day recording capability. Staff document room checks on a form entitled Dorm Verification and Head Count Sheet. Supervisory staff are required to conduct room checks at three random times during the shift. Each supervisory room check was documented on the form in red ink. Reviewed room check sheets revealed supervisory checks had been conducted according to policy for the past six months. All checks were documented properly and each were conducted within the required ten-minute time frame. Six various time frames were reviewed from video surveillance and room check sheets within the last thirty days, to ensure room checks were conducted appropriately. Each observed room check revealed staff utilized a flashlight to observe youth in dorm rooms, paused at each room door to view youth, and documented the room check on the room check form.

Five staff interviews indicated the room checks are conducted between eight and ten minute intervals.

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 procedures which address population 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 program utilizes the master logbook to document youth counts and movements. The logbook is utilized to maintain a chronological record of events as they occur. The program headcounts are conducted by supervisory staff at the beginning of each shift to verify accuracy and all other counts are conducted at least hourly and documented in the program's master logbook. Counts are also conducted at beginning of shift, end of shift, after outdoor activities, and emergency situations. The logbook also tracks youth intakes, releases, and movement outside of the facility. The program utilizes an alert board which is located in the program's conference room, to track the daily count of all youth in and out of the program. Counts were observed being conducted during the week of the annual compliance review. Staff were aware of all youth whereabouts 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 case of 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 maintains a policy and procedures addressing logbook entries and shift report reviews. The program maintains a chronological record of events, incidents, and activities in a living unit logbook in accordance with Florida Administrative Code. Logbooks utilized by the program during the last six months were reviewed. Each reviewed logbook is bound with numbered pages and entries were made in ink with no white-outs or logbook entries being removed or missing. Logbook entries included youth movements, admissions, releases, emergencies, security risks, incidents, transports, and staff assignments. Further review of logbooks revealed each on-coming staff member participates in a shift briefing and signs the logbook acknowledging they are aware of all information from the last two shifts and alert changes. Each reviewed logbook entry was legible and included the time and date of the entry, printed name and the signature of the staff member making the entry. The logbook is maintained by the shift supervisor and is available for all staff to review whenever needed. The program had five incidents reported to the Central Communications Center (CCC) during the past six months. All five were noted in the logbook.

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 procedures to address key control. The policy addresses key assignments, inventory and tracking of keys, secure storage of keys, procedures addressing missing or lost keys, and reporting and replacement of damaged keys.

Staff keys are locked in a locked key box located in the master control area in front of 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), maintenance manager, and shift supervisors have access to key lock boxes. All keys are counted daily and results are documented in the program's daily key log binder. All visitors including volunteers keys are collected by program staff when entering the facility. A member of the review team observed staff shift change and the collection of visitor keys during the week of the annual compliance review. 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 signed the key log, ensuring the information is accurate. Program keys are also inventoried when staff return program keys and are issued their personal keys. Three random key rings were observed and all keys matched the key information on the tab. All keys were secured on a tamper-proof key ring to ensure they were secure. Observations of the key storage area and key area verified they were properly secured. A random check of staff during the annual compliance review revealed no staff had personal keys on the secure floor. All staff's personal keys were secured in the key lock box.

The AFA and shift supervisor were interviewed on key control procedures and both staff were knowledgeable regarding the program's policy on key control. Staff explained the process for restricting usage of keys for medical, mental health, case management, and vans. All five interviewed staff revealed each understood the proper procedures to take on a daily basis as well as if a key is lost, stolen, missing, or damaged. Staff interviews also revealed youth are not allowed to have access to staff keys.

5.08 Contraband Procedure	**Satisfactory Compliance**
The program's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

The program maintains a policy and procedures addressing contraband. The policy lists all required items considered contraband and the process to follow if contraband is discovered in the facility, as well as staff who is found in possession of those items and contacting law enforcement if any item found is considered illegal. The program utilizes room searches, facility searches, body searches, and visual searches to prevent the introduction of contraband to the

facility. The program has a system in place for documenting confiscated items. The youth are given a copy of prohibited items and the consequences of having these items within the program. Prohibited items, and the consequences of introducing these items into the facility, are listed in the program's policy and procedures, youth handbook, and the parent handbook. Although there were no confiscated items documented during this annual compliance review period, the program has a method of documenting and discarding any contraband discovered in the facility. Facility dorm rooms are searched by staff, at a minimum, of once a week. The room searches are documented on the facility's Room Search Log and stored in the facility's Room Search and Contraband Tracking Log.

The facility administrator (FA) interview indicated any contraband found will be documented in the logbook as well as the Monthly Contraband Log with a photo of the contraband. The contraband will be turned over to the FA and disposed of off-site by the FA. If the Department's Central Communications Center (CCC) needs to be contacted, the assistant facility administrator (AFA) or FA will report the incident as required by policy. Any illegal contraband will be turned over to law enforcement.

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

The program maintains a policy and procedures addressing searches and full body visual searches.

The program conducts searches as a method to prevent the introduction of contraband and unauthorized items into the facility. Policy indicates searches of youth are conducted after off-site transports, after visitation, before moving youth from an outside area into the building, and prior to moving youth from the building to an outside area. The program had no off-site transports during the week of the annual compliance review. The review team observed several youth searches during the week of the annual compliance review. 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. Searches were thorough and done in a manner which did not degrade the youth. All searches were documented in the program's shift logbook. A full body visual search (FBVS) could not be observed during the week of the annual compliance review.

Although a FBVS was not observed, youth and staff interviews revealed all parties were aware of proper search procedures and when the searches take place; prior to each movement.

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

The program maintains a policy and procedures addressing vehicles and maintenance. The program utilizes one vehicle for youth transports. The vehicle passed an annual inspection on January 17, 2020. The vehicle is also inspected weekly by the maintenance manager and/or the facility administrator (FA). Results of weekly inspections are documented and stored in the program's vehicle maintenance log/binder. A member of the annual compliance review team inspected the vehicle and all required equipment was observed, which included a seat belt cutter, window punch, and fire extinguisher. The first aid kit is not stored in the van to preserve the items inside of the kit. Staff check out a first aid kit prior to a transport and returns the kit to the program upon return. Staff are required to check out a first aid kit each time the program van is utilized for transport. The first aid logs were reviewed to verify kits are checked out during transports. All seatbelts in the van were in proper working condition. A random check of personal vehicles and the van were conducted during the annual compliance review and were found to be locked. No transports occurred during the annual compliance review; therefore, an observation could not be completed. Informal staff and youth interviews revealed the transport van is inspected prior to each transport and youth and staff are required to wear seat belts at all times.

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 procedures addressing transportation of youth, outlining staff to youth ratio during transports as one to five; however, if there are five or less youth, a minimum of two staff are needed to perform all transports.

The program's transport vehicle was inspected by an annual compliance review team member and the vehicle's rear door could not be opened from the inside. The transport vehicle is equipped with a safety gate separating the driver from the passenger's compartment. The program has an approved transport list which is updated monthly to ensure staff driver's licenses are valid. This approved driver's list is located in the master control area 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.

No transports were scheduled during the week of the annual compliance review but interviews were conducted with five staff to determine the program's 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, and staff do not conduct transports in personal vehicles.

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

The program maintains a policy and procedures which address who is responsible for a weekly safety and security audit, development and implementation of corrective actions warranted as a result of the safety and security deficiencies, and an internal system to verify the deficiencies have been corrected. The program provided completed Weekly Safety and Security Audit forms for the last six months. Each report was completed properly and, at a minimum, every seven days. Each report contained an anticipated correction date for each area in need of improvement. The interview with the assistant facility administrator (AFA) revealed facility improvements are reviewed during the daily management meeting.

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 procedures to address tool inventory and management. The policy addresses the issuance, inventory, and control of equipment and tools. The program has identified their 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 and with a high potential to be used as a weapon to inflict serious bodily harm such as knives, hammers, screw drivers, and electric drills. Class B tools do not have sharp edges or points such as brooms, mops, and scrub brushes.

All tools are secured behind a locked door and are placed beside a photo of the tool to identify proper placement. Class A tools are secured in the plant manager's office. Upon observation, the plant manager's office was neat, clean, and organized. All class A tools were neatly stored on the maintenance office walls with a photo of the tool to identify the tool belonged in the proper place. All class A tools were in good repair and accounted for. 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. 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. All tools were properly identified during inspection by the reviewer. The three pre-service and three in-service training records indicated all staff were trained on the safe use of tools. Three youth records were reviewed and all indicated youth have been trained on the proper usage of tools during their orientation process and the youth signing an acknowledgement of tool training.

During an interview, the program's plant manager is was aware of the proper procedures to follow if tools are missing or damaged, in accordance with the program's policy and procedures. The plant manager stated there were no tools which were currently damaged or out of use.

Five staff and five youth were interviewed and each confirmed youth are only allowed to use a mop, broom, and scrub brush. One staff interview indicated youth are allowed to use other tools after being screened and under supervision such as a screwdriver, hammer, and saw. Another staff stated a leaf blower can be used by youth.

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

The program maintains a policy and procedures addressing youth tool handling and supervision. The policy outlines proper procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries to youth and staff.

During a work project, the program will use a staff to youth ratio of one to five. Three youth case management records were reviewed and all records indicated youth have been trained on the proper usage of tools during their orientation process. Youth signed an acknowledgement of tool training during the orientation process. The signed acknowledgement form is filed in each youth's record. Although each youth receives a risk assessment monthly, during the week of the annual compliance review there were no work projects which involved youth and the use of tools; therefore, no youth were observed handling tools.

Five youth interviews confirmed youth are only allowed to use a mop and broom. Five staff interviews revealed youth are allowed to use class A tools if an assessment is completed and class B tools after the orientation training.

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 procedures which address outside contractors. The program has established guidelines for outside contractors which includes information regarding tool control and restrictions. The program has a form to be 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 cell phones and/or equipment capable of taking pictures and/or recording audio/video in secure areas. The form also requires contractors to list each tool brought into the facility. This list is reviewed by the plant manager or designee before the contractor has access to a secure area. This list is again reviewed before the contractor exits 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 or designee any time they are within the facility. Although no outside vendors were scheduled during the annual review week, an interview with the program's plant manager revealed this practice is followed for each outside contractor. Sample size of program invoices were cross checked to ensure outside contractor agreements were signed on the date of service. All invoices and contractor agreements matched and there were no discrepancies found.

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

The program maintains a policy and procedures to address fire, safety, and evacuation drills.

The program conducts fire, safety, riot, disturbance, Continuity of Operations Plan (COOP), and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster. Drills are consistent with the program's COOP. All drills were properly documented in the facility shift logbook and documented on the facility's designated drill form. Each drill form contained the type of drill, a description of the drill, the date the drill was conducted, the date and time of the drill, and participants' signatures. A review of drills revealed thirty-nine various drills were conducted over the past six months of one drill each shift monthly. Fire evacuation routes and egress plans were posted throughout the facility. All fire extinguishers were inspected on an annual basis.

An interview with the assistant facility administrator verified fire drills are conducted monthly on all shifts. COOP drills are completed at least quarterly. Five interviewed staff indicated staff have participated in fire, escape, weather, major disturbance, mental health/suicide, and medical drills. Five interviewed youth indicated all youth line up during a fire drill, which has been conducted since their arrival at the program. Youth also stated they will follow staff and head counts are conducted.

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 procedures addressing the Continuity of Operations Plan (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 April 18, 2019. The plan addresses all required topics including alternative housing plans and current delegation of authority, cooperative agreements, vendor contact list, emergency staff contact numbers, and the county cooperation checklist. A copy of the COOP is available in the facility administrator's (FA) office and the facility's conference room for staff member access. Each youth has a "Grab and Go" record which was located in the program's master control area. It was observed each record contained a form with a picture of the youth, the youth's full name, the Department of Juvenile Justice Identification number, the admission date, the date of birth, gender, race, the name, address and telephone number of the youth's parent/guardian, and the name, address and telephone number of the person with whom the youth resides, as well as the name, circuit, and contact information of the youth's juvenile probation officer (JPO). The records also contained the name of the youth's committing judge, state attorney, public defender and their accompanying contact information, the committing offense, and the circuit where the youth offense occurred. Each record also had a physical description of the youth and overall health status. The FA interview indicated the COOP is maintained in the FA 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 maintains a policy and procedures addressing storage and inventory of flammable, poisonous, and toxic items and materials.

The program's flammable, poisonous, and toxic materials are stored in a flame-resistant cabinet inside the sally port area. The program stores fuel in the cabinet and maintains proper inventory of these items. The program's plant manager is the only individual authorized to handle flammable, poisonous, and toxic items. A binder is stored in the flame-resistant cabinet containing the Safety Data Sheets (SDS) for the items located in the cabinet. The program also stores cleaning supplies in a locked cabinet in a room on the youth dorm area. The cabinet is locked at all times and can only be accessed by staff using a key. The items in this cabinet are inventoried and have an accompanying SDS located in a binder. Staff sign these items in and out with each use.

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

The program maintains a policy and procedures addressing youth handling and supervision of flammable, poisonous, and toxic materials. The policy prohibits youth using those items and materials. The flammable, poisonous, and toxic materials are stored in a room in a file cabinet located on the youth dorm hall. Youth do not have access to these items and are supervised by staff during daily cleaning. Although youth were not observed participating in facility clean-up during the week of the annual compliance review, five youth interviews indicated they are prohibited from using chemicals/cleaning products. Staff spray chemicals and youth wipe the area.

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

The program maintains a policy and procedures addressing disposal of all flammable, toxic, caustic, and poisonous items. The policy prohibits chemicals from being poured on the ground or being disposed of by any method other than what is outlined by the biohazard guidelines. The program's plant manager is the only individual authorized to handle flammable, poisonous, and toxic items. The program's plant manager was interviewed on the proper procedures of disposing chemicals and stated all items for disposal are collected by the Polk County Resource Management Division. The plant manager further stated the program has not needed to dispose of any chemicals since the last annual compliance review. An interview with the assistant facility administrator validated this practice.

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 maintains a policy and procedures outlining the guidelines for visitation and communication for youth while in the program. The program's visitation policy establishes procedures which provide the youth with opportunities to re-establish and maintain family and community ties while at the program. The policy indicates youth shall be provided with opportunities to establish and maintain family, court, and community ties through correspondence. Furthermore, the program shall provide writing materials and postage to youth for mailing at least two letters a week. A review of the program's posted schedule indicated visitation occurs every Saturday and Sunday from 10:00 a.m. to 12:00 p.m. The program maintains a visitation binder which
tracks each visitor entering the program and identifies what youth they visited. The visitation log documented the name of the visitor, the date and time of the visit, and the youth who they visited. Visitation rules are reviewed with visitors before each visit and all visitors are searched before entering the secure area. Program staff verify each visitors' identity via state-issued identification and youth face sheet.

Program visitation schedule, telephone protocols, and mail practices are reviewed with youth during the orientation process. The program allows each youth to mail two letters a week and free weekly telephone calls to approved correspondents. The length of telephone calls varies depending on each youth's level in the program. The telephone and mail log were reviewed and all telephone calls and attempts, as well as incoming and outgoing mail is logged by the program staff.

During an interview, the case manager indicated visitation occurs regularly as scheduled; however, when extenuating circumstances occur, the case manager works with program administration, the juvenile probation officer, and family to allow for special visitation. Five youth were interviewed and each indicated they were given the opportunity to communicate with family by mail or visitation, as well as telephone calls. Five youth stated they could communicate with family members.

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.

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

The program maintains policies and procedures addressing the safety planning process for youth. The program maintains a binder in the conference room containing the most recent safety plan for each youth. Each of the three youth safety plans contained the youth's warning signs, baseline behaviors, crisis recognition, and intervention strategies preferred by the youth. Each plan was created in a collaborative effort with the youth, the youth's parent/guardians, and specified program staff.

Three records were reviewed. In two records, the program was unable to locate the initial safety plan completed and was able to provide an updated safety plan which was completed three and four months after the youth's admission to the program. The third initial safety plan was completed six days late.

Five interviewed staff indicated staff members were aware of the location of the youth's safety plans and acknowledged changes to youth safety plans are reviewed with staff. Five youth interviews indicated only one was aware of the location of the safety plans.