STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

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

Review Date(s): April 2-5, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions that 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 that 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 that 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:

Patrick M McKinstry, Office of Program Accountability, Lead Reviewer (Standard 3)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Jessica Gibson, Office of Programming & Technical Assistance, Technical Assistance Specialist (Standard 2 & SPEP)
Melissa Johnson, Office of Program Accountability, Regional Supervisor (Interviews)
Ken Phillips, Office of Program Accountability, Regional Monitor (Standard 1)
Cheri Williams, Associated Marine Institute, Business Manager (Standard 5)

Program Name: Polk Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Polk County / Circuit 10
Review Date(s): April 2-5, 2019

MQI Program Code: 1049
Contract Number: 10359
Number of Beds: 24
Lead Reviewer Code: 144

Methodology

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.

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **NA** # Case Managers
- **NA** # Clinical Staff
- **NA** # Food Service Personnel
- **X** # Healthcare Staff
- **X** # Maintenance Personnel
- **X** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **X** # Other (listed by title): **Regional Compliance Manager**

Documents Reviewed

- ☒ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- **5** # Health Records
- **5** # MH/SA Records
- **12** # Personnel Records
- **5** # Training Records/CORE
- **3** # Youth Records (Closed)
- **5** # Youth Records (Open)
- **X** # Other: **JJIS**

Observations During Review

- ☐ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☒ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Limited
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	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	* Treatment and Discharge Planning	Satisfactory
3.08	* Specialized Treatment Services	Satisfactory
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Satisfactory
3.12	* Suicide Precaution Observation Logs	Satisfactory
3.13	* Suicide Prevention Training	Satisfactory
3.14	* Mental Health Crisis Intervention Services	Satisfactory
3.15	* Crisis Assessments	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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff 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 Handlins 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	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Polk Halfway House is a twenty-four bed non-secure 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. Prior to July 20, 2018, the program was for male youth ages ten to fourteen. The program provides mental health overlay services (MHOS). In addition, the program fosters each youth by providing Thinking for a Change (T4C) and the Impact of Crime (IOC) curriculum. Additional treatment services provided includes family and individual therapy, religious and spiritual opportunities, community involvement, and job training placement. Program administration is comprised of a facility administrator, assistant facility administrator, director of clinical services, health services administrator, and a tranistion services manager. Case management services are provided by one case manager. Mental health staff at the program includes one director of clinical services, two therapists, and a contracted psychiatrist. Medical services are offered 7:30 a.m. to 4:00 p.m. and are provided by one full time registered nurse (RN), and two part-time RNs, and one contracted designated health authority. Educational services are provided by the Polk County School Board. At the time of the annual compliance review, the program had eight vacant positions; six direct care staff, one part-time RN, and one recreational therapist. The layout of the program includes: one building, which encompasses administration, medical, mental health, case management, youth housing, and education. Dining for the youth is provided for through a contract with Trinity Food services at a separate location; food is brought in individually packaged and served to youth. As of April 11, 2019, the program has contracted with Linton Food Services Management to provide meals to youth at the program. The program has a total of sixteen operating security cameras providing coverage; as of date of annual compliance review, only fifteen security cameras were operational.

Strengths and Innovative Approaches

- The youth are given a choice on which activities and community involvement event they participate in based on what they have learned while in the program. They are also exposed to career choice opportunities, exercising positive behaviors when going out into the community, and community connections. They have also organized community events such as going to the movies, bowling, football games, basketball games, Golden Corral, etc.

- Holidays and special interests are celebrated and observed through group and recreational activities. Youth participate in activities such as decorating Easter cookies, Earth Day art, making Mother's Day cards, writing cards of encouragement to breast cancer patients, and Halloween fun of getting ready to Trick-or-Treat.

- Through the agriculture course, the youth have a beehive where they cultivate honey and learn the value and delicate balance of nature and society's impact upon it. They gather honey and see how it can be sold to those who value the pureness of it.

- The youth have the opportunity to learn about the aquaponics. This is a system where live Tilapia are raised in a several hundred-gallon tank. The waste from the fish is collected through a special filter and is used to nurture plants in an adjacent growing bed. The specialized gravel system of the growing bed then filters water, so it can be used to then replenish the fish. They are involved in the maintenance and upkeep of the system and provide food and care for the fish as needed.

- The youth have been exposed to local history to include the Polk County Historical Museum and Historical and Genealogical Library located in the Old Polk County Courthouse. There have also been outings set up to include, The Mulberry Phosphate Museum located in Mulberry in Polk County, Florida. Located in the city's original railroad depot, the museum was established in 1986. Exhibitions include fossils, memorabilia and exhibits about the phosphate mining industry.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

Eleven staff, which included one contracted staff, were reviewed for completion of initial background screening requirements. A review of all eleven personnel records found evidence each staff had a background screening, and were determined to be eligible for hire, prior to their initial hire date. The criminal history report documentation was also present for each record reviewed. The program utilizes the ErgoMetric pre-employment assessment tool for direct care applicants. A review of all direct care staff training records, of whom required an initial background screening, had a completed passing pre-employment assessment within their training records. The program's human resources manager provided documentation of the employee/volunteer Clearinghouse roster which included all applicable staff reviewed. An interview with the human resources manager and regional director of human resources revealed the program completes initial background screening on all new hires, along with a review of the Department's Central Communications Center (CCC) information, criminal history report information, Staff Verification System (SVS), and Federal Department of Law Enforcement information. The program indicated there were no volunteers who required background screening for the scope of this annual compliance review period. The program provided evidence the Annual Affidavit of Compliance with Level Two Screening Standards was completed and sent to the Background Screening Unit December 3, 2018. The program provides educational services to youth through an agreement with the Polk County School Board. The Polk County School system is responsible for conducting annual screening for their staff. The program also provided documentation of the Affidavit of Compliance with Level Two Screening Standards for School Board Personnel, which was completed November 29, 2018.

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.).	

One staff was applicable for a five-year background re-screening. A review of this staff's personnel record found evidence the background re-screening occurred within the five-year requirement, but no more than twelve months prior to their five-year anniversary date. The re-screening was submitted to the Background Screening Unit (BSU) Clearinghouse at least ten days prior to the staff's five-year anniversary date.

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.

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are 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.*
- *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.*

The program had a written policy and procedures which included steps for abuse and neglect reporting. The program's procedures state TrueCore Behavioral Solutions has a zero-tolerance policy in regard to any abuse. All staff shall immediately report any knowledge or suspicion regarding an incident of abuse or sexual harassment which has occurred in the program. Staff are also required to report any retaliation against youth or other staff who reported an incident, and any staff neglect or violation of responsibilities which may have contributed to an incident or retaliation. The procedures for reporting indicates all staff, interns, volunteers, and contracted staff who have knowledge, or reasonable cause to suspect a youth is being abused or neglected shall report the information to either the Florida Abuse Hotline or Central Communications Center (CCC). Once the call has been completed, the staff must notify the supervisor on-duty as soon as possible. Each youth, upon their admission to the program, receives a youth handbook which contains the emergency telephone numbers for abuse reporting, and notifies the youth they have unimpeded access to report allegations of abuse or neglect. During the annual compliance review, observations were made throughout all program areas, including youth living quarters, of positing's for the Florida Abuse Hotline number, and number for the CCC, for youth who are eighteen years of age or older. A review of four staff personnel records found evidence all staff sign for and receive the employee handbook, which contains the program's Principles of Conduct and Code of Ethics. The program's facility administrator reported the program prohibits abuse, falsification, contraband, foul language, threats, and weapons, which is indicated in the employee code of conduct. The facility administrator reported violations may result in disciplinary action including written reprimands, suspension, and/or termination. The facility administrator further indicated all CCC reportable incidents are to be reported within two hours.

Youth have unimpeded access to the CCC and Florida Abuse Hotline. If an abuse allegation is accepted, the CCC will then be called. Five interviewed staff denied ever hearing another staff refusing a youth the opportunity to make an abuse report. The five staff were questioned regarding the program's abuse reporting process. One staff reported the youth will make the call. Three staff reported the supervisor must be notified. One staff stated staff are allowed to make the call. All five staff denied ever observing staff use profanity, threats, or intimidation when speaking with youth. Five interviewed youth all reported they felt safe in the program. All

five youth denied ever being stopped from reporting abuse. The five youth were asked if they've heard staff use curse words when speaking with them or other youth. Two youth stated never, two stated occasionally, and one stated often. A youth stated everyone has a time when they get upset and curse words slip out. The results of the youth interviews were discussed with program administration. The facility administrator reported issues with any staff using profanity will be discussed in an all-staff meeting. In addition, any staff named within the youth interviews will be required to attend. The program reported having had three incidents which were reported to either the CCC or Florida Abuse Hotline, which involved allegations of abuse or neglect. There was one substantiated incident related to abuse (staff was reported cursing at youth) since the last annual compliance review. The remaining two incidents were unsubstantiated.

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 facility administrator reported there was one substantiated incident related to abuse since the last annual compliance review. The incident involved the program's recreational therapist, who was reported cursing at a youth. The incident was reported to the Central Communications Center (CCC), and an inspector general report was completed. The staff member was immediately suspended and subsequently terminated, according to documentation provided and an interview with the facility administrator. In addition, the facility administrator conducted an internal investigation of the incident. According to an interview with the facility administrator, staff are knowledgeable of abuse reporting requirements through staff meetings and annual in-service and pre-service training. In addition, all reports are reviewed and discussed in morning management team meetings.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The facility administrator was interviewed and indicated all Central Communications Center (CCC) reportable incidents are to be reported within two hours. Youth have unimpeded access to the CCC and Florida Abuse Hotline. If an abuse allegation is accepted, the CCC will then be called. A sample of five CCC incidents were reviewed for reporting requirements. Four of the five were applicable, and were reported by the program, within the two-hour timeframe. The one remaining incident was reported by an outside agency. All incidents were documented in the program's unit logbook. A review of internal incident reports and grievance information found no further incidents which should have been reported to the CCC. The program has experienced a decrease in the total number of incidents reported to the CCC since the last annual compliance review.

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.	

Five Protective Action Response (PAR) reports were reviewed for reporting and documentation requirements. All five reports were completed by the end of the staff member's workday. One of the five PAR reports did not have sections two and three completed on page one of the PAR incident report form. Four of the five reports included statements from all staff involved. Mechanical restraints were not utilized in any of the reports reviewed. None of the five reports documented the PAR incidents resulted in youth injury, nor alleged abuse by the youth. A PAR medical review was not documented as necessary in any of the five reports reviewed. All five reports included a signature of review by a PAR certified instructor or supervisory staff member. The program completes the Post-PAR interview on a separate form which is attached each PAR incident. A review of the five PAR reports found this documentation included in each. Each Post-PAR interview was documented as completed by the administrator or designee no longer than thirty minutes after the incident. All of the reports were reviewed by the facility administrator or designee within seventy-two hours of the incidents. All PAR reports are placed in a binder within forty-eight hours of being signed by the facility administrator. The program provides a monthly summary of all PAR reports to the Department's Residential Operations. A review of the program's PAR training plan found it was approved by the Office of Staff Development and Training on December 21, 2018. A review of the program's PAR report information found the program has not experienced an increase in the total number of PAR incidents since the last annual compliance review. The program has consistently remained below the statewide average PAR rate. In the first quarter of this reporting period, the program's PAR rate was 1.14, which was below the statewide average of 1.55. For the second quarter of this reporting period, the program's average PAR rate was at .94, which was again below the statewide average which is 1.40. The facility administrator was interviewed and stated all PAR incidents are reviewed during Morning Management Team Meetings the following day. In addition, video is reviewed after a PAR intervention in order to ensure techniques were appropriate and not abusive.

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

Five staff training records were reviewed for pre-service training requirements. All five staff exceeded the required 120 hours of pre-service training. All of the staff completed training and certification within 180 days of their hire date. Each of the staff received training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, Prison Rape Elimination Act (PREA), and child abuse reporting. All of the staff successfully completed forty-hours of Protective Action Response (PAR) training. A review of the program's contractual agreement found additional pre-service training requirements to be the following: gender responsive services, behavior management and modification, restorative justice programming, post-traumatic stress disorder, and universal precautions training. All five staff completed each of the contractually required trainings with the exception of gender responsive services. Only two of

the five staff completed this training complete. The program's regional compliance manager provided documentation these staff completed the training April 4, 2019, which was during the annual compliance review week. A review of staff training records found the program documents all trainings within the Department's Learning Management System (SkillPro). The program submitted, in writing, a list of pre-service training to the Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any instructor-led training. This information was submitted January 10, 2019 and signed by the Department January 16, 2019.

1.08 In-Service Training	Satisfactory Compliance
Residential 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.*	

Five staff training records, which included two supervisory staff, were reviewed for in-service training requirements. Each of the five-staff had over the minimum twenty-four hours of in-service training. All training was documented within the Department's Learning Management System (SkillPro). Each staff received in-service training for cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) eight-hour refresher training, and professionalism and ethics. Each staff also received six hours of suicide prevention training, which included two hours of SkillPro training, and four hours of instructor-led training. There were no other required annual trainings according to the program's contractual agreement. Four additional training records were reviewed for staff who provide mental health services, to include therapeutic and delinquency intervention groups. All staff received trainings to deliver the curriculum in which they facilitate. Two supervisory staff training records were reviewed for the additional eight hours of required annual supervisory training in areas to include management, leadership, personal accountability, employee relations, communication skills, and fiscal training. Both supervisors received over the eight hours of training required. One received fifteen hours, and the other received nineteen hours of supervisory training. A review of instructor qualifications and training records, found all instructors were qualified to deliver trainings, as provided. The program has one full-time registered nurse (RN), and two part-time nurses. All have a clear and active RN license. A review of all three RNs found each had a current certification in CPR and AED. An interview with the program's staff development and training manager was completed. The manager reported all staff are certified in PAR, to include medical staff. These staff may be eligible to supervise youth only if performing the job outside of their normal job functions. The program provided evidence of an annual in-service training calendar which was able to be updated if any changes occur. The program submitted, in writing, a list of in-service training to the Office of Staff Development and Training including course names, descriptions, objectives, and training hours for any instructor-led training. The documentation was submitted January 10, 2019 and signed by the Department on January 16, 2019.

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

The program has a written policy and procedures for youth grievances. The policy includes training requirements for staff. The policy indicates staff will ensure any youth requesting to file a grievance be given the proper forms and assistance, if needed. Program staff are required to complete grievance training as part of their pre-service training plan requirements. A review of five pre-service training records found all staff received the training, as required. The grievance process is included in youth handbooks, which are provided to each youth upon admission to the program. The program's grievance process includes an informal phase, formal phase, and appeal phase. The policy indicates informal complaints are to be handled as expeditiously as possible, but no more than twenty-four hours from when the youth submitted the formal complaint. The program provides blank grievance forms throughout program areas; there is also a locked drop box beside the forms. The program's assistant facility administrator reports he, or a supervisory designee, are required to check the boxes daily. At the formal phase, the supervisor reviews the grievance and must provide a response within seventy-two hours from the date it was received. In the event the youth is dissatisfied with the outcome of the formal phase, he can elect to move to the final, or appeal phase. At this phase, program administration have seventy-two hours from the date of receipt to review the grievance and provide a decision. A review of the program's grievance binder and log found the program did not have any grievances submitted during the scope of the annual compliance review. The program provides youth other avenues to express needs and input as well. Conference Request forms are also available to youth in program areas, along with Hygiene Request forms. The forms may be completed for youth to request to speak with a certain staff member, or in the event items are needed. The program provides a drop box for these forms, and the box is also checked daily by staff. Samples of these completed forms were provided to show consistency with youth using this practice. The facility administrator was interviewed and was able to summarize the program's grievance process. Five youth were interviewed concerning the grievance process. Youth responded stating forms were available throughout the program. Three youth reported the phases included timeframes. One youth reported he had never completed a grievance. The remaining youth were familiar with the process, but were unable to accurately describe each phase. All five interviewed youth reported they could ask staff if they ever needed assistance in completing a grievance. Five interviewed staff were able to summarize the program's grievance process. All staff reported the forms were available throughout program areas.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

The program's contractual agreement does not address a specific delinquency intervention. An interview with program administration found the program utilizes the Thinking for a Change (T4C) curriculum as their primary service. The program submitted a Designated and Request to

Change Evidence Based Practices form to designate T4C as their primary service. The form was reviewed and approved by the Department's Office of Residential Services. The T4C curriculum is evidenced-based. A review of the program's activity schedule determined the program is providing structured, planned programming or activities at least sixty-percent of the youth's awake hours. Group sign-in sheets were reviewed to determine groups were being facilitated and delivered, as designed. A review of therapeutic staff training records found evidence all staff designated to facilitate therapeutic groups received the appropriate training and educational experienced required. The program employs three mental health staff who facilitate the groups. A review of staff training records revealed all three are master's-level educated, and one of the three serves as the program's director of clinical services. One staff has six years of experience working with adult or juvenile offenders. One staff has twelve years of experience, and the third staff has fifteen years. The facility administrator reported all of the therapists are master's-level and are all qualified to conduct therapeutic groups at the program. The facility administrator further stated youth are matched with counselors during staffings based on comprehensive evaluations, and determined by the therapists' strengths. A review of five youth mental health and case management records found evidence each youth was participating in T4C. A review of the youths' treatment plans found the intervention addressed at least one of each youth's top three criminogenic needs.

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

The program provides life and social skills intervention addressing communication skills, relationships, non-violent conflict resolution, anger management, and problem-solving skills. The program utilizes the Thinking for a Change (T4C) curriculum to address life skills training. A review of the program's activity schedule and group attendance sheets revealed groups were provided, as required. A review of therapeutic staff training records found evidence all staff designated to facilitate therapeutic groups received the appropriate training and educational experienced required. Five youth were interviewed concerning groups and activities they have participated in at the program. Four of five youth stated they have participated in groups such as T4C, Skill Streaming, anger management, and teen relationships. One of five youth stated he did not remember. All youth were able to explain or summarize skills they have learned in groups such as anger control, thinking before acting, and how to better deal with people. The youth also indicated they practice these skills in groups, as well as with other youth. Five youth mental health and case management records were reviewed, and revealed all five youth have been participating in, or are currently receiving services as outlined in their performance and/or treatment plan.

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

A review of the program's contract revealed the Impact of Crime (IOC) curriculum was the required service to be provided for youth to enhance restorative justice awareness for youth. The IOC curriculum is designed to assist youth to accept the responsibility for harm they have caused by their past criminal actions and teaches them about the impact of their crime on the

victims. The groups expose youth to victim perspectives through victim speakers or victim impact statements and provides youth opportunities to participate in activities intended to restore victims and communities, such as restitution activities and community service projects. A review of five staff training records found evidence all five staff received restorative justice awareness as part of their pre-service training requirement. A review of the program's activity schedule found the program has not ran the IOC groups since December 2018. The program reported having only one staff who was trained to facilitate the IOC curriculum. A review of five youth mental health and case management records found one of five have had evidence they participated in the IOC Curriculum during their commitment to the program. The program administration reports youth have the opportunity to complete community service hours and involve themselves in community service projects through the program's behavior modification system and thus earning this privilege. In addition, the program reported they provide other curriculums such as Thinking, Feeling, and Behaving, Young Men's Work, Teen Relationships, and Pathways to Self-Discovery and Change which help youth to focus on the impact their criminal behavior has had on its victims.

1.13 Gender-Specific Programming	Satisfactory Compliance
The program provides delinquency intervention and gender-specific treatment services.	

A review of the program's contractual agreement revealed the curriculum Young Men's Work was the designated service used at the program for gender-specific programming. The groups are facilitated by the therapeutic staff. A review of the three therapeutic staff training records found each has received the required training and educational experience needed to facilitate the curriculum. The program uses Young Men's Work to address their targeted gender group, and designs its services based on the common characteristics of the primary target population. A review of the program's activity schedule and group sign-in sheets found evidence the program was providing the service, as required. The facility administrator was interviewed and stated the Young Men's Work, as well as recreational activities, and vocational training were all used to address the program's male youth population.

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

The program has a written policy and procedures for internal alerts and alerts entered within the Department's Juvenile Justice Information System (JJIS). A review of the program's internal alert system revealed consistency with program alerts and alerts within JJIS. The program has a master internal alert board located in the main conference room, which included information for youth alerts for medical, gang, security, vulnerability to victimization, and mental health. A review of unit logbooks found alerts for youth are also documented daily. On-coming staff are

required to review and sign the logbook upon coming on shift. A review of this documentation was observed. Discussion with annual compliance review team members reviewing areas such as safety and security, medical, mental health, and case management verified alerts were entered as required within JJIS, with no deficiencies noted. A review of five youth records found all five youth had alerts in the program's internal alert system, which mirrored alerts entered within JJIS. None of the alerts reviewed were applicable for entry into the program's master log book. All alerts were verified prior to entering into JJIS. The name of the individual entering or downgrading alerts matched the responsible party, as required by the program's policy. The facility administrator was interviewed and stated the program uses the internal alert board in the conference room to notify staff of alert information. In addition, alerts are discussed during the morning management meetings. Alerts are also posted in the facility administrator's office. The clinical and medical department's complete their respective alerts, while alert information for youth identified as gang involved are completed by case management staff. Five interviewed staff indicated they are informed of youth alerts through postings on the alert board, unit log book, shift briefings, and medical alert charts.

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

The program separates the youth records into separate records: an individual management record, individual healthcare record, and mental health and substance abuse record. All youth records are marked 'confidential.' All records are maintained in locked cabinets within the responsible program area's office. All records were observed to be inaccessible to youth. Office area doors are marked 'confidential.' A review of seven individual management records found each record had a file tab which included the youth's name, Department identification number, date of birth, county of residence, and committing offense. Each record was divided into the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous.

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

The program makes efforts to solicit input from youth. The program holds Community Meetings, which include all youth. These are done weekly. Youth Advisory Board Meetings include youth representatives from living areas. These meetings are done monthly. Samples of the meeting minutes, agenda topics, and sign-in sheets were reviewed to confirm the practice. In addition, the program facilitates youth surveys on a quarterly basis. The surveys are facilitated by a representative from the program's corporate office. The youth are selected at random, and the surveys are completed on the computer. According to the regional compliance manager, the results of the youth surveys are graphed, and a trend analysis is developed, which is forwarded to the corporate office to track and evaluate. The results of youth meetings and surveys are reportedly discussed at morning management team meetings and staff meetings. The regional compliance manager also stated the program provides the youth parent/guardian a survey upon each youth admission. These are referred to as Satisfaction Surveys, which are also administered at some point during a youth's commitment, and prior to each youth's discharge. These parent/guardian surveys are also conducted electronically. In addition, the program

provides grievances, Hygiene Request forms, and Conference Request forms. These forms were observed available and accessible in youth dayrooms and living areas. Upon completion of these forms, there is a locked drop box available, which is checked daily by the assistant facility administrator or designee. The facility administrator reported the following formal processes are available to promote and encourage youth input: Youth Advisory Board, Speak Out forms, grievances, and meetings with the program administration. Four of the five interviewed youth reported the program has processes in place such as advisory boards and Conference Requests to allow youth to give input. One of five stated they did not.

1.17 Advisory Board	Limited Compliance
The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.	

The program has a Community Advisory Board which is required to meet at least quarterly. The program maintains meeting sign-in sheets, minutes, and agenda topics in a Community Advisory Board binder. The meetings are facilitated by the program's facility administrator. A review of the Community Advisory Board binder and elements included found evidence the program solicits information from law enforcement, victim advocates, judiciary staff, community partners, business community, school board, and the faith community. The program did not have evidence of attempts to solicit a member representing a parent/guardian of a child who had previously been involved in the juvenile justice system. A review of the advisory board meetings conducted found the program completed meetings for three of the previous four quarters. Telephone contact was made with a community member to confirm their participation in the meetings. The individual contacted was a representative of the school board and confirmed they have enjoyed participating with the program, and they are notified of meeting dates through email and telephone calls. The facility administrator was interviewed and stated the community advisory board meets quarterly. The board has also been involved in family days for youth, weekly church groups, and Christmas activities. The facility administrator also indicated the board assists in providing church services on Sundays and Tuesdays. One community advisory member has been the community service liaison for the program and helps get youth into programs such as The Mission and Bartow Baptist Church.

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 written policy and procedures in place to determine the program's system of staff communication, opportunities for staff to provide input, and feedback on program operations. The program conducts formal surveys with youth and parents/guardians. The information gathered in the surveys are shared in management team meetings and with the program's corporate office to develop trend analysis and track data in order to work on improvements to residential programs provided. Examples of the parent/guardian and youth surveys were observed to confirm the practice. The program's regional compliance manager and facility administrator were interviewed. They indicated comprehensive accountability reports, quality improvement reports, and surveys are discussed at the regional and corporate level, along with the program's morning management team meetings. The program conducts these morning management team meetings daily. The information is captured electronically. Examples of these were reviewed. Topics of discussion included items such as Protective Action Response (PAR) reports and incidents, reports made to the Central Communications Center (CCC), health and mental health services, and human resources issues. The information

is also disseminated to staff within the program during General Staff meetings, which are conducted monthly. Samples of these monthly General Staff meetings were also observed to confirm the practice. Topics during the General Staff meetings included things such as drill information, trainings, youth issues, open floor discussions, and deficiencies identified. The General Staff Meetings are facilitated by the facility administrator or assistant facility administrator. Copies of the program's practice taken to minimize staff turnover were provided and reviewed. A review of the provider's contractual agreement revealed an amendment which purpose was to implement retention bonuses for direct care workers for Fiscal Year 2018 and 2019. The contract amendment was signed by the Department October 5, 2018. The program also has a written policy and procedures regarding staff recognition, which indicates all full-time staff are eligible to be nominated for Employee of the Month, Employee of the Quarter, and Employee of the Year. The winner of each award will receive a pre-determined amount of monetary value. Examples of employee recognition awards were also reviewed to confirm the program's practice of employee recognition and retention programming. Four of the five staff interviewed reported staff meetings were held monthly. One staff reported they were held bi-weekly. The five interviewed staff reported meeting topics included things such as call-ins, policies and procedures, dress code, red flags, and youth issues. Three of five interviewed staff reported they were briefed on CAR reports, annual compliance reports, and youth and parent/guardian survey results. Two of five reported they weren't. Three staff reported they felt communication among staff at the program was very good. One reported it was good, and one reported it was fair. The facility administrator was interviewed and stated the program has had a high number of turnover in the last year including the facility administrator, recreation therapist, shift supervisors, and youth care workers. There have been minimal resignations, but mostly terminations due to conduct related issues. Staff morale has improved from the previous months based on changes implemented by the current administration. The program has a corporate recruiter who helps find applicants and schedules interviews. The program has attended several job fairs this past year, and has an internal job posting system. The program also has Spirit Week throughout the year, as well as Employee of the Month and monthly drawings for the TrueCore Way Recognition Program.

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

The program has a written policy and procedures for evaluating staff performance. The program conducts evaluations at least annually for all staff. According to the program's human resources manager, the program also conducts an evaluation at the staff's first thirty-day and ninety-day marks, and semi-annually. The evaluation process was defined in an interview by the facility administrator as completing ninety-day evaluations, annual performance evaluations, clinical supervision, and coaching for staff. A review of three staff personnel records for three different job positions found each position description outlined in detail within the personnel record. The job descriptions matched performance standards required for each position. Each record had evidence the staff received an annual performance evaluation as required. A review of the program's contractual agreement revealed vacancies for one part-time nurse, and one recreational therapist. In addition, the current facility administrator is in an acting capacity, as the program has recently hired a new facility administrator who was in training during the annual compliance review period.

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.	

Five youth case management records were reviewed for initial contacts to parents/guardians and court notifications. All five case management records contained documentation indicating each parent/guardian was contacted by telephone within twenty-four hours of the youth's admission. All five case management records contained documentation the program notified the parent/guardian in writing within forty-eight hours of the youth's admission. All five records contained documentation the court, juvenile probation officer, and post-residential services counseling were notified within five working days of the youth's admission.

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

Five youth case management records were reviewed for documentation indicating youth orientation began on each youth's day of admission. All five records contained documentation the program provided each youth an orientation on the youth's day of admission. The orientation packet included services available, the daily schedule, expectations and responsibilities of the youth, written behavioral management system provided in a resident handbook, availability of and access to medical and mental health services, access to the Florida Abuse Hotline, access to the Central Communications Center for youth eighteen and older, contraband items, performance planning processes to develop the goals for each youth, dress code, hygiene practices, procedures on visitation, mail, and use of the telephone, anticipated length of stay, community access, grievance procedures, emergency procedures, physical design of the facility, and assignment to a living unit, room, and treatment team. A youth admission did not occur during the annual compliance review. The transitional services manager was interviewed. The transitional services manager assists in the orientation process and was able to describe the full orientation process as described in the program's policy. A review of the youth five interviews determined orientation began within twenty-four hours of admission.

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

The program changed population seven months ago; the prior population consisted of youth ages ten to thirteen. The population after the changeover included youth who were eighteen or turned eighteen while at the program. The program provided documentation of written consent for youth eighteen or older before providing or discussing with the parent/guardian information

related to physical or mental health screening, assessment, or treatment. The program had two examples taking place during the scope of the annual compliance review.

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

The program has a written policy and procedures which clearly outlines the classification process and includes a classification system promoting safety and security, as well as effective delivery of treatment services. The policy and procedures included 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. The policy and procedures address youth for reassessment and reclassification to participate 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.

Five youth case management records were reviewed for the program's classification factors, procedures, and reassessment for activities. All five records contained documentation of initial classifications conducted the day of admission. The documentation on the admission classification forms included physical characteristics, age, maturity level, identified special needs, including medical, mental health, developmental, physical disabilities, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization. The admission classification forms identified risk factors to include suicide risk, medical risk, escape risk, and security risk. All five case management records contained documentation the youth were classified for purposes of assignment to a living area, sleeping room, and staff. All five case management records contained documentation of the classification being entered into Juvenile Justice Information System.

Five youth case management records were reviewed for classification reassessments. The program maintains all reclassification records in a binder labeled "Youth Risk Assessment Log." All five youth had documentation of reassessments completed for an increase in the youth's 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, and participation in off-campus activities.

The program has a continually updated internal alert system which is easily accessible to program staff and keeps them alerted about youth who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

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 binder titled "Gang Log" which contains all information regarding gang members entering the program. Five case management records were reviewed, of which three youth records were for youth who were affiliated with gangs. All three case management records contained documentation local law enforcement was notified of suspected gang activity by the program. The case management records had documentation indicating the youth were not currently housed in their home county. There was documentation in each of the case records the youths' home county sheriff's departments were notified of the youth's gang affiliation. All of the case management records contained documentation the education staff and juvenile probation officers were notified of the youth's gang affiliation.

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 runs Impact of Crime (IOC) groups and gang awareness groups for identified gang members within the program. Although all youth are eligible for IOC groups, the program prioritizes youth who are identified as gang affiliates to attend the group first. The program is not currently holding IOC groups, but have a plan to begin groups within the next week. The gang awareness groups are facilitated by the assistant facility administrator on a weekly basis. Documentation of youth attendance in IOC groups are maintained in a binder titled, "PHH SPEP Documentation." The gang awareness group attendance sheets are maintained in the binder titled, "Gang Log." All three applicable youth were identified on the attendance sheets for gang awareness groups in the Gang Log. All three youths' performance plans included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program.

2.07 R-PACT Assessment 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.	

Five youth case management records were reviewed to ensure the Residential Positive Achievement Change Tool (R-PACT) was completed in a timely manner. All five case management records had R-PACTs completed within thirty days of admission and the initial assessment was maintained in the Department's Juvenile Justice Information System (JJIS).

Five youth case management records were reviewed to ensure the R-PACT Reassessments were completed within ninety days after completion of the initial R-PACT assessment. All five youth received R-PACT Reassessments every ninety days, as required. One of the five case

management records indicated an updated reassessment was completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program maintained all reassessment documentation in the youth's official case management record.

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

Five youth case management records were reviewed for completion of the Youth Needs Assessment Summary (YNAS). Each of the youth case management records had documentation the YNAS was completed within thirty days of the admission date. Each YNAS was documented in the Department's Juvenile Justice Information System.

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

The treatment team, including the youth, meet and develop the performance plan based on the findings of the initial assessment of the youth, within thirty days of admission. Five youth case management records were reviewed and contained documentation showing the individualized performance plans were developed within thirty days of the youth's admission date. The individualized performance plan was developed after the initial assessment.

Each of the five youth case management records had documentation the treatment team leader, youth, administrative representative, living unit representative, treatment staff, and educational staff were present during the development of the individualized performance plan. Three of the five case management records were applicable for Department of Children Families involvement and the caseworkers were present by phone. All five case management records had documentation indicating the individualized performance plans were signed by the youth, treatment team leader, and all other parties who had significant responsibility in goal completion. All five youth records indicated the parent/guardian signature sheet sent to the parent/guardian; however, none of the records had documentation showing the signature sheet was sent back to the program.

Five of five performance plans included individualized goals based upon the prioritized needs of the youth, reflecting the risk and protective factors identified during the initial assessment process. All five individualized performance plans included the top three criminogenic needs

addressed. All five individualized performance plans included specific delinquency interventions, with measurable outcomes which will decrease criminogenic risk factors and promote strengths, skills, and reduces the likelihood of the youth reoffending. All five youth performance plans included court-ordered sanctions which could be reasonably initiated/completed while in the program. All five plans included transition activities targeted for the last sixty days of the youth's anticipated stay, youth's responsibilities to accomplish, program staff responsibilities to enable youth to complete goals, and appropriate target dates for completion.

Five of five youth case management records documented the individualized performance plan was sent with a transmittal letter to the committing court, juvenile probation officer, and parent/guardian. All three applicable youth case management records documented the Department of Children and Families counselor was mailed a copy of the individualized performance plan with transmittal letter.

Five interviewed youth reported participating in the development of their performance plan and knew their current performance plan goals. Each interviewed youth reported having a copy of their performance plan.

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.	

Five youth case management records were reviewed for revisions to the performance plans. All of the performance plans demonstrated progress and lack of progress toward completing a goal. Revisions were made to all five youth performance plans to facilitate transition activities during the last sixty days of the youth's stay. None of the youth's performance plans required revisions based upon Residential Positive Achievement Change Tool (R-PACT) results.

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.*	

Five youth case management records were reviewed for performance summaries. Four of the five performance summaries were completed every ninety calendar days following the signing of the performance plans. One of the reviewed performance plans was approximately thirty days late. Four of the five performance summaries were prepared prior to the youth's release, discharge, or transfer from the program. One youth reviewed did not have release requested at the time of the annual compliance review.

Two of five performance summaries reviewed had the youth's status on each performance plan goal. Three of three closed records had the youth's status on each performance plan goal. Five open case management records documented all five performance summaries included overall

treatment progress, academic status, credits earned in the program, performance and behavior in school, youth's overall program behavior, level of motivation and readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, significant positive and negative events. Four of the five performance summaries were prepared prior to the youth's release, discharge, or transfer from the program. One youth reviewed did not have release requested at the time of the annual compliance review.

Five youth performance summaries documented the youth had the opportunity to read and add comments prior to signing, youth were provided a copy of the performance summaries, and the original performance summaries were filed in the case management record. All five performance summaries were signed and dated by the treatment team leader, staff member preparing the summary, facility administrator or designee, and youth.

Five of five case management records documented copies of the performance summaries were sent within ten working days to the committing court, juvenile probation officer, youth, and parent/guardian. Three of the youth's case management records documented the youth's Department of Children and Families case worker was sent a performance summary within ten working days.

Three of five case management records documented the youth's original performance summary was sent with a justification for release with the Pre-Release Notification (PRN) to the juvenile probation officer within the appropriate timeframe from the program. The signed copy of the release summary was retained in the youth's case management record.

Three closed case management records were reviewed for the written notification to the parent/guardian of the youth's planned release. All three closed case records included written notification to the youth's parent/guardian of planned release. All three closed case management records included a completed Residential Positive Achievement Change Tool (R-PACT) for the youth's exit.

Three closed case management records documented the juvenile probation officer was provided the performance summary, transition plan, and psychological/psychiatric reports done while youth was in the program.

All five interviewed youth indicated they were provided a copy of their performance summary which was sent to the court.

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

The program encourages the involvement of the youth's parent/guardian in the case management process. Five youth case management records were reviewed for parental involvement in case management services. Youth records documented parent/guardian participation in the youths' assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. If the parent/guardian could not attend in person at the meetings this was noted on the signature pages. There was evidence in four of five case management records of parents/guardians attending by phone. One record had a parent/guardian signature. The program sends

notifications to the parents/guardians each month when treatment team is scheduled. The program calls the parents/guardians during the treatment team, which was observed during the annual compliance review week. During the treatment team observed, two out of three parents/guardians were able to participate by phone.

During an interview, the facility administrator indicated the program encourages parental involvement in the case management process through letters, phone calls, family days, and home visits the youth can earn. Five youth interviews indicated the parents are involved in their case management services.

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

Five youth case management records were reviewed for composition of treatment teams. Treatment team members in each of the records included the youth, an administration representative, a living unit representative, treatment team staff, an educational representative, juvenile probation officer (JPO), parent/guardian, a medical staff, and transition specialist.

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

Five youth case management records were reviewed to verify if performance plans referenced or incorporated the youth's treatment or care plans. Each of the five case management records had the youth's academic plans and mental health treatment plans referenced in their individualized performance plans. Three youth of the five youth were also involved with the Department of Children and Families (DCF). The program requested the DCF plans for all three youth; however, the plans were not provided and the program was unable to incorporate the plans into the performance plans.

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 R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

The formal treatment team meets every thirty days, unless scheduling conflicts require it be moved. Each youth is assigned a specific date and time of their treatment team to attend. During formal treatment team meetings, all parties are encouraged to attend, to include the youth's juvenile probation officer, parent/guardian, and other pertinent parties. Five case management records documented a formal treatment team packet, which included sections for

the case manager, education, mental health, and nursing staff to provide input regarding the youth. Five youth treatment team packets were reviewed, each documented the youth's name, date of review, meeting attendees, comments from treatment team members or others, brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and Residential Positive Achievement Change Tool (R-PACT). All five youth treatment team packets included a description section of the youth demonstrating skills acquired in the program. Staff members present during treatment team discussed behavior changes they have witnessed with the youth. All of the records indicated all formal treatment team meetings were held, as required.

Four of the five youth case management records documented biweekly informal reviews. One case management record was missing two biweekly reviews. The informal performance reviews were documented and included youth's name, date of review, meeting attendees, any comments from treatment team members or others, brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and R-PACT results. A section on the informal treatment team packets included the youth's opportunity to demonstrate skills acquired at the program.

A formal treatment team was observed during the annual compliance review week. All required staff were present except for education staff, due to it being Florida Standards Assessment (FSA) testing day. Education staff did provide input for the case manager to read during the formal treatment team. The treatment team discussed and documented the youth's progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, and youth's treatment progress. All team members were actively participating in the meeting and each youth was given the opportunity to demonstrate skills acquired in the program.

Five interviewed youth reported they are provided the opportunity during treatment team meetings to demonstrate skills the youth has learned in the program and staff reviews the youth's performance to include progress on performance plan goals, positive and negative behaviors, and treatment progress.

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

Three closed case management records were reviewed for career education. All three youth closed case management records included youth with employability as a goal. All three closed case records included sample employment applications, a resume summarizing education, work experience, and career training, appropriate documents essential to obtaining employment, and documentation the youth's parent/guardian and juvenile probation officer are aware of the vocational plan for the youth. One of the three closed case management records did not contain a calendar or schedule which will identify an appointment with Career Source Center.

The program offers Type 2 educational programming. The program provides vocational programming appropriate for the youth. The career education program is appropriate for the educational abilities and goals of the youth and for the length of stay and custody characteristics of the youth in the program. The career education program includes communication, interpersonal, and decision-making skills.

The facility administrator's interview indicated the following career education services are offered to the youth in the program: resume writing, mock interviews, completing applications, horticulture, and agriculture classes. The lead teacher's interview indicated the following career education services and assessments are offered at the program: My Career Shines Interest Inventory, horticulture, Career Research and Vocational employability skills, Safe Staff Food Handler, SERV Safe Food Manager, and Occupational Safety and Health Administration (OSHA) certificates.

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

The program's schedule, daily school schedule, and the school year calendar were reviewed. The program provides 250 days of instruction for educational and career-related programs over twelve months. The program uses ten days or less of the 250 days for teacher planning or training. The youth receive credits for the educational and training experience. A review of the program's logbooks and activity schedule documented minimal interference of educational instruction and education classes take place as scheduled. Five youth interviews determined there was minimal interference of education instruction.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

Three closed youth case management records were reviewed for documentation an education transition plan was developed prior to release including provisions for continuation of education and/or employment. Three closed case management records had an individual education transition plan developed based on the youth's post release goals. For all three closed education transition plans, the transition activities included the youth, parent/guardian, education representative, post-release staff/re-entry personnel, certified school counselor, registrar or designee of the program's district who has access to the District's Management Information System, and the transition plan was developed with youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. All three closed case management records included an education transition plan which addressed services and interventions based on the student's assessed educational needs and post-release education plans, recommended educational placement for post-release is based on individual needs and performance, and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. All three youth closed case management records included a transition goal of employability. All three closed education transition plans included provisions for continuation of education and/or employment, sample completed employment applications, a resume summarizing education, work experience, and/or career training, a valid Florida identification card, appropriate documents essential to obtaining employment upon leaving the program, and evidence the youth's case manager and parent/guardian are aware of the plan, documents, and post-release discharge plans. One of the three closed case management records did not include an appointment with the Career Source Center within the vicinity where the youth will be seeking employment.

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.*	

Three closed case management records were reviewed for transition conference requirements. All three records documented a transition conference was held at least sixty days prior to targeted release dates. All three records contained evidence the following attended the transition conference: youth, treatment team leader, program director or designee, and other team members. All three records documented the following were invited and encouraged through advance notification to participate in the transition conference and if participation could not be arranged, the following invited provided written or verbal input: the youth's juvenile probation officer, parent/guardian, education staff, and any other pertinent parties. All three records documented the participants reviewed transition activities on the youth's performance plan, revised performance plans, identified additional transition activities, identified target completion dates, identified persons responsible for completion, treatment team leader obtained attendees' dated signature, and representing their acknowledgement of the transition goals and accountability for completion. All three records documented a copy of the transition plan was sent with a request for return with signature to anyone not in attendance who has a responsibility for completion of transition goals. All three closed records documented the transition plan being transmitted electronically to the juvenile probation officer with the email acknowledgement receipt printed and filed with the transition plan.

Three closed case management records documented the Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release. Three closed records documented the case manager and all three youth participated in the CRT. Three closed records had evidence of an invitation to participate in the CRT.

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

Three closed case management records were reviewed for exit portfolios. All three closed records included documentation the exit portfolio was discussed and initiated for the youth at the transition conference. All three closed exit portfolios included a state-issued identification card, copy of the youth's transition plan, birth certificate, educational records, school transcripts, resume, and completed sample job application. One of the three closed records did not include

a calendar with all dates/times/locations of follow-up appointments in the community and vocational certificates earned in the program. None three closed records included a social security card. There was evidence in all three closed records the social security cards were requested from the parent/guardian within the transition meeting invitation and parent/guardian contact letters. All three closed records documented the youth's exit portfolio was verified at the exit conference. All three closed records documented the youth's exit portfolio was completed and provided to the youth upon released as evidenced by a signature page signed by the youth and a picture taken of the youth with the exit portfolio. All three closed records documented the program staff forwarded the exit portfolio information to the juvenile probation officer. All three closed records documented the education staff forwarded the exit portfolio information to the receiving school district. A review of the program's residential contract confirmed the program is meeting all requirements of the exit portfolio.

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

Three closed case management records were reviewed for documentation of the exit conference. All three closed records documented the exit conference occurred after the program notified the juvenile probation officer of release and the conference was conducted at least fourteen days prior to release of the youth. The closed records documented the dates, signatures, participants participating by telephone, and a summary pending transition goals. All three closed records documented the date of admission and date of termination in the case record. All three dates correlated with the end dates in the Department's Juvenile Justice Information System. All three closed records documented a review of transition activities established at the transition conference and finalized plans for the youth's release. All three exit conference forms documented the following participated in the exit conference: intervention and treatment team leader, parent/guardian, and education representative.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA). The LMHC is licensed under Chapter 491, Florida Statutes. A review of the LMHC's license was conducted, which revealed the license is clear and active and expires March 31, 2021. The LMHC is employed with the program as a full-time employee and is on-site a minimum of forty hours a week; sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse treatment services. The LMHC has been the DMHCA since April of 2018. A copy of the LMHC's licensure and position description was available for review while on-site. The program provides specialized treatment services; 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. An interview with the DMHCA revealed she understands her role in the coordination and implementation of mental health and substance abuse services at the program. She is on-site for a minimum of forty hours a week, in addition to being available by phone twenty-four hours a day, seven days a week. The program offers group therapy, utilizing the Thinking for Change (T4C) curriculum.

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

The program's mental health and substance abuse staffing is in accordance with the program's contract and Florida Administrative Code, 63N-1. The program has a licensed mental health counselor (LMHC), who serves as the designated mental health clinician authority (DMHCA). A review of the LMHC's license was conducted, which revealed the license is clear and active and expires March 31, 2021. The licensures for all qualified mental health and substance abuse professionals are available for review on-site.

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

The program has 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 has been at the program since September 2016. One of the previous non-licensed clinical staff resigned her position in February 2019 and another non-licensed staff was hired shortly thereafter. The non-licensed mental health and substance abuse clinical staffing at the program is in accordance with the current contract and Florida Administrative Code, 63N-1. The designated mental health clinician authority (DMHCA) assures the non-licensed clinical staff working under her supervision are performing services they are qualified for. Supervision is accomplished 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 twenty-six weekly face-to-face interactions (in a group or individually) were reviewed. Each of the twenty-six face-to-face supervisions were conducted by the clinical supervisor, as required. All of the face-to-face supervisions conducted, were recorded on a similar form to the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log, which included all necessary information. Each of the non-licensed clinical staff hold the appropriate level of education necessary and are in accordance with Florida Administrative Code, 63N-1 and the contract between the program and the Department. The non-licensed clinical staff hold a master's-level degree from an accredited university. The program is licensed under Chapter 397, Florida Statutes, to provide substance abuse treatment services; certified by the Department of Children and Families (DCF), which expires April 7, 2019. DCF was on-site at the program March 28, 2019, conducting the program's licensure renewal. The program should have their renewal license within the week. Each of the non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk (ASR), mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff's training was documented on a form developed by the program which contained all the information required in the Department's Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk Form. The DMHCA providing direct supervision, reviewed and signed four of the five-comprehensive mental health and substance abuse evaluations completed by the non-licensed clinical staff. The remaining one comprehensive mental health and substance abuse evaluation was completed by the program's licensed mental health counselor (LMHC). All of the five youth's initial and individualized treatment plans completed by the non-licensed mental health clinical staff, were each reviewed by the licensed mental health professional providing direct supervision. Four of the five ASRs were completed by non-licensed mental health clinical staff, which were reviewed by the programs licensed mental health professional. The programs LMHC completed the one remaining applicable ASR.

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.	

Five youth records were reviewed for a mental health and substance abuse admission screening. The five youth records reviewed 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 five MAYSI-2 screenings were completed on date of the youth's admission to the program in a confidential manner. Four of the five MAYSI-2 screenings were conducted by non-licensed clinical staff. The remaining one MAYSI-2 screening was completed by the programs licensed mental health counselor (LMHC). All the MAYSI-2 screenings completed were conducted by staff who completed the appropriate training. The MAYSI-2 screenings were each administered in the Department's Juvenile Justice Information System (JJIS). All five MAYSI-2 screenings conducted, indicated further assessments were required. There were no indications where staff believed a youth had a mental health or substance abuse problem or was a suicide risk. In addition, there were no indications where staff determined a referral for further evaluation was needed, whereas, the MAYSI-2 does not indicate a referral is necessary; however, the staff enters the information, observations, events, or concerns leading to the determination into JJIS. Each youth was subsequently referred for an Assessment of Suicide Risk (ASR). Each ASR was completed within twenty-four hours of the referral. All five of the youth administered the MAYSI-2, were referred for a comprehensive evaluation. Each of the youth referred had a reason for referral documented.

The program's written facility operating procedures (FOP) were reviewed, whereas it was noted, the facility administrator is responsible for developing written FOP's for the implementation of a standardized admission or intake mental health and substance abuse screening process. The written FOPs addressed the following: A standardized screening process which included the review of commitment packet information, reports, and records; the administration of the MAYSI-2 in JJIS; screenings are to be conducted by a "qualified professional" and referral made when youth identified by screenings, are in need of further evaluation or immediate attention. The program's FOP, also identified staff training in mental health and substance abuse issues and administration of the MAYSI-2. In addition, FOPs identified a standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional, or when immediate attention is necessary for a hospital, or Baker Act, or Marchman Act receiving facility.

The facility administrator was interviewed, wherein he discussed the program completes an ASR, crisis assessment, MAYSI-2, Substance Abuse Screening Inventory (SASSI), and referrals to mental health clinical staff and or psychiatrist to identify youth at risk for mental health and substance abuse issues, need for medication, and/or suicide assessment.

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

Five youth records were reviewed for a mental health and substance abuse evaluation. The five youth records reviewed each had a new mental health evaluation completed within thirty calendar days of admission. Four of the five new mental health evaluations were conducted by a non-licensed mental health clinical staff, one was completed by the program's licensed mental health counselor (LMHC). Three of the four mental health evaluations completed by a non-licensed mental health clinical staff, were reviewed and signed within the required ten days by the LMHC. The remaining one mental health evaluation was reviewed and signed by the LMHC within twelve days of completion. Each of the new mental health evaluations contained demographics, reason for evaluation, relevant background information, behavioral observations, mental status examination, discussion of findings, diagnostic impression, and recommendations. All five youth records reviewed, contained a completed substance abuse assessment. The substance abuse assessments conducted, were completed under the program's licensure, Chapter 397, Florida Statutes. Each of the five youth had a signed consent for substance abuse services. The assessments were completed within thirty calendar days of admission. The new substance abuse assessments contained a reason for evaluation, relevant background information, behavioral observations, 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, clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorder, and recommendations. The five new substance abuse assessments addressed the original referral reason.

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.*	

A total of five youth records were reviewed for mental health and substance abuse treatment. Each of the youth records indicated the youth were assigned to a treatment team upon arrival to the program. The program's multidisciplinary treatment teams are comprised of the youth, program administration, staff from the residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. In each of the records reviewed, documentation was found which validated treatment teams were comprised of representatives from administration, education, vocational training, medical, mental health and substance abuse staff, the youth, and, when possible, the youth's parent/guardian. All five youth were determined to be in need of substance abuse treatment. Each of the youth were in receipt of either individual, group, family counseling, and/or psychiatric medication management. 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. All five youth records reviewed were applicable for mental health treatment. The program has twenty-four beds for mental health overlay services. The five youth each had a properly executed Authority to Evaluate and Treatment (AET) form on file. In addition, there was documentation of a clinical impression to include diagnose from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) mental disorder were included for each youth reviewed. Each of the five youth records reviewed for substance abuse treatment contained a signed substance abuse consent and release form. The forms were completed on the Department's Youth Consent for Substance Abuse Treatment Form and 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 of the required information within Department's Counseling/Therapy Progress Note Form. Youth sign-in sheets for mental health overlay services (MHOS) were reviewed. Each demonstrated group therapy did not exceed ten youth. Youth sign-in sheets for substance abuse treatment groups documented the groups were limited to fifteen or fewer youth. Each of the five youth records contained documentation indicating the 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 "Young Men Work" curriculum for psychosocial skills training. Substance abuse treatment is provided for by a licensed qualified professional or a non-licensed substance abuse clinical staff, who is an staff of a service provider under Chapter 397, Florida Statutes.

Five staff interviews were conducted, which revealed none of them facilitate any mental health or substance abuse groups. The designated mental health clinician authority (DMHCA) was interviewed and reported the program offers MHOS. The MHOS treatment services and for those youth dual-diagnosed, are provided with group, individual, and or family therapy.

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.*	

Five youth records were reviewed for an initial mental health and substance abuse treatment plan. Each of the initial mental health and substance abuse treatment plans were site-specific, which included all the information contained within the Department's Initial Mental Health/Substance Abuse Treatment Plan Form. Each of the initial mental health and substance abuse treatment plans reviewed, were developed within seven days of admission. All of the initial 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. All of the initial treatment plans reviewed were signed by treatment team members who participated in the development of the plan. The initial treatment plan note was completed and signed by the mental health clinical staff and the youth.

Five youth records were each reviewed for an individualized treatment plan and subsequent reviews. All of the youth records contained an individualized treatment plan, which was developed within thirty days of the youth's admission to the program. The individualized treatment plans reviewed were developed on a site-specific form, which contained the necessary information on the Department's Individualized Mental Health/Substance Abuse Treatment Plan Form. The individualized treatment plans were completed by a non-licensed mental health clinical staff and were subsequently reviewed and signed by the program's licensed clinical supervisor within ten days of completion. Each of the five individualized treatment plans were signed by treatment team members who participated in development of the plan, along with the youth. Four of the five individualized treatment plans were missing documentation to support as to whether or not the parent/guardian participated/signed the plan. The remaining one individualized treatment plan did contain documentation to support the parent/guardian participated in the development of the treatment plan. Two applicable individualized treatment plans, contained the psychiatrist's signature; each of the youth were either on or later placed on psychotropic medication, requiring input by the psychiatrist on the youth's treatment plan. Both of these treatment plans included psychotropic medication and frequency monitoring by the psychiatrist. A total of thirty-one individualized treatment plan reviews were conducted for all five youth records reviewed. Each of the treatment plan reviews conducted were documented on a site-specific form, which included the information contained within the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review Form. The individualized treatment plans reviewed, documented the on-going prescribed services; individual, group, family, and/or psychiatric services, as required.

Three separate youth records were reviewed for completion of discharge plans. The three discharge plans were documented on Department form Mental Health and Substance Abuse Treatment Discharge Summary. 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. The three discharge plans reviewed, contained documentation of where the discharge plans had been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during an exit conference. A copy of the mental health and substance abuse treatment discharge summaries were provided to each youth, JPO, and parent/guardian in each of the three youth records reviewed.

3.08 Specialized Treatment Services (Critical)	**Satisfactory Compliance**
Specialized treatment services shall be provided in programs designated as "Specialized Treatment Services Programs" or are designated to provide "Specialized Treatment Overlay Services.".	

The program has a contract to provide mental health overlay services (MHOS). The scope of the MHOS treatment service delivery is outlined within the contract between the program and the Department. The program provides up to twenty-four MHOS beds for male youth, between the ages of fourteen and eighteen years old. The program provides daily group therapy, bi-monthly individual therapy, and monthly family therapy, when indicated. The program provides daily group therapy, which utilizes mental health, substance abuse, and psychosocial skills training curriculum. The psychiatrist is on-site bi-weekly, on Tuesday afternoons. 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. If licensed mental health professional coverage is needed, the provider's regional clinical director can be on-site as needed. The program has a contract with a licensed psychologist to provide services, as needed. Each full-time therapist (non-licensed mental health clinical staff) generally carries a caseload of ten youth and the designated mental health clinician authority carries a caseload of four youth. An interview with the program director revealed the program is contracted to provide mental health overlay services (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.	

Five youth records were reviewed for the inclusion of psychiatric services. Each of the youth records reviewed were applicable for referral of psychiatric services. Each of the initial diagnostic psychiatric interviews included a youth history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5), treatment recommendations (if applicable), prescribed medications (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring. Youth referred for the initial diagnostic psychiatric interview were seen within fourteen days of the referral. All five initial diagnostic interviews were documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as "initial diagnostic psychiatric interview." One 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 in order to document the initial diagnostic psychiatric interview. One youth who was originally seen by the psychiatrist for an initial diagnostic psychiatric interview, was later referred, and subsequently placed on psychotropic medications. Two of five youth were taking psychotropic medications. Each of the youth on prescribed psychotropic medication, were seen for medication monitoring review by the psychiatrist every thirty-days.

The program has an agreement with a psychiatrist, who is licensed under Chapter 459, Florida Statute, and meets all requirements outlined with Florida Administrative Code 63N-1. The psychiatrist's license is clear and active and expires January 31, 2020. A copy of the contract between TrueCore and the psychiatrist was available for review while on-site. The psychiatrist is available on call and for 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 either through face-to-face interaction or telephonic communication with a representative or treatment team. 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 registered nurse practitioner (ARNP). A review of the program's psychiatric log (sign-in/out log) for the psychiatrist, confirms his visits during the past six months, validating he was on-site every two-weeks. The psychiatrist is on-site every two-weeks and is available to evaluate and monitor youth, as needed. Each youth prescribed psychotropic medication, receives psychotropic medication monitoring and review at a minimum of every thirty days. The psychiatrist is ultimately responsible for the prescription and monitoring of psychotropic medications at the program. A review of youth records revealed the psychiatrist

actively participates in, manages, and supervises psychotropic medication services within the program. There were no indications of the program having any standing orders for psychotropic medications. In addition, there were no indications of any emergency treatment orders for psychotropic medications.

An interview with the psychiatrist confirmed his role within the program; participating in treatment teams and on-site every two-weeks. The psychiatrist meets with the program's designated mental health clinician authority (DMHCA) and facility administrator to discuss youth receiving psychiatric services while on-site; bi-weekly. 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 health care 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 has a written suicide prevention plan which details suicide prevention procedures. The program's written suicide prevention plan, includes identification and assessment of youth at risk of suicide. In addition, staff training (total of six hours annually, to include mock drills for all staff). Also, suicide precautions, levels of supervision (one-to-one, constant, and close supervision), referral, communication, notification, documentation, immediate staff response, and a review process. The program's written suicide prevention plan is reviewed annually. The last date the plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and program director was April 30, 2018.

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.*	

Five youth records were reviewed for suicide prevention services. Each youth reviewed had an Assessment of Suicide Risk (ASR) administered upon admission to the program. An ASR referral was made for each of the identified youth. The five youth were placed on precautionary observation (PO) and under staff supervision until completion of the ASR. The ASR was completed within twenty-four hours, using the required Assessment of Suicide Risk Form. The youth were screened and subsequently placed on standard supervision. A suicide PO log was completed for each youth reviewed. Documentation of PO was completed on the Department's mental health and substance abuse form Suicide Precautions Observation Log. Each of the POs were authorized and mental health staff provided supportive services, as needed. In each of the five reviewed youth records, a conference between the designated mental health clinician authority and facility administrator was documented in order to reduce the level of supervision.

Four of the five ASRs completed were 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 one ASR, was completed by the program's licensed mental health professional. The youth on PO, are allowed to participate in select activities with other youth in designated safe housing areas of the program. These youth were not limited to an individual cell or restricted to his sleeping room. None of the five youth assessed were determined to be in any kind of crisis. None of the five ASRs were conducted outside of the program. The program does not utilize secure observation. The program's written facility operating procedure (FOP) also address the absence of this practice; secure observation is not used as a suicide precaution within the program.

The program has two suicide response kits on-site. One of the suicide response kits were located within the front office and the other kit was in the laundry room, which is located on the youth dormitory. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. The program's written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan, addresses the facility administrator's 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, 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.

Four of the five staff interviewed responded they would notify mental health staff should youth express suicidal thoughts. The one remaining staff stated they would place the youth on alert. Four of the five staff interviewed, were able to identify the locations of the program's suicide response kits. The remaining one staff when asked about the suicide response kits; she wasn't sure.

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

A total of five precautionary observation (PO) logs were reviewed. Each of the PO logs were documented on the Department's Suicide Precautions Observation Log. The PO logs were maintained for the duration the youth was on suicide precautions. Each of the PO logs documented the appropriate level of supervision and observations of the youth's behavior. Staff recorded observations of youth behaviors in real time, at a minimum of thirty-minute intervals. There were no noted or needed warning signs documented on any of the PO logs reviewed. The five PO logs were reviewed and signed by each shift supervisor. The PO logs were reviewed and signed off by the mental health clinical staff. The PO logs had supervisory reviews conducted. All five PO logs included specific language documenting safe housing areas within the program.

Four of the five youth who had previously been on suicide precautions upon admission to the program reported staff were with them at all times and were never left alone. The one remaining youth was out of the program to court at time interviews were conducted.

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

The program has three operating shifts. The program conducted a total of eleven mock suicide drills for the first shift. The program conducted a total of ten mock suicide drills for the second shift and a total of seven mock suicide drills for the third shift. Each of the shifts had at a minimum of one drill completed for each of the quarters reviewed. All twenty-eight drills included action to be taken by staff; a method for contacting other program staff by radio or for back-up support to include emergency medical services 9-1-1. In addition, each of the mock suicide drills, included life saving measures such as cardiopulmonary resuscitation (CPR) and/or the use of the suicide response kit. Staff with direct contact, on a day-to-day basis with youth, participated in at least one quarterly mock drill semi-annually. The program has a process in place which allows staff not present during a mock suicide drill to review each drill scenario and procedures. Five staff training records were reviewed for suicide prevention training. Each staff completed required six hours annual suicide training.

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 written mental health crisis intervention services plan. The written mental health crisis intervention services plan includes a notification and alert system, means of referral (including youth self-referral), communication, supervision (one-to-one, constant, and standard supervision), documentation, and a review process.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working	

under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.

The program has only two crisis assessments to review since the last annual compliance review. Each assessment was completed on the Crisis Assessment Form. The two crisis assessments 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, and notification to parent/guardian. One youth was determined to not be in crisis and remained on standard supervision; therefore, a mental health alert was not required to be entered into the Department's Juvenile Justice Information System (JJIS). The other youth was placed on constant supervision. Recommendations for follow-up were documented accordingly. Notifications to the parents/guardians were made, as required. A JJIS alert was placed. Documentation of constant supervision was recorded on the Mental Health Alert – Observation Log. A follow-up mental status examination was completed on the one youth who had been placed on constant supervision, subsequently, he was transitioned back to standard supervision. Both of the crisis assessments were completed by a designated mental health clinician authority. Both crisis assessments reviewed were conducted by mental health clinical staff immediately upon notification of the youth being in crisis.

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

The program has a written emergency mental health and substance abuse plan. The written emergency mental health and substance abuse plan includes immediate staff response, notifications, communication, and supervision. In addition, includes authorization to transport for emergency mental health services or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act) and transport procedures for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The written emergency mental health and substance abuse plan also includes, documentation, training, and a review process.

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

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

Standard 4: Health Services

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

The program's designated health authority (DHA) is a licensed osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida. The DHA's specialty training is in Internal Medicine (with experience with adolescents). The DHA does not designate a physician assistant (PA) or advanced registered nurse practitioner (ARNP) as they are not employed by the program. The DHA is on-site at least once a week and documentation reflected no more than seven days passed between on-site visits. Copies of the DHA's sign-in/out logs were provided during the annual compliance review. If the DHA is on vacation or on a scheduled absence, coverage is arranged. During the DHA's absence, a medical doctor (MD) has been designated to perform clinical services and perform administrative duties, a copy of their credentials was available for review. The DHA is available twenty-four hours a day, seven days a week by phone and electronically for acute medical concerns, emergency care, and coordination of off-site care. The DHA reported he is available by phone when not on-site. The DHA reported his responsibilities included performing Comprehensive Physical Assessments, sick call as needed, consults with nursing staff, and approves policy and procedures.

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

The program has written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and facility administrator signs and dates all respective treatment protocols. Nursing staff reviews, signs, and dates a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by nursing staff for changes which occur between annual compliance reviews. An annual review of all FOPs and protocols is completed by the program. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies and procedures, given by a registered nurse. A copy of the health care staff orientation packet was provided by the program. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures ensuring the completion of an Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in their custody. Each of the five youth individual healthcare records reviewed reflected evidence of an AET, each of

which were stamped “copy” in red ink. AETs are valid until the youth’s eighteenth birthday. Copies of parental notifications are maintained behind the AET in the youths’ records.

4.04 Parental Notification	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.	

Each of the five individual healthcare records were reviewed for parental notification. Five of five records reflected documentation of parental notification for over-the-counter medications beyond what is covered in the Authorization for Evaluation and Treatment (AET). Two records reflected documentation of significant changes in medication. One youth required emergency off-site care and documentation of parental notification was present. Four of five youth records reflected parental notification for off-site care. The program sends written notification regardless of telephone notifications. Documentation reflected staff members witness all telephone attempts or contacts in five of five records. None of the youth reviewed were applicable for involvement with the Department of Children and Families due to parental rights being terminated.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

Two of five individual healthcare records reviewed were applicable for notification by Clinical Psychotropic Progress Note (CPPN). One additional record was reviewed for an applicable youth. For all three youth, documentation for parental notification of prescribed, discontinued, or dosage adjustments were present. The notification for each of the three youth was sent by certified mail along with the CPPN (page three) to include explanatory information for the initiation of psychotropic medication. Additionally, notification was observed to be sent when changes in medication occurred for all three applicable youth. Documentation in three of three records reflected verbal consent was obtained for the CPPN, in which a staff member signed indicating they witnessed the call. The parent/guardian signatures were observed in three of three records for consent.

4.06 Immunizations	Satisfactory Compliance
All youth’s immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

The program has a written policy and procedures ensuring relevant information regarding a youth’s immunization history is obtained to ensure youth receive proper immunizations. Five of five youth individual healthcare records reflected immunizations were verified within thirty days of admission. Immunizations for five of five youth reviewed were found to be up to date upon admission to the program. None of the youth reviewed were applicable for refusing consent or refusing consent due to religious reasons. The program’s Health Services Administrator (HSA) who is also a registered nurse (RN) reported immunizations are verified by the youth’s school immunization records and by Florida Shots. Additionally, the HSA added if a youth requires an immunization, these will be provided off-site by the Polk County Health Department.

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

The program has a written policy and procedures to ensure youth receive routine health care screenings and evaluations upon admission to the program. All five youth individual healthcare records were reviewed for the Facility Entry Physical Health Screening (FEPHS) form. Each of the five records reflected the FEPHS form was completed for each youth on the day of admission to the program. Each FEPHS form reviewed was completed by the registered nurse (RN).

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

The program has a written policy and procedures in place to ensure all staff are made aware when a medical or mental health issues exist which may affect the safety and security of the youth in the facility and which may necessitate the need for emergency medical or mental health services. Three of five youth reviewed were applicable for medical related alerts. Alerts documented in the program's internal alert system were found to correspond with the youth alerts in the Department's Juvenile Justice Information System (JJIS). Two of the three applicable youth were applicable for chronic conditions and reflected a medical grade of two and five. The third youth reviewed was applicable for psychotropic medications was observed to be a medical grade five. Nursing staff verify alerts are up to date. A master alert board was observed in the staff conference room in which the alerts observed matched those on the internal alert roster and alerts in JJIS. Five of five staff interviewed reported alerts are discussed at shift briefs, communicated by medical staff, and observed on the alert board.

4.09 Youth Orientation to Healthcare Services	Satisfactory Compliance
All youth shall be oriented to the general process of health care delivery services at the facility.	

The program has a written policy and procedures in place for all youth to be orientated to the program's health care system upon admission or the next available opportunity. Five of five individual healthcare records were reviewed for orientation to healthcare services. Documentation in all five records reflected youth received healthcare services orientation upon admission to the program, as indicated by the youth signature and date of the healthcare orientation packet. The program's healthcare orientation included the following: access to medical care, sick call, what constitutes and "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers. The program employs a physician who serves as the designated health authority, and a licensed psychiatrist who serves as the designated mental health clinical authority, in which both are available by phone twenty-four hours a day, seven days a week.

4.10 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.	

Five youth individual healthcare records were reviewed for designated health authority (DHA) notification. One of the five records reflected the DHA was notified of admission for a youth with a suspected chronic condition. None of the youth required immediate notification for need of emergency response. All five records reflected documentation indicating the DHA was notified by the registered nurse by telephone on the day of the youth's admission.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

Five youth individual healthcare records were reviewed for a healthcare admission rescreening. None of the five records reflected a change in the youth's physical custody since their admission to the program; however, the program was able to provide two additional records for review for healthcare rescreening. For the two of two applicable records reviewed, documentation reflected a Facility Entry Physical Health Screening (FEPHS) form was completed by the registered nurse (RN) upon the youth's return to the program. The program's written policy and procedures includes the course of action to take in the event nursing staff is not on-site, but according to the RN, there have been no instances in which a youth has returned to the program when nursing staff has not been available.

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

The program has a written policy and procedures to ensure youth receive routine health care screenings and evaluations upon admission to the program which includes a Health Related History (HRH). Five youth individual healthcare records were reviewed for completion on a HRH form. Documentation in each of the five records reflected a new HRH form was completed on the date of admission for each youth. All five records reflected the registered nurse (RN) completed the HRH form and there was indication the designated health authority (DHA) reviewed the HRH form. Four of five HRH forms reflected the HRH form was completed before the Comprehensive Physical Assessment (CPA). One record reflected the HRH form was completed at the same time as the CPA.

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

The program has a written policy and procedures ensuring all youth receive a physical health evaluation subsequent to admission to the program. Five youth individual healthcare records were reviewed for completion of a Comprehensive Physical Assessment (CPA). All five records reflected a new CPA was completed by the designated health authority (DHA) within seven calendar days of admission to the program. The CPAs reviewed reflected three youth entered

the program as a medical grade one, one as a two, and one as a five. Each CPA was completed in accordance with the Health Service Manual requirements. All sections of the CPA were marked with an “O” or an “X.” Those sections marked with an “X” reflected comments by the DHA in the comments section of the form. The statement “deferred by clinician” was observed on applicable sections of the exam. None of the youth refused any part of the examination. The problem list was observed to be updated in five of five records reviewed.

4.14 Female-Specific Screening/Examination	Non-Applicable
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

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

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

The program has a written policy and procedures in place to ensure youth receive routine healthcare screenings and evaluation upon admission to the program for latent or active tuberculosis (TB) as well as environmental controls for the program. The written policy and procedures were observed to be in compliance with the Centers for Disease Control and Prevention and Occupational Safety and Health Administration standards. Five youth individual healthcare records were reviewed for a TB screening. Five of five records reflected each youth had a verified tuberculin skin test (TST) completed in the last year. All of the records indicated the youth had a Tier I B screening completed on the day of admission to the program. Each youth was assessed prior to being placed in the general population. The results of the TST were observed to be documented on the Comprehensive Physical Assessment (CPA) in all five records reviewed.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

The program has a written policy and procedures which ensure youth receive sexually transmitted infection (STI) screenings, evaluation, and testing. According to the written policy and procedures, when applicable, testing, screening, results, clinical evaluation, and diagnosis are documented on the Infectious and Communicable Disease (ICD) form. Additionally, the policy requires sexually active youth who have been out of custody for more than thirty days or symptoms are present, there will be a rescreening. Five youth individual healthcare records were reviewed for STI screening. All five records reflected youth were screened for STIs upon admission to the program. None of the five youth reviewed were referred for testing based on the results of the screening.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

The program has a written policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, referral for medical treatment, as indicated, education and prevention counseling. According to the written policy and procedures, test results are filed in a confidential manner consistent with F.S. 381.004, a certified HIV counselor conducts the testing, and a youth's HIV status is never to be included on with the internal alerts. Five of five reviewed youth individual healthcare records reflected all five youth were offered testing, counseling, and treatment upon admission to the program. Documentation reflected all five youth refused these services. There are currently no youth in the program who have consented to testing. HIV testing is conducted at the program by the health services administrator (HSA) who is a certified HIV counselor. The program provided their 500/501 certified for review. Four of five interviewed youth reported they can ask for HIV testing, one youth responded they could not.

4.18 Sick Call Process – Requests/Complaints	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 has a written policy and procedures to ensure a system is in place to respond to the complaints of a youth illness or injury of a non-emergent nature. Three of five youth reviewed were applicable for sick call. Documentation of sick calls were present in each of the three applicable youth individual healthcare records. None of the youth required a referral to the designated health authority (DHA). The sick call was completed by the registered nurse (RN) for all three youth reviewed. None of the youth presented with similar complaints three or more times within a two-week period or complained of anything staff was unfamiliar with. Sick call is conducted seven days a week from 12:00 p.m. until 12:40 p.m., as contractually required. A registered nurse provides sick call. Sick call forms were observed to be available to youth throughout the program. The program does not utilize a computerized system for sick call. Youth will out sick call forms and place them in the sick call box. In the event nursing staff is not on-site, a shift supervisor will check the sick call box. The shift supervisor will review the sick call, and if deemed to require immediate care, the supervisor will notify the on-call licensed health care staff for consultation and instructions. Five of five youth interviewed reported they see a nurse within one day of placing a sick call.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

The program has a written policy and procedures to ensure a system is in place to respond to the complaints of a youth illness or injury of a non-emergent nature. Three of five youth reviewed were applicable for sick call. The sick calls were completed by the registered nurse (RN). Sick call forms and progress notes were observed documented in accordance with the Department's Rule. Sick calls were observed to be documented on the youth's sick call index in the individual healthcare records, as well as the Sick Call Referral log. Documentation reflected both the youth and staff signed, indicating the youth were seen. Youth privacy during sick call

encounters is ensured. Sick call forms were observed available to youth throughout the facility. According to the RN, the exam table and equipment are used when performing sick call. There were no sick calls placed during the annual compliance review and, therefore, sick call was not able to be observed. Five of five staff interviewed reported the nurse conducts sick call.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program does not utilize restricted housing; therefore, this indicator is rated as non-applicable.

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

The program has a written policy and procedures in place to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed, in response to unexpected illness, accidents or conditions which require immediate attention or an immediate professional assessment to determine their severity. Two of five youth reviewed were applicable for episodic care. One additional applicable record was reviewed. Two of the youth were referred for off-site for care. Progress notes contained all required elements, the referral needed, parental notification, and plans for follow-up/future care observed. On-site care provided by licensed healthcare staff and subjective, objective, assessment, and place (SOAP) format was observed. Emergency medical and dental care, including EMS services are available twenty-four hours a day. The program has four first aid kits located in master control, education, and on the living unit. All first aid kits contained approved and are inspected weekly by the registered nurse. The designated health authority approved all contents in the first aid kits. The episodic care log documents all instances of first aid/emergency care. Logs for the previous six months correspond with all on/off-site events observed in youth records. All five interviewed youth stated they can see a doctor, if needed.

4.22 Emergency Care	Satisfactory Compliance
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The program has a written policy and procedures in place to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed, in response to unexpected illness, accidents or conditions which require immediate attention or an immediate professional assessment to determine their severity. The program has one automated external defibrillator (AED) located in the front hallway near medical, administration, and the case manager's office. Instructions are located inside the AED. The registered nurse (RN) performed a self-test of the AED during the annual compliance review. The batteries in the AED expire October 21, 2020 and the spare batteries expire January 2023. The AED pads being used expire November 20, 2019. The spare set of pads expire November 2020. The AED batteries were last changed on July 26, 2017 and the AED pads were previously replaced in June of 2018. The AED is inspected monthly by the RN and the AED check logs from the previous six months were available for review. In accordance with the program's written policy and procedures, the program conducts medical drills monthly, on each shift. A review of drill

documentation reflected the program has conducted drills monthly and on each shift since the last annual compliance review. Additionally, drills included the use of cardiopulmonary resuscitation (CPR)/AED or the administration of first aid quarterly, and on each shift. The program has a list of emergency numbers, including Poison Control Information Center, posted where they are inaccessible to youth. The program's health care staff and direct care supervisory level staff have been trained in the administration of an epinephrine autoinjector. There are currently no youth in the program who require an epinephrine autoinjector. Five of five interviewed staff reported they are personally allowed to call 9-1-1 if a youth has a medical emergency.

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

The program has a written policy and procedures ensuring the program will provide timely referrals and coordination of medical services to an off-site health care provider (emergent and non-emergent). Three of five youth individual healthcare records were applicable for off-site care. All three records reflected documentation of parental notification and completion of the Summary of Off-Site Care form. Discharge documents were observed filed in three of three records. The designated health authority's (DHA) signature was observed on all three off-site care findings, instructions, and information. Two of the three applicable youth required follow-up in which documentation reflected referrals were tracked and youth received appropriate, timely follow-up care, as needed.

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

The program has a written policy and procedures to provide guidance to institutional health services personnel in the areas of chronic illness monitoring and clinic establishment guidelines. Two of five youth individual healthcare records were applicable for chronic illness. One additional applicable record was reviewed. All three youth were observed to be identified as having a chronic illness on the program's internal alert roster. All three youth were observed to be classified with a medical grade of two to five. None of the youth reviewed were taking ant-tuberculosis medication. Periodic evaluations are tracked by the health services administrator (HSA). Documentation reflected all three youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. None of the periodic evaluations were conducted off-site. The Department's problem list for each youth was updated in accordance with the Health Service Rule 63-M. According to an interview with the facility administrator, important medical issues pertaining to youth at the program are reviewed daily at the morning management meetings. According to the designated health authority (DHA), youth receive periodic evaluations every sixty days and every thirty days if the youth has two or more chronic conditions. Additionally, the DHA reported periodic evaluations are monitored by a scheduler/tracker.

4.25 Medication Management – Verification	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

The program has a written policy and procedures in place ensuring any medications arriving with a newly admitted youth are verified. One of five youth individual healthcare records indicated the youth was admitted to the program with medication. None of the other youth currently in the program were admitted with medication. The Facility Entry Physical Health Screening (FEPHS) form indicated the youth was currently taking prescribed medication and the Non-Licensed Staff Medication Record form reflected the transfer of medication from detention to the residential program. Prescription verification for the applicable youth was observed in the chronological progress note in the record. After the verification process, documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. The program's practice is to notify the DHA of admission regardless if a youth is taking prescribed medication.

4.26 Medication Management – Orders/Prescriptions	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

The program has a written policy and procedures ensuring all youth receive prescription medications, as prescribed. Two of five youth individual healthcare records reviewed were applicable for prescribed medication. One additional applicable record was reviewed. All prescribed medications were observed to have a current, valid order and were given pursuant to a current prescription. Current medications prescribed prior to admission are renewed or refilled for the life of the prescription as long as there are no changes in the total dosage or route. When current medications are continued, discontinued, changed, or new ones are orders, the designated health authority (DHA) placed a practitioner order in the progress notes. Two youth were administered over-the-counter (OTC) medications which are not listed on the Authorization for Evaluation and Treatment (AET), which were administered in accordance with approved protocols. None of the parent/guardians prohibited the administration of OTC medications by way of the AET.

4.27 Medication Management – Storage	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

The program has a written policy and procedures ensuring medications meet or exceed state regulations and accepted medical practices for custodial care. According to the written policy and procedures the health services administrator (HSA) is responsible for ensuring all chemical products, drugs and medicines and medical instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. All medications were observed to be in a separate, secure areas inaccessible to youth. All non-controlled medications (prescribed and over-the counter) are stored in a separate, secure, locked area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth

medications. All expired or discontinued medication is returned to the contracted pharmacy within ten days for disposal.

4.28 Medication Management – Medication and Sharps Inventory	Satisfactory Compliance
All medications and sharps shall be inventoried as per department requirements.	

The program has a written policy and procedures ensuring all chemical products, drugs and medicines and medical instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. All over-the-counter (OTC) medications are inventoried weekly. The program maintains a perpetual inventory with running balances maintained on all controlled substances with a shift-to-shift inventory. Syringes and sharps are counted whenever used and inventoried weekly by nursing staff. The health services administrator (HSA) explained if there was a discrepancy, follow-up with the nursing staff would be conducted, the facility administrator would be notified, and the program would stop all movement and begin searches, if necessary. An inventory of three youth medications was conducted during the annual compliance review, one of which was a controlled medication, and medication on hand matched the inventory. An inventory of three OTC medications was conducted during the annual compliance review and the medication count matched the inventory. An inventory of three sharps was conducted during the annual compliance review and the sharps counts matched the sharp inventories. Inventories for medications and sharps were available for review for the previous six months. All expired or discontinued medication is returned to the contracted pharmacy within ten days for disposal. Additionally, the program is contracted with Stericyle to dispose of biohazardous medical waste. Stericyle comes once a month as evidenced by the disposal logs.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a written policy and procedures ensuring medications meet or exceed state regulations and accepted medical practices for custodial care. The program's written policy and procedures articulate a shift-to-shift inventory with running balances with two signatures observed. When nursing staff is not on-site, supervisory level non-health care staff have been trained and authorized in the delivery and oversight of medication. The program currently has two youth who are prescribed controlled medications. An observation of counts of two controlled medications was able to be observed during the annual compliance review and the counts matched the corresponding inventory. Controlled medication was observed to be stored in the secure medication cart inside a separate locked box from all other medication. Inventories from the previous six months were available for review.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

The program has a written policy and procedures in place ensuring medications are properly administered for custodial care. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Each youth in the program has a MAR. Five youth individual

youth healthcare records were reviewed. The MAR for each youth included: youth's name, Department identification number, date of birth, allergies, precautions, and medical grade. The MAR for the current month for each youth is kept in a binder located in the nurse's station. Photographs of each youth were attached to their corresponding MAR. For each of the five youth reviewed, the MAR indicated the youth received medications as prescribed, and documented start and stop dates. Over-the-counter (OTC) medications were also observed documented on the MARs. There was no indication of lapses or errors in medication administration. The registered nurse (RN) initials the MAR for each medication entry. Trained, non-licensed staff administering medication initial as well as the youth. Nursing staff documents weekly side effect monitoring on the MAR. No refusals were observed in five of five records reviewed. In the event a youth refused medication, the refusal is clearly documented on the MAR. There were no instances of missed psychotropic medication observed. Only one of the five youth reviewed was admitted to the program with medication. The progress notes and orders corresponded with the administration of medication on the MAR.

4.31 Medication Management – Medication Administration by Licensed Staff	**Satisfactory Compliance**
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

The program has a written policy and procedures ensuring medications are properly administered for custodial care. None of the five youth reviewed were applicable for parenteral medication. Medication administration was observed during the annual compliance review in which three youth attended. The nurse's station was observed to be clean and organized. The nurse had control of the medication cart. There is a structured process by which youth approach the nurse. All three youth approached the cart and stated their name, date of birth, and confirmed their medication. The Five Rights of Medication Administration were verified. Verification of the medication administration record (MAR) was observed. Allergy and alert status was verified by the nurse. The nurse was observed questioning youth about possible medication side effects. The nurse did not pre-pour any of the of the medications. None of the youth refused their medication. If a youth refuses medication, it is clearly documented on the MAR. After swallowing the medication, each youth was observed opening their mouth, moving their tongue from side to side, running their fingers around their gum lines, and then turning their head and coughing. Four of five staff interviewed reported the nurse gives youth their medication, one staff reported the supervisor provides medication to the youth. Two of five youth interviewed reported they receive their medication from the nurse. Three youth reported they do not take any medication.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	**Satisfactory Compliance**
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program has a written policy and procedures ensuring medications are properly administered for custodial care. Three of five youth individual healthcare records indicated instances of the administration of over-the-counter (OTC) medication by non-licensed health care staff. The staff non-licensed staff who administered the medication on the Medication Administration Record (MAR) was cross-referenced with the trained non-licensed health care

staff at the program, all of whom are supervisors or youth care worker II. For all three youth, there were no instances on non-trained staff administering medication. Documentation further reflected both staff and youth initialed the MAR. According to the written policy and procedures, non-licensed staff assisting youth with medication delivery do not conduct or supervise any program activities during this time. Staff verify allergies, alerts, and observe the youth to ensure the medication is swallowed. Medications are no pre-poured from the original packaging and placed in another container for subsequent use. Four of five interviewed staff reported the nurse gives youth their medication, one staff reported the supervisor provides medication to the youth. Two of five youth interviewed reported they receive their medication from the nurse. Three youth reported they do not take any medication.

4.33 Medication Management – Psychotropic Medication Monitoring	**Satisfactory Compliance**
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

The program has a written policy and procedures to provide psychiatric services to youth in the program which include: psychiatric evaluations, psychiatric consultations and medication management. One of five youth reviewed was applicable for prescribed psychotropic medication upon admission to the program, in which case documentation reflected the designated health authority (DHA) and psychiatrist was notified. There were no other examples of youth being admitted on psychotropic medication within the current population of the program. The psychotropic medication the youth was receiving prior to admission was continued to be administered until an initial diagnostic psychiatric review was conducted. An initial psychiatric interview is conducted for all youth admitted to the program within fourteen days. The youth receive medication monitoring by the program's psychiatrist. One of the five youth reviewed was prescribed psychotropic medication subsequent to admission, and one additional record applicable for psychotropic medication was provided by the program. For youth prescribed psychotropic medication subsequent to admission, documentation reflected a referral was made for both youth. In both cases, the mental health staff referred the youth to the psychiatrist within twenty-four hours of the mental health evaluation. Documentation reflected the psychiatrist determined psychotropic medication was needed for both youth. An in-depth psychiatric evaluation was complete on all three youth prescribed psychotropic medication upon within thirty days of admission or within thirty days of the initial prescription of the psychotropic medication subsequent to admission. The program uses the Department's Clinical Psychotropic Progress Note (CPPN). The prescription of new, or changes in the existing medication were observed documented on the CPPN for all three applicable youth. The CPPN included the following documentation: each youth's diagnosis, target symptoms of medication, evaluation and description of the effect of prescribed medication on target symptoms, side effects, youth's adherence to the medication regimen, laboratory findings, and telephone contact with the parent/guardian to discuss the medication. The psychiatrist's signature and date were observed on the CPPN in all three records. Medication monitoring was observed in all three records reviewed, which reflected monthly monitoring of psychotropic medication by the psychiatrist. There are no standing orders for psychotropic medication. There are no emergency treatment orders for psychotropic medications and no PRN orders for psychotropic medication.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility 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 program has a written policy and procedures addressing infection control. The program's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC) guidelines. The program's infection control procedures include the following: common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. There have been no instances of which the local health department, CDC, or the Central Communications Center (CCC) should have been notified.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

The program's comprehensive infection control education plan includes pre-service and in-service training for all staff as required by the Centers for Disease Control and Prevention (CDC) guidelines. A review of five pre-service training records and five in-service training records reflected all ten staff completed training on infection control. A review of five youth individual healthcare records reflected all youth received infection control education.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program's exposure control plan was found to be written in accordance with Occupational Safety and Health Administration standards. The plan is available to all staff. The plan is reviewed and signed annually by the facility administrator. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. In the event youth or employees experience an occupational exposure, the facility administrator establishes a separate file and records are maintained for ten years. The program has not had any instances of reportable infectious disease needed to be reported to the local county health department during the scope of the annual compliance review. The facility administrator reported the exposure control plan is located in medical, the facility administrator's office, and the staff conference room.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

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

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

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

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

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.	

Based on observations made during the annual compliance review, program staff maintained active supervision of all youth, to include, interacting positively with youth, maintaining a one to eight ratio, engaging in a full schedule of constructive activities, and closely observing behavior and any changes. The behavior modification system (BMS) was consistently observed and program staff were able to account for all youth under their supervision during the annual compliance review. The youth-to-staff ratio during daytime activities, was one to eight and one to twelve during night time hours. On the first day of the annual compliance review, youth were observed in class with six youth and two staff. All the youth were at their desks, a staff was standing at the back of the classroom and the teacher was walking around the classroom giving instructions to the class. On the second day of the review, a language arts class was observed where there were six youth, one staff, and one teacher present. All youth were at their desks; the staff member was sitting at the back of the classroom. Youth were observed at lunch and were in ratio of six youth to two staff. Youth were observed preparing for recreation; ratio remained eight youth and three staff. On the third day of the review, the youth were observed sitting down preparing for breakfast. The ratio was seven youth to two staff. On the fourth day, morning wake up routine was observed. Ten-minute checks were completed with checks documented at every six to eight minutes. Youth were treated with dignity and staff were consistent with the four to one positive to negative consequence requirement reinforcement. There were four different transitions with staff-to-youth remaining at eight to three ratio or better. Staff members were asked on three different occasions what their youth count was and each time the count was correct without the staff having to recount. The written policy and procedures defines active supervision as staff being within sight and/or sound of all the youth at all times. The activity schedule is planned for each day. Current daily schedule is posted in the dayroom and in the dormitory. During observations made throughout the annual compliance review of the program, youth were busy and did not have any unstructured time. The staff were observed closely monitoring the youths' behavior and changes in behavior. The BMS was observed throughout the annual compliance review; the youths' points were discussed with youth by youth care workers or the assistant facility administrator. Staff were able to account for the youth under their supervision at all times. Youth were accounted for and accompanied at all times; they were not permitted to roam freely. The review of staff completing ten-minute checks found staff were walking around with a flash light and looking into each youth's window at a minimum of every eight minutes. Three staff were asked what the procedure is when they cannot reconcile the count, each staff stated the supervisor is informed and all activity stops until the count is reconciled.

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

The program's behavior management system (BMS) was reviewed. There is an agreement between the program and the school related to the BMS practices. The facility administrator trained the education staff in the jointly combined BMS plan to include use of BMS during school. The BMS is clearly written and is part of the youth's handbook. All case management records had a document signed by the youth indicating the youth received a copy of the student handbook at intake. Rules governing conduct and positive and negative consequences for behaviors are posted, as well as included in the youth handbook. The program's BMS has not been changed since the last annual compliance review. The BMS was posted in the dorms and in the large group area of the program. Five staff training records were reviewed for completion of the BMS training; each of the staff have been trained in BMS implementation at the program. Each of the five staff interviewed understood the BMS and indicated they received on the BMS plan, to include use of the BMS during school. Five of the five youth interviewed understood the BMS. The facility administrator was interviewed and confirmed BMS practices are reinforced through daily incentives and daily youth meetings to review who made their day. In addition, he was able to outline the different levels of the BMS. The program's written BMS included practices to assist in maintain order, security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions which are non-punitive, opportunities for positive reinforcement, recognition of accomplishments and positive behavior at a four to one ratio, promotes socially acceptable means for youth to meet their needs, process for explaining to the youth the reason for any sanction imposed, an opportunity to explain his behavior, an opportunity for staff and youth to discuss impact of behaviors on others. Youth and staff discuss alternate behavior, by referring to the treatment plan and identifying coping skills. The BMS promotes positive dialogue and peaceful conflict resolution. Separation of youth from population is minimized and rare with the population served at the program. There is a coordinated effort between staff of the youth's individual behavior plans. There is consistent implementation and treatment through oversight; three different individuals oversee the implementation of the BMS.

Staff and youth interactions were observed for adherence to the BMS. The ratio was observed at a four to one ratio; positive to negative consequences. There were no occasions of negative consequences observed during the annual compliance review, due to staff consistently applying positive reinforcement to each youth. The program's written BMS policy and procedures address staff to apply a positive-to-negative consequence of four-to-one. Negative consequences are in direct relation to the severity or seriousness of the inappropriate behavior exhibited by youth. There is a variety of rewards and incentives offered through the BMS. The BMS includes special provisions in the provider's contract including, but not limited to, nightly incentives, off campus trips once youth have reached the appropriate level, golden tickets, extra phone time, thirty minutes of video games, and a movie night. All five interviewed staff indicated youth have a variety of incentives including special food, extra phone call minutes, video game time, and off campus trips. All five interviewed youth indicated there are a verity of types of reward/incentives such as canteen, golden tickets, extra phone time, video games, playing ping

pong, and other daily incentives. The facility administrator stated the shift supervisor and the assistant facility administrator review the point card daily and positive behavior reports.

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's written policy and procedures were reviewed to ensure there is a protocol where staff are provided feedback regarding their implementation of the behavior management system (BMS). The youth care worker job description outlines specific qualifications of staff whose job function includes implementation of the program's behavior management system. The program's contract was reviewed and all required parties were involved in the development, implementation, and on-going maintenance of the applicable BMS. Staff utilizes point cards, special treatment teams, as well as treatment teams to review over BMS practices for youth. The facility administrator stated the youth care workers tally points on the point card for any points and the assistant facility administrator ensures the cards are correctly tabulated. All five interviewed staff indicated supervisors monitor staff use of the BMS and provide feedback through reviews and staff incentives.

The program's BMS includes a process where staff explain to youth the reason for any sanction imposed. The youth are given an opportunity to explain his behavior, and staff take the time with the youth to discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternate acceptable behaviors. The program does not use room restriction and there was no use of room restriction found during the annual compliance review period. The BMS does not include any increased length of stay, denial of basic rights, promotion of punishment, punishment of youth by other youth, or disciplinary confinement. Staff interviews and staff indicate staff tells the youth if they have a sanction imposed through a meeting with the assistant facility administrator, case manager, and therapist. Five of five youth indicated they had never been on room restriction. The BMS includes special provisions outlined in the provider's contract. The facility administrator stated the assistant facility administrator reviews point cards and the referral form to monitor how consequences and or punishment are monitored within the program.

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 assistant facility administrator stated the program has sixteen cameras, of which fifteen were operable. The assistant facility administrator stated the cameras digital video recording

(DVR) system holds thirty days of recordings. A copy of the work order was provided showing a work order for the one camera which was not operational. Ten random ten-minute checks where observed and compared to the log book. The log book and the camera times matched and checks were completed in less than eight minutes each, with staff initials next to each documented check. Five different staff were observed performing ten-minute checks, each of the staff used flashlights when looking in all the youths' rooms when rooms were dark. Five staff were interviewed, each staff stated youth checks must be conducted every eight minutes or less.

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 practicable 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's written policy and procedures was reviewed and the youth's census, counts, and tracking were observed to be conducted as required. The counts are conducted at the beginning of each shift and after each movement. Review of log books indicate counts are being conducted at the beginning of each shift, after each outdoor activity, and during emergency drills. The Continuity of Operations Plan (COOP) was reviewed. The program has one log book, which is carried by the shift supervisor throughout each shift. The log book contains the total daily census count, head counts, youth movements, new admissions, releases, alerts, and youth temporarily away from the program. The log book was reviewed, and counts are conducted at the beginning of each shift, after each outdoor activity, and after youth return from an off-site activity. There were no emergency counts noted during this annual compliance review. All five interviewed staff indicate youth counts are conducted every time there is movement and at the beginning and end of each shift.

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 log book was reviewed and is bound with numbered pages, without any pages missing or falling apart. All entries are made in ink without erase marks or areas whited out. There were no log book entries obliterated or removed. All errors were struck through with a single line and dated and initialed by the person correcting the error. All entries include the date and time of the

event, with the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry. The program does not utilize a living unit log book. The program summarizes in shift reports the event, incident, and activities documented in the central log book, and all staff initials the shift report. The program supervisor verbally briefs incoming staff about the contents of the shift reports; incoming staff will review the shift reports. Incoming staff sign and date the shift report from the previous shift to document he/she has reviewed or has been verbally briefed about contents. A copy of the shift report is in the conference room. The program documents incidents, and activities in a central log book, which is handled by the shift supervisor. Special instructions from supervisors about monitoring of youth were noted in the log book. Population counts at the beginning and end of each shift are recorded in the log book. Perimeter security checks and other security checks conducted by direct care staff are documented in log book. Transports away the facility, including the names of the staff, youth involved, and the destination are documented in the log book. Request by law enforcement to access any youth is documented in the log book. Removal from the mainstream population is documented in the log book; however, none of the youth were documented as being removed from the mainstream population. Admissions and releases including the name, date, and time of anticipated arrival or departure and mode of transportation is noted in the log book. There were no attempted escapes noted during the annual compliance review period. There were three incidents reported to the Florida Abuse Hotline, which were noted in the log book. All Central Communications Center (CCC) calls were noted within the log book.

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's written policy and procedures on key control address key assignment and usage including restrictions on usage, inventory and tracking of keys, and the secure storage of keys not in use. In addition, procedures are in place addressing missing or lost keys, and practices to report and replace damaged keys. The distribution and collection of keys were observed. Keys are collected in front lobby by staff, no personal keys are permitted to enter the building. The building keys are located behind a secure area, each staff must enter an assigned number to obtain and return facility keys. The key inventory was reviewed, the key inventory matches the actual keys in use. The key storage area was observed and determined there is a high level of security. Keys are locked up and only given out in exchange for personal keys along with the key log sheet. Keys must be returned to master control to obtain personal car keys. Damaged keys are logged into a report and replaced by maintenance. The procedures to report a lost or missing key include to inform the facility administrator or designee, lock down movement of facility, inform the Central Communications Center. The assistant facility administrator stated special area keys are assigned to individuals on their facility roles such as medical, case management, youth care, mental health, and maintenance. The program's method for the daily tracking and reconciliation of keys is to collect transactions each day and pull reports for the team working during the current day. Three staff were checked for personal keys and three staff did not have their personal keys. The youth interviews did not indicate if youth had access to

keys. All five interviewed staff stated all staff are given a number to check assigned keys in and out of the key control box.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.* *The program shall document the confiscation of any 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.*	

The program's written policies and procedures on contraband were reviewed and it aligns with the Department's recommended guidelines for contraband. The program conducts searches of every individual entering the program; everyone goes through a metal detector and gets scanned by a wand as they enter the building. The Program's staff handbook defines what contraband is and the student handbook indicates the only items they can have at the program. The youth are provided with a list of items which they are permitted to have at the program and are told if something not on the list it is considered contraband. The youth hand book lists consequences for having contraband as a three-day suspension. All common areas and rooms are searched and logged. The facility grounds are searched and logged. The youth are searched as they leave the dining hall, dorm, class rooms, group rooms, and recreation. Incoming mail is opened by the case manager with the youth present. All outgoing mail must remain open until case manager seals the outgoing letter. The programs written policy for staff introducing contraband is clear, if a staff brings contraband to the facility the staff will be fired, and law enforcement maybe involved if contraband is a safety security risk. The program's standard of conduct stated, all staff who are found in possession of contraband in the program will be subject to disciplinary action up to and including dismissal this does include administration. As stated in the program's standard Code of Conduct for program staff on page eleven item two "Introduction of unlawful activity is grounds for termination and potentially the application of criminal charges under Florida Statute which is a felony of the third degree." The program clearly delineates items considered contraband, to include, but not limited to the following illegal items, sharps, escape paraphernalia, drugs, to include prescription or over the counter medications, tobacco products, electric or vapor less cigarettes, non-program issued program equipment, and/slash or devises, unauthorized food or beverage, metals, cell phones, cash, keys or any item not deemed safe to security. The program documents confiscation and disposition of contraband on discipline reports. The documentation was maintained in each of the five reviewed records. There was not illegal contraband found during the review period. No illegal contraband disposal is document in case record. The program log book, incident reports are conducted daily and include the results of each search. The student handbook includes items considered contraband and list consequences. The facility administrator was interviewed

and stated, 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 facility administrator and disposed of off property. Contact will be made to the central communication center (CCC) if necessary and required. 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.	

Youth searches were observed before and after groups. Youth were observed between education transitions and were searched before leaving the classroom and randomly searched before entering the next class room. The youth were treated with dignity and respect during searches and youth appeared relaxed. The searches were conducted by the two staff and all searches were completed by male staff, using a four-quadrant approach. Each youth was thanked and encouraged before going into the next class after each search. The searches conducted were completed, as required, by the Protection Action Response (PAR) standards. All five interviewed youth indicated the searches are conducted after each movement. All five interviewed staff stated searches are conducted after every movement; one staff indicated youth receive whole body search after returning from being off campus.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.*	

The program has a written policy and procedures addressing vehicle security and the transportation of youth. The program has one vehicle which is utilized to transport youth. The program provided documentation of the annual safety inspection and maintenance records completed for the vehicle. The maintenance staff keeps a monthly inspection sheet on the van. The van was observed to be secured when not in use. The van was equipped with a fire extinguisher, seat belt cutter, window punch, and appropriate number of seatbelts. The first aid kit for the vehicle was maintained in master control. A transport was not able to be observed during the annual compliance review. Staff indicated youth are not to be attached to any part of the vehicle by any means other than proper use of a seat belt. According to the program, there is an additional van on property and is not utilized by the program, which has been sitting in the parking lot for approximately two years. This van is part of the Departments Residential inventory. The additional van is dirty with four flat tires.

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

The program has a written policy and procedures to ensure compliance of all requirements outlined by the Department relating to the transportation of youth and driver eligibility. A cellular phone and two-way radio is issued to a transporter before each off-campus trip. There is a one to five, staff to youth ratio with all transports having a minimum of two staff attending each transport. The program has the ability to provide secure transportation for high-risk and maximum risk youth. In addition, secure transportation for non-secure youth determined to be a greater risk. One staff of the same gender must be on each transport. A random check of personal vehicles and facility vehicles was conducted, and all vehicles were locked. The program's one transportation vehicle was inspected to ensure it was equipped with a safety screen separating the front seat or driver's compartment from the back or rear passengers' compartment for the youth. There were no transports during the annual compliance review to observe use of seatbelts. Observations of the vehicle made by the review team found; e vehicle has a rear door which cannot be opened from the inside and doors to the youth passenger area cannot be opened from the inside. All staff operating program vehicle have a current driver's license. Staff are not allowed to leave youth unsupervised in a vehicle as required by the program's written policy and procedures. Youth are not permitted to drive facility vehicles. Five of five staff stated the ratio of staff to youth is four to one however all staff indicated two staff were on all transports of youth. Five of five staff indicated they do not use personal vehicle to transport youth. Four out of five staff indicated staff have a company cell phone. One out of five staff indicated how and when they would use a two-way devise during a transport.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a written policy and procedures which outlines the audit inspection process at a minimum. The facility administrator or the assistant facility administrator is responsible for completing the weekly audits and safety inspections. The facility administrator is responsible for development and implementation of corrective actions warranted because of safety and security deficiencies found during any internal or external review, audit and or inspection. There are internal systems to verify the deficiencies are corrected and existing systems are improved. The program's written policy and procedures meets all the requirements of Florida Administrative Code. During the annual compliance review there was a minimum of one weekly security audit and safety inspection during the past six months.

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

The program has a written policy and procedures to provide instruction on the control of tools and sensitive items within the program, to ensure the safety, security, and accountability of all youth, staff, and tools. Only maintenance, facility administrator, and the assistant facility administrator have keys to tool room and chemical closet. Tools are marked for easy identification and are maintained securely within the maintenance office and outside in a

secured shed. An inventory of all tools was inventoried prior to being issued for work and following work activities. A daily inventory is conducted on maintenance's tool bag, which includes a sharp-edged, pointed tool. The program used a system of tool management, where all tools were marked, and photos are taken of hand held tools within toolboxes, along with the corresponding number of tools in each drawer. Any tool which is checked out by maintenance would be signed out. A monthly inventory of all tools was also completed by the maintenance staff person. Machetes, bowie knives, and other long blade knives are prohibited in this program. An inventory of kitchen tools was also conducted, on which all items were accounted. Damaged tools are replaced and disposed of by completion of a 'Tool and Key Issue' form. The damaged tool will be disposed of by maintenance and replaced if necessary. The program also maintained limited number of cleaning tools, such as a mop and broom, within a secured closet located in the dayroom on the youth's module. The doors to these closets were observed to be secured. There is a 'Class B Sign In/Out Form' on the module when these items are being used. There are three youth who are currently being trained in lawn equipment safety. All three youth have documentation they have received safety training for this class. Five staff pre-service training records were reviewed, each staff received training in tool safety and control.

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

The program has a written policy and procedures for supervision requirements when youth are using tools. The program's procedures for using tools for youth and staff, including youth's risks to self and others was reviewed. The procedures determined the established ratios, tool distribution and collection, and search criteria was reviewed. Staff to youth ratio was maintained at one staff to five youth during activities using tools and one staff to three youth during discipline work projects. Youth were observed completing work detail in the dorms and was within ratio. Youth are searched after each work project with a frisk search. Risk assessments were reviewed; five of five youth had risk assessments completed. Risk assessments are completed on youth participating in tool projects or activities. Youth were interviewed and indicated youth can use mops, brooms, rakes, and paint brushes.

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

The program has a written policy and procedures for addressing outside contractors when entering the program to perform a work project which requires the use of tools. Approved vendors who enter the program must have his/her tools inventoried by the supervisor or designee. An 'outside contractor on-site work project log' is completed when entering the program, which lists the tools. All tools will be checked going in and out. When a contractor is on-site, no youth are allowed in the work area. There are instructions of what to do if a tool goes missing. A review of project invoices submitted to the program by the vendor was completed and the sign-in sheets matched the dates of the projects which were completed. The program's written policy and procedures outlines who is responsible for providing approval personal cellular phones and or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area.

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 Continuity of Operations Plan (COOP) was reviewed, and the program conducts practice drills and is prepared for immediate implementation or mobilization of plans whenever an emergency or disaster situation is necessary. The program conducts fire drills at a minimum of three every month. The program conducts COOP plan drills quarterly. Fire evacuation routes and egress plans are posted throughout the facility. The facility administrator stated he conducts fire drills, escape drills, evacuation drills, and hurricane drills. Three youth indicated fire drills were performed once a month, one youth indicated fire drills were performed twice a month and one youth stated drills were conduct once a shift per month. Three of five staff stated there are weather drills, two of five staff stated there are major disturbance drills, one of five stated there are bomb and chemical drills, three of five stated there were escape drills, four of five stated there are fire drills, two of five stated there are mental health, two of five stated there are medical drills.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The Continuity of Operations Plan (COOP) is easily accessible in the control room readily available to all staff. The COOP was last updated and submitted to the Department's residential regional director on May 3, 2018.The Program's COOP addressed alternative housing plans approved by the Department. Provision of equipment and supplies required for continuous operation and services where observed. The facility administrator stated the COOP was located in the master control room. The programs COOP contains: fire and fire prevention and evacuation, severe weather, disturbance or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff rolls and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions of continuity of care and custody of youth, and provisions for public protection.

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

The program has a written policy and procedures which addressed flammable, poisonous, and toxic item control. The written policy requires these items to be stored in secure areas which are in inaccessible to youth. These items were observed to be secured in the maintenance room behind two locked doors. The program stores the flammable materials such as diesel, gas, or pesticides outside the program in a metal storage unit in the sally port. The program maintained an accurate inventory of all the chemicals, flammables, and toxics in each area. The only person authorized to handle these items in the program is the maintenance person. Safety Data Sheets (SDS) are kept within a binder in each storage unit area. The binder also included a

copy of the program's written operating procedure for flammable, poisonous, and toxic control items, as well as a copy of the chemical disposal protocol. A review of each item observed found the corresponding SDS. Only maintenance staff has a key to have access to the chemical storage areas.

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 has a written policy and procedures regarding handling and supervision of flammable, poisonous, toxic item and materials. The program has all poisonous, flammable and toxic materials locked behind two doors. Youth do not use, handle, or clean-up dangerous or hazardous chemicals. Youth do not clean, handle, or dispose of any person's bio-hazardous material, bodily fluids, or human waste. There is restricted youth access to areas where items are being used or stored. Staff sprays area and youth wipe away cleaning solutions. All five interviewed youth stated staff spray the area and youth wipe away cleaning solutions.

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

The program has a written policy and procedures which addressed flammable, poisonous, and toxic control, and the disposal of these items. The maintenance staff is the only individual authorized to dispose of these items. There was documentation provided where maintenance had received training for disposing hazardous items and toxic materials. Maintenance staff stated he follows the Safety Data Sheets (SDS) sheets for disposal of these items. The kitchen is not used at this program. According to the maintenance staff, all corrosive and flammable items are disposed of through a hazardous waste container taken to the Bartow dump. Hazardous waste is disposed of in accordance with the SDS and stored in a hazardous storage area. Liquid wastes, such as dirty mop water, are disposed of in plumbing drains. There are no kitchen chemicals used at this program. Upon becoming aware of a chemical spill, the shift supervisor directs the shutdown of all air handlers and ventilation systems and closes all windows and doors at the direction of the on-scene supervisor. Assistance from outside the facility is contacted, as necessary, consistent with emergency procedures. The facility administrator was interviewed and stated maintenance staff places items on disposal list, transports material to dump for hazardous material disposal.

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

The program's activity schedule was reviewed. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth.

Activities are documented in the log book according to the activity schedule. The program's written policy and procedures provided activities based on the developmental levels and needs of the youth within the program. The activity schedule includes a choice of leisure and recreation options. Youth are encouraged to explore options and activities of interest. Youth are engaged in constructive leisure time type activities according to the program's activity schedule. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program was observed taking precautionary measures to prevent over-exertion, heat stress, dehydration, and existing illness or physical injury. The program has a full time recreational therapist position; however, the position was vacant for three months. The program has recently hired a new recreation therapist, who will start training within one week of this annual compliance review. The program did go through the hiring process with another recreation therapist; however, the individual declined the position the day before she was supposed to begin employment with the program. The youth have a daily schedule and participate in treatment team meetings with the recreation therapist when the position is filled. Therapeutic activities are provided and are incorporated in five of the five youth's treatment teams. The program has a peer counsel and holds meetings monthly. The youth indicated they are involved in at least one hour of sports activity daily. They stated they play cards, basketball, pin pong, and football. Staff interviews indicate youth play a minimum of fifty minutes of recreation activity a day.

5.22 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 water-related activities; therefore, this indicator rates as non-applicable.

5.23 Visitation and Communication	Satisfactory Compliance

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

The visitation schedule is posted and occurs at 10:00 a.m. to 12:00 p.m. on Saturdays. The program's written policy and procedures address visitation, youth correspondence, and the use of the telephone. The visitation log and schedule are consistent. Telephone logs and schedules were also reviewed and were consistent with documentation reviewed. Correspondence logs and schedules were reviewed and were found to be consistent. Alternative visitation is available for youth with their parents/guardian, when necessary. Youth can communicate with family by mail. Youth are given the opportunity to communicate with family members by telephone. The youth indicated they can mail two letters a week, unlimited legal correspondence. The youth stated they are allowed one call a week from approved list; all five-youth reviewed had call logs.

5.24 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.

5.25 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.

5.26 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.

Program Name: Polk Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Polk County / Circuit 10
Review Date(s): April 2-5, 2019

MQI Program Code: 1049
Contract Number: 10359
Number of Beds: 24
Lead Reviewer Code: 144

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.12 Restorative Justice Awareness for Youth	
1.17 Advisory Board	