STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Pompano Youth Treatment Center

Sequel TSI of Florida, LLC
(Contract Provider)
3090 North Powerline Road
Pompao Beach, Florida 33069

Review Date(s): October 29 - November 1, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Teves Bush, Office of Program Accountability, Lead Reviewer ([Standard 1])
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 5)
Charline Moxey, Circuit 15 Probation and Community Intervention, Senior Juvenile Probation Officer (Standard 2)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 3)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Pompano Youth Treatment Center
Provider Name: Sequel TSI of Florda, LLC
Location: Broward County / Circuit 17
Review Date(s): October 29 - November 1, 2019

MQI Program Code: 1290
Contract Number: 10112
Number of Beds: 24
Lead Reviewer Code: 154

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.17 Advisory Board	
2.07 Residential Assessment for Youth (RAY)	
5.06 Logbook Entries and Shift Report 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	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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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	Limited
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Satisfactory

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Program Overview

Pompano Youth Treatment Center is a twenty-four-bed program, for male youth ages thirteen to eighteen, located in Pompano Beach, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides substance abuse treatment overlay services (SAOS), mental health services, case management services, healthcare services, gender-specific programming, psychiatric services, as applicable, diagnostic evaluation services, educational services, and vocational training. In addition, each youth is provided services through the Impact of Crime (IOC) curriculum, Thinking for a Change (T4C), and New Freedom/Phoenix Resource delinquency interventions, along with Talk's My Father Never Had with Me, a gender-specific intervention. Additional treatment services provided includes group counseling, individual, and family therapy, recreational and equine assisted therapy. Program administration is comprised of a facility administrator (FA), assistant facility administrator (AFA), designated mental health clinician authority (DMHCA), director of nursing, business office human resource manager, food service manager, and an administrative assistant (AA). There are two full-time case managers, two non-licensed master's-level therapists, a transitional services manager, and a recreational therapist working under the direct supervision of the DMHCA, who is a licensed mental health counselor (LMHC). The program has a contract with a licensed medical doctor (MD) to serve as the designated health authority (DHA). The program also has a licensed psychiatrist, psychologist, and pharmacist, as well as a dietician to manage food services. There are two full-time registered nurses (RN), one who serves as the director of nursing. The medical clinic is staffed seven days a week on a rotating schedule from 8:00 a.m. to 6:30 p.m. Educational services are provided by the Broward County School District in portable structures contained within the perimeter fence. At the time of the annual compliance review, the program had seven vacant positions which included five youth care workers (YCW), one shift supervisor, and one food service worker. The layout of the program includes a single secure structure with an electronically operated security main entrance. All services are conducted within the main secure building, which includes a dormitory area for the twenty-four beds, a recreation and honors dorm room, laundry room, a kitchen, a dining and living area in the main day room, medical clinic, and the administration. The supervisor's office is located within the day room area. Within the secure perimeter fence is a basketball court and grassy recreational space which allows for youth to engage in other large muscle activities such as football or soccer. In addition, the program has a horticulture area where vegetables, flowers, and native Florida plants are planted. Adjacent to the single secure structure is a storage shed for chemicals, tools, and lawn maintenance equipment. The program has a total of thirty security cameras. At the time of the annual compliance review, all cameras were operable.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a written policy and procedures in place to ensure all newly hired staff and volunteers receive an initial background screening. The program had a total of eleven new staff hired since the last annual compliance review. A review of background screenings verified each staff received an initial background screening. Each new staff received a background screening prior to their start date and completed a pre-employee eligibility assessment with a passing score. The program also reviewed the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS), and the Florida Department of Law enforcement (FDLE) results for each newly hired staff prior to hiring. The program had no volunteers at the time of the annual compliance review. The Annual Affidavit of Compliance with Level 2 Screening Standards was signed on December 27, 2018 and was received by the Department's Background Screening Unit on January 2, 2019, meeting the annual requirement. The Department of Education received an annual screening on January 22, 2019, meeting the annual requirement. There were no new teachers hired since the last annual compliance review.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.).	

The program has a written policy and procedures to ensure all staff and volunteers receive a background rescreening every five years from their initial date of employment. There were four staff eligible for five-year rescreening during the annual compliance review period. Each reviewed staff received a background rescreening within ten business days prior to the staff's five-year anniversary date. The program had no volunteers or interns during the annual compliance review period.

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

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

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

The program has a written policy and procedures ensuring the program provides an abuse free environment. The facility operating procedures for abuse and neglect reporting, along with the program's manual, addresses the code of ethics. Staff are required to sign an acknowledgment form indicating they reviewed the required information. A review of five staff personnel records reflected all staff reviewed the program's code of ethics. Observations during the annual compliance review week indicated staff modeled pro-social behavior for youth throughout the day. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were also observed to be posted throughout the program. A telephone located in the day area has been designated for youth to contact the Florida Abuse Hotline or the CCC if youth feel they have been abused or neglected. At the time of the annual compliance review, there were three incidents reported to the CCC for physical, psychological, or emotional abuse since the last annual compliance review, of which one was substantiated for the use of physical abuse. There were no Prison Rape Elimination Act (PREA) investigations, nor any open Department of Children's and Families (DCF) investigations, law enforcement, or Office of the Inspector General (OIG) investigations pending. An interview with the facility administrator (FA) indicated, as a responsible corporate citizen, Sequel wants to ensure it operates in compliance with all federal, state, and local requirements. Sequel has a strong reputation for integrity and honesty and operate business ethically, and in full compliance with applicable laws. Achieving business results by illegal acts or unethical conduct is not acceptable and will not be tolerated. Each supervisor and manager are responsible for assuring all personnel they supervise or manage are acting ethically and in conformance with applicable laws, regulations, and this code. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues related to their jobs and for seeking appropriate advice regarding such issues. At all times, the program takes all allegations seriously and all charges are investigated with interviews of all involved including witness statements, cameras views, and other resources available where the allegations were stated to have happened. The staff is

removed from contact with the youth. When necessary, the Department of Children and Families (DCF) and the Department will be contacted. Five staff were interviewed, and each stated they have never observed a co-worker telling a youth they cannot make an abuse call or ever heard staff using profanity, treats, intimidation, or humiliation when interacting with youth. Five youth were interviewed, and each stated they feel safe in the program, and staff are respectful when they speak to them. Five youth were interviewed, and one youth stated they have never heard staff use curse words when speaking to youth and four stated occasionally.

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

The program has a written policy and procedures to ensure the program takes immediate action to address incidents of physical, psychological, and emotional abuse. The program had three incidents of abuse toward a youth since the last annual compliance review. A review of the reports indicated the facility administrator (FA) took immediate action to address the concerns by removing the staff from youth contact. The program found one incident to have substantiated findings of physical abuse and placed the staff on administrative leave. Five staff were interviewed and were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC) to report suspected abuse. An interview with the FA indicated staff and youth are trained and updated regularly on the rights of program youth. The program has signs posted throughout the building which display the telephone numbers for the Florida Abuse Hotline and CCC numbers. There is a telephone located on the wall for youth to utilize to call the Florida Abuse Hotline or CCC. At all times, if a youth asks to make the call, they are given privacy and are allowed to place the call. Any time a complaint is submitted, it is addressed in the management meeting along with staff meetings to insure this is not a future issue.

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

The program has a written policy and procedures for reporting incidents to the Department's Central Communications Center (CCC) within the required two-hour time frame. The program had a total of twelve CCC reports for the past six-months. A random review of five CCC reports verified each incident was reported within the two-hour time frame and documented in the facility logbook, as required. A review of the program incident reports and youth grievances indicated none were required to have been reported to the CCC. An interview with the facility administrator indicated the program will comply with and support the Department's policy on abuse reporting, all allegations of child abuse or suspected child abuse will be immediately reported first to the Florida Abuse Hotline and to the Department's Central Communications Center (CCC) within two hours of the incident or knowledge of the incident.

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

The program maintains a written policy and procedures related to Protective Action Response (PAR) including the use of verbal and physical intervention techniques and mechanical restraints. A review of the program's PAR binder indicated there were no PAR incidents in the past six months. The program has a current PAR plan approved by the Department's Office of Staff Development on January 16, 2019. The program's PAR rate during the annual compliance review period was 0.00, which is below the statewide Residential PAR rate of 1.59. An interview with the facility administrator (FA) regarding the process for monitoring PAR incidents and use of force found all PAR incidents are monitored by the FA and all reports and witness statements are read along with a review of camera footage. The FA indicated the program makes sure to interview any witnesses to the incident along with making sure the youth is seen by medical. The program also uses these incidents as a training issue for staff members.

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

The program has a written policy and procedures outlining the pre-service training requirements for newly hired staff. The program's policy indicates all newly hired full-time and part-time staff will receive a minimum of 120 hours of training which are computer-based and/or instructor-led topics and shall be completed within 180 days of employment. An annual training plan for pre-service training was approved by the Department's Office of Staff Development and Training on January 30, 2019. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. An informal interview with the facility administrator (FA) indicated youth care workers are Protective Action Response (PAR) certified direct care positions and are included in the staff-to-youth ratios. All supervisors, the FA and assistant FA (AFA), medical staff, mental health staff, case management staff, and maintenance staff are PAR certified and are qualified to supervise youth in special circumstances when they are not working in their current function. A review of five staff pre-service training records verified each reviewed staff completed all required pre-service training requirements within 180 days of employment to include suicide prevention, emergency procedures, child abuse reporting, professionalism, ethics and standards of conduct, cardiopulmonary resuscitation (CPR), first aid, emergency procedures, Prison Rape Elimination Act (PREA) trainings. None of the reviewed staff positions required any specific training indicated by the contract. All reviewed pre-service training was entered in the Department's Learning Management System (SkillPro).

1.08 In-Service Training	Satisfactory Compliance
Residential contracted provider staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.*	

The program has a written policy and procedures outlining the in-service training requirements for program staff. The program has an annual training plan approved by the Department's Office Staff Development and Training on January 30, 2019 to include all Departmental required trainings, as well as the program's required internal trainings. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. A review of five staff in-service training records indicated all staff had supporting documentation to reflect their cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid trainings were up-to-date. Each reviewed record also verified completed training in suicide prevention, ethics, Protective Action Response (PAR), communications skills, professionalism, as well as the contract required training elements of Facility Entry Physical Health Screening, Residential Assessment of Youth (RAY), Massachusetts Assessment of Youth Screening Instrument (MAYSI), and the Department's Juvenile Justice Information System (JJIS). Two supervisory staff training records were reviewed and indicated each supervisory staff completed the required eight hours of management training. All trainings were found to be documented in the Department's Learning Management System (SkillPro).

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 three-phase grievance process which consists of informal, formal, and appeal phases. Youth are informed of the grievance process at the time of admission into the program. Grievance forms are available and accessible to youth in the day area located in a file holder next to the locked grievance box. Youth who have difficulty completing the form may receive assistance by staff on the instructions, preparing, and submittal of a grievance. The program had a total of one grievance submitted during the past six months. All grievances are to be maintained in a designated binder for one year. The one grievance was found in the designated binder. A review of the grievance form verified the youth were provided the proper form and was resolved at the formal phase. A review of five staff training records verified grievance training was provided. An interview with the facility administrator (FA) indicated the grievance process has three phases to include informal, formal, and appeal phases. If a youth feels they are being treated unfairly, they will use the informal phase and speak to the staff they are having problems with and try to work it out. If they cannot resolve the problem, then the youth will file a written explanation of their grievance on a youth grievance form. Grievance forms are available next to the grievance box. A supervisor will review the grievances. A supervisor will get back with the youth and provide an opportunity to process the situation. The supervisor and youth will sign the grievance form verifying acknowledgement of the grievance. If

the youth is unsatisfied with the supervisor's response, the youth may request a review by the assistant facility administrator (AFA). The AFA will review the grievance and meet with the youth within forty-eight hours of the request for review of the supervisor's decision. The AFA will provide the youth with their findings and both will sign the grievance form verifying whether the grievance has been satisfied. If the youth is still unsatisfied with the AFA's response, the youth may request the grievance to be reviewed by the FA. The FA will review the prior two steps and responses and decide in writing. Once the FA has presented their decision, this decision is final. Both the youth and the FA will sign the decision. Five staff were interviewed and knew the program's grievance process. Five youth were interviewed and were able to explain the program's grievance process and stated they can receive assistance if they need complete a grievance.

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

The program provides interventions and treatment which incorporates evidenced-based models which are cognitive-behavioral and based upon social learning theory and highlights skills and modeling of anti-criminal attitudes and behaviors. The evidenced-based curriculum used by the program include Thinking for Change (T4C). The program has a total of two clinical staff and three non-clinical staff trained in facilitating evidenced-based, promising practice, and/or practice with demonstrated effectiveness groups. Each clinical staff holds at a minimum a bachelor's-level degree and non-clinical staff hold at a minimum an associate's-level degree. Each of the five staff have over five years of experience working with youth. A review of the program's activity schedule, coupled with the group sign-in sheets and the treatment sessions table identified in the program's contract, indicated groups were held seven days a week and conducted by the appropriate counselor, as scheduled. A review of five youth performance plans verified a goal identified the need for youth to participate in at least one of the required group trainings. During an interview, the facility administrator (FA) reported a staff's education and work experience is taken into consideration while also considering the strengths of each staff along with their life experiences when groups are assigned. These groups are coordinated by the clinical director and staff. Further interviews with the FA indicated the program works to match youth with staff members who the youth ask to work with. The program has some youth who do not want to work with a certain gender and this is honored. The FA indicated they believe the youth need all opportunities to open up with their issues or challenges and they welcome the forum which works best for each youth in the way it helps them. This is discussed with each youth while in their treatment team meeting. Five youth were interviewed, and each stated they are receiving counseling.

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

The program's treatment services includes the use of social and life skills curriculum including New Freedom/Phoenix Resource curriculum, which is geared for youth who have been identified as a gang member or gang associate, and Thinking for Change (T4C). The program identifies youth in need of services by reviewing the risk and criminogenic needs identified from the Residential Assessment of Youth (RAY). A review of the program activity schedule and group sign-in sheets verified groups were held, as required, with a majority of the youth's time spent in structured, therapeutic activities, with a minimum of one hour of each youth's day devoted to the delivery of treatment services targeted to address identified risk, criminogenic, and treatment needs. The program has a total of five staff trained to provide service delivery. A review of staff training records verified the program has three staff trained to deliver life skills training groups. Five youth were interviewed and was able to describe the new skills and behaviors they have been taught. Each of the five youth also stated they practiced the skills outside of group such as breathing techniques, walking away, counting to ten, and medication.

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

The program utilizes the Impact of Crime (IOC) curriculum to assists the youth to accept responsibility for the harm their criminal actions have caused in the community. The program provides opportunities for the youth to participate in activities intended to restore victims and communities such as volunteering at food banks. An interview with the facility administrator (FA) indicated the program utilizes the IOC curriculum where youth are exposed to victim's statements by way of video tape, written material, and victim speakers to learn of the impact of being a victim of crime. Youth participate in on-site and off-site community service work projects to heal some of the harm they caused. Group sessions are held on Tuesdays and Thursdays by staff trained to provide the service. A random review of youth performance plans and group sign-in sheets, coupled with the program's activity schedule, verified the practice. A review of staff training records indicated staff providing the service are trained in the curriculum.

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

The program provides delinquency intervention and gender-specific treatment services for each youth in the program which demonstrates a component addressing the needs of a targeted gender group. The program utilizes the Talks My Father Never Had with Me curriculum for young men who could benefit from a mentor or positive male role model. A review of the curriculum and the program's activity schedule indicated gender-specific groups are designed to target the needs of the youth in the program and were conducted, as required. Five youth were interviewed and were able to describe the new skills and behaviors they have been taught. Each of the five youth stated they have practiced skills in group.

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

The program has a written policy and procedures for an internal alert system designed to inform staff of youth with health-related concerns, mental health, and safety and security risks. The program maintains an on-going alert system to ensure information concerning a youth's special conditions, suicide risks, safety and/or security risks are effectively communicated to staff in a manner which preserves the youth's privacy. Alerts are identified at the time of admission either through an interview with the youth and/or supporting documentation within the admission packet. Alerts are then entered into the Department's Juvenile Justice Information System (JJIS) and added to the program's internal alert list. The internal alerts list is posted in master control, and the briefing room which identifies security risks, mental health/clinical staff for suicide risks and other mental health alerts, along with medical for health conditions and medications, and the food service staff for dietary and allergies. Mental health staff can enter alerts when the youth is added, removed, and/or stepped down from precautionary observation (PO). For medical alerts and food allergies, medical staff enters the alerts in JJIS and initiates the internal alert. The assistant facility administrator (AFA) and director of case management (DCM) updates the youth with security alerts on the internal alert list and JJIS. A random review of five youth who had a total of eight alerts entered in JJIS were also documented on the program's internal alert system. Two youth who had off-site transports reflected JJIS was updated. A review of JJIS supported the licensed mental health clinician and the registered nurse entered and closed the applicable medical and mental health alerts. There were no reviewed alerts required to be entered or closed by the AFA or the DCM. An interview with the facility administrator (FA) indicated healthcare staff review the important medical issues pertaining to youth during morning meetings, classification meetings, and meetings with the lead nurse and designated health authority (DHA). At all times, the privacy of the youth is taken in consideration not to use their names. Other areas of concern are posted in the nurse's area and area where the alert is an issue. All alerts which involve medical are entered in JJIS by nursing staff. Mental health issues are entered by the clinical director or facility administrator. All alerts are reviewed and adjusted as needed. Seven staff were interviewed and indicated each is informed of youth alerts including, mental health, medical, and security alerts.

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 has a written policy and procedures for record management. The program maintains individual records for case management, healthcare, and mental health and substance abuse. A review of five individual healthcare, five mental health and substance abuse, and five case management records were observed to have been marked "confidential." Youth records are secured in the respective program office inaccessible to youth and identifies the youth's name, Department identification number, and date of birth. The case management records are also labeled with additional youth information such as name, date of birth, committing offense, legal information, county of residence, and the assigned juvenile probation officer. In addition, the separate sections of the records were broken into demographic and chronological information, treatment team activities, correspondence, and a miscellaneous section.

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

The program has a student council to promote a formal process for youth to have constructive input regarding the program. Student council members are chosen by way of a youth voting process along with input from staff. Student council meetings are held quarterly, and address issues initiated by the youth in the program. Agendas, sign-in sheets, and minutes are maintained in a designated binder. A review of the binder verified meetings are held, as required. Youth can also utilize the Speak Out form system which allows the youth to share their thoughts and feelings about a specific issue within the program. The program also engages in town hall meetings with the youth at least monthly to discuss any issues with the program. An interview with the facility administrator (FA) indicated there are many ways for the youth to have input on issues which impact the community. One is the Request for Services form, and grievance forms if the request for service form does not meet the youth's desired outcomes. Another is when they are in formal and informal treatment team meetings. The youth are asked if they have any items which need to be addressed. The largest forum the youth have is the town hall meetings which are held at least once a month. Each youth is encouraged to share any issues and concerns along with suggestions to the staff. In addition, the Residential Advisory Council provides for a forum to formally solicit youth input. Five youth were interviewed, and each indicated the program has a student council board and hold town hall meetings for youth to provide input about what happens in the program.

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

The program established a community advisory board which meets quarterly to serve as a support to the program and a link to the community. The facility administrator (FA) solicits and maintains a collaborative partnership with the Department and local stakeholders in the community. Partnerships consist of letters of support, community service projects, participation

in community board meetings, and public service events. A review of the program's 2019 community advisory board roster consisted of education, faith community, medical, victim advocate, parents/guardians, judge, and law enforcement; however, none are committed members. A review of the advisory board agendas, minutes, and sign-in sheets for April 30, 2019 and September 25, 2019 verified meetings are held quarterly; however, only three recruited board members from the school board, faith community, and other community member attended the meetings. Documentation confirmed letters were forwarded to solicit law enforcement, judge, business, and a parent/guardian to attend the meetings but there was no follow-up documentation to confirm if the program contacted the prospective board members to verify their participation in any of the meetings. An informal interview with facility administrator (FA) indicated the program has actively solicited a law enforcement officer from the Fort. Lauderdale Police Department to become a member. A review of the visitor sign-in sheet indicated the officer visited the program on October 21, 2019. A letter was sent to inform the officer of the next meeting which is scheduled for December 13, 2019. During the annual compliance review week, the officer was contacted by the review team and it was stated they were unaware of their recruitment by the program. It was explained to the officer a notice was sent to them by the program on October 21, 2019; however, the officer stated he has not received an email or a hard copy letter referring to the meeting or recruitment. An interview with a prospective board member from the business community listed on the roster was contacted and indicated they conduct occasional business with the program but is not a member and does not care to be a member. An interview with the FA indicated advisory board meetings are held quarterly at the program. The board makes suggestions during the meeting and sometimes meet with the student council to find out what they would like to see different in the program and things which can be improved.

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 to establish and utilize effective channels of communication among the program staff, corporate leaders, other agencies, stakeholders, and between youth and staff. The program conducts shift briefings, monthly all staff meetings, daily management team meetings, and quarterly community advisory meetings to review and address pertinent information and follow up on program operations, health services, mental health services, case management, education, human resource, and support services. The program has employee of the month to recognize staff who demonstrate teamwork, leadership, and positive culture. The program also incorporates staff outings, monthly birthday celebrations, and team spirit Friday's when staff are allowed to wear their favorite athletic team shirt. The program has also developed a staff moral committee to create different ideas to reduce staff turnover and provide for a healthy work environment. An interview with the facility administrator (FA) indicated there has not been a significant amount of turnover since the last annual compliance review. Youth and parent/guardian surveys are conducted during visitation and upon the youth's release from the program. A review of the surveys found they included feedback for case management, mental health, food, and medical services. An interview with the FA indicated the information received from the youth and parent/guardian surveys are reviewed by the FA during manager meetings, all-staff meetings, and incorporated into the program's planning process. Five staff were interviewed, and stated meetings are held weekly, bi-monthly and monthly. The topics which are discussed in the meetings are safety and security, youth behavior, operations updates, behavioral management system (BMS), alerts, and drills. Five staff were interviewed and three stated they are briefed on the Comprehensive Accountability Reports (CAR), annual compliance reports, and youth and parent/guardian

survey reports. Two staff stated they were not briefed on the reports. An interview with the FA indicated the CAR report and any other report published by the Department are shared with staff through monthly staff meetings. The FA also indicated the program conduct daily morning meetings, monthly all-staff meetings and bi-weekly all staff meetings. Five staff were interviewed on how they believe the communication is amongst the staff in the program. Four staff stated communication is very good and one stated communication is poor.

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 to ensure all staff receive a written performance evaluation. New staff are evaluated the first ninety-days of completed work and yearly thereafter on their job performances. A review of five performance evaluations verified new staff are evaluated during the first ninety-days of employment and yearly thereafter. Staff are provided feedback on their job performance and allowed to comment. A review of program job descriptions indicated each specified the required qualifications, performance measures, and job duties to include the implementation of the behavior management system (BMS) and the delivery of specified interventions. A review of the program's contractual requirements indicated all specified key positions are filled and being performed as outlined in the job descriptions. An interview with the facility administrator (FA) indicated staff will be given the initial ninety-day probationary evaluation. When staff have successfully completed the evaluation period, they will then be given an annual evaluation around twelve months from the date they were hired. The evaluation will be performed by the staff's immediate supervisor and prior to reviewing the evaluation with the staff, the supervisor will get additional feedback form other department heads based on the role/responsibility of the staff. There is a section on the evaluation where the supervisor will also be responsible for creating goals on the evaluated as part of the staff's growth and development. Five staff were interviewed on how often they have a formal evaluation of their performance. Three stated yearly, and two stated monthly.

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

The program has a written policy and procedures regarding recreation and leisure activities. The activities are geared to provide a range of supervised and structured indoor and outdoor recreation activities for the youth and shall be based on the developmental levels and needs of the youth in the program, as well as youth input about their preferences and interests in various activities. According to the program's contract, the program is required to have a recreational therapist to provide treatment services and recreational activities to the youth by using a variety of techniques such as proper body mechanics, sports, music, arts and crafts, and community outings. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. A review of educational credentials reflected the recreational therapist holds a master's-level degree in recreation and sports management and has over five years of experience working with youth. The program maintains a monthly calendar of indoor and outdoor recreation activities for the youth targeted to promote team building and leadership skills. A review of the program's activity schedule and facility logbook documentation reflected recreation activity is provided each afternoon for one hour. Observations of recreation during the annual compliance review validated the activity listed on the recreational schedule was the

activity being performed. Further observations of recreational activities confirmed youth are provided with at least one hour of outdoor recreation a day. Recreational therapy activities are also incorporated into goals on each youth's individualized treatment plan. Each youth works with the recreational therapist to develop a wellness plan to achieve their desired goals while in the program. A random review of five youth treatment plans verified each had a wellness goal, as required. Five youth were interviewed, and each stated they are provided at least one hour of physical and leisure activity to include basketball, football, kickball, dominoes, cards, and board games. Five staff were interviewed, and stated youth receive a minimum of one hour of indoor and outdoor activity to include basketball, football, soccer, cards, board games, and watch television.

Standard 2: Assessment and Performance Plan

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

The program has written policy and procedures to notify a youth's parent/guardian by telephone, as well as in writing regarding each youth's admission into the program. The program's policy also identifies procedures to provide written notification to the youth's committing court judge and the juvenile probation officer (JPO) upon each youth's admission. Five youth case management records were reviewed, and each contained documentation indicating the youth's parent/guardian was notified by telephone within twenty-four hours and in writing within forty-eight hours of the youth's admission into the program. Five reviewed youth case management records also contained documentation indicating the JPO and the committing court judge were notified of the youth's admission into the program within the initial five-day time frame.

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

The program has written policy and procedures in place to ensure each youth is oriented to the program on the day of admission. An orientation checklist is used to explain and discuss the program rules, schedules, and services available. Youth are also provided a copy of the program's youth handbook which includes information regarding services available, program goals, expectations and responsibilities and rules of the youth, emergency procedures, daily schedules, room assignment, search policy including which items are considered contraband, visitation, grievance procedures, the behavior management system (BMS), dress code, hygiene practices, performance planning, how to access medical and mental health services, key staff and their roles, access to the Florida Abuse Hotline, and access to the Central Communications Center (CCC) for youth eighteen years of age or older. Each youth signs an acknowledgement form to indicate their receipt of the youth handbook. Five youth case management records were reviewed, and each record contained documentation indicating each youth received an orientation on the day of their admission, as well as a youth handbook with a copy of the signed acknowledgement form. There were no admissions during the annual compliance review. Five youth were interviewed and each stated they received an orientation within twenty-four hours of admission and was able to explain the orientation process.

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

The program has written policy and procedures to ensure written consent is obtained from youth eighteen years of age or older before providing or discussing the youth's physical and mental

health and/or substance abuse assessment and treatment with parent/guardian or any other interested party. Three of the five reviewed youth case management records were applicable for and contained a signed written consent for youth over the age of eighteen.

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

The program has written policy and procedures regarding a classification process to assign youth to a living and/or sleeping room on the day of admission. The program's policy also indicates procedures to reassess and/or reclassify youth to determine youth risk eligible for off-campus activities and to participation in work projects or other activities involving tools or instruments. The program utilizes a classification system to promote safety and security for which a youth's classification is determined by their individual and risk factors. Five youth case management records were reviewed, and each contained an admission classification form which identified physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, aggression, suicide risk, medical risk, escape risk, and security risk of each youth. A review of the Department's Juvenile Justice Information System (JJIS) confirmed alerts matched the identified alerts found and utilized during each youth's classification. Further review indicated room assignment was based on the youth's classification and each reviewed youth received a risk reassessment prior to participation in off-campus activities or participating in work detail which required the use of tools. Five reviewed youth case management records documented reclassification forms were routinely completed based upon a youth's behavior and assessments for activities on and off campus and tool use. The program maintains a continually updated internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth stay at the program. An interview with the facility administrator (FA) indicated at the time of a youth's admission, a classification meeting is held to gather information regarding a youth's risk. The information is shared with administration and a decision is made regarding room assignment. In some instances, during a youth's stay, room assignment may be changed due to interpersonal conflicts with peers.

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

The program has written policy and procedures to screen youth during the admission and classification process, to determine if they are a gang member or gang affiliated. Three of the five youth case management records were applicable for youth being documented as a gang member. In each applicable record, the program notified local law enforcement and the youth's home county law enforcement, in writing, of the youth's gang status. Each of the three reviewed records reflected the information was also shared with the youth's juvenile probation officer

(JPO), educational provider, after-care provider, and documented in the Department's Juvenile Justice Information System (JJIS) as an alert. Additionally, gang information pertaining to these three youth records was documented on the program's internal alert system, which is continually updated throughout the youth's stay in the program.

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

The program has written policy and procedures to ensure implementation of gang prevention and intervention strategies are provided when youth are identified as being a gang member or affiliated gang member. Youth are screened during the admission process to determine if he is associated with a gang or an active gang member. Any youth displaying gang signs, paraphernalia, slogans, participating in any gang-related activity to include flashing gang signs, wearing gang colors, tagging, recruitment, and/or promoting a gang lifestyle will be identified and addressed by administrative staff and the treatment team. The program utilizes the New Freedom/Phoenix and Impact of Crime (IOC) intervention groups as part of their gang prevention curriculum. Three of the five youth case management records were applicable for youth being documented as a gang member. Each of the applicable youth case management records were reviewed and identified goals were included in each performance plan relating to gang prevention/intervention. In each instance, the youth was given the opportunity to develop the plan. Further review of group sign-in sheets verified each of the five youth participated in gang prevention/intervention groups.

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

The program has written policy and procedures to ensure an assessment of each youth using the Residential Assessment for Youth (RAY) is completed within thirty days of admission and RAY reassessments are continuously completed in ninety-day intervals after completing the initial RAY assessment. Five reviewed youth case management records indicated each youth was assessed using the RAY within thirty days of admission and were complete in the Department's Juvenile Justice Information System (JJIS). Five case management records were applicable for RAY ninety-day reassessments. Five youth records documented RAY reassessments were completed in JJIS within ninety days of the initial RAY assessment. Five youth case management record were applicable for subsequent RAY ninety-day reassessments. Each reviewed case management record documented RAY reassessments were completed in JJIS; however, the subsequent reassessments were not completed within ninety days. The reassessments were completed forty-eight, forty-seven, thirty-one, thirty, and nineteen days late. All RAY assessments were maintained in the youth's confidential case management record. The program provided a training session to the case managers on October 26, 2019 to address deficiencies with updating the RAY.

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

The program has a written policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed on each youth in the program within the first thirty days of admission to the program. Five youth case management records were reviewed, and each contained a YNAS completed within thirty days of the youth's admission and were documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has written policy and procedures to ensure the intervention and treatment team members, including the youth, meet to develop a performance plan for each youth within thirty days of admission. Each performance plan goal shall specify target dates for completion, the youth's responsibilities to compete the goal, and the program's responsibilities to enable the youth to complete the goal. The plan shall be dated and signed by the youth, intervention and treatment team leader, the treatment team members, parent/guardian, if possible, and any other parties with significant responsibilities toward completing the goals. Five youth case management records were reviewed for performance plan development. Each reviewed individual performance plan was developed within thirty days of the youth's admission, contained measurable goals developed by the treatment team and the youth, identified court-ordered sanctions, contained a transition goal to address barriers for a successful release, included the responsibilities of the youth and staff, addressed the top three criminogenic needs, and identified target dates for completion. One youth individual performance plan was completed prior to the completion of the initial Residential Assessment for Youth (RAY). The case manager revised the individual performance plan (IPP) to include the RAY. In each reviewed performance plan, development of the plan involved the treatment team leader, youth, parent/guardian, administrative representative, living unit representative, treatment team staff, educational staff, Department of Children and Families (DCF) staff, when applicable, and was signed by all parties. Each reviewed case management record contained the original performance plan and a copy was provided to the youth. Five youth were interviewed on the treatment process. Each interviewed youth knew the program's treatment process including the development of their performance plan, knew the goals on their plan, and received a copy of their performance plan. Five youth case management records were reviewed for performance plan transmittal. Each of the reviewed case management records documented a copy of the

performance plan was sent to the youth's parent/guardians, juvenile probation officer (JPO), and committing court.

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

The program has written policy and procedures in place regarding revision of each youth's performance plan. The program's treatment team may revise a youth's performance plan at any time a new need is discovered based upon Residential Assessments for Youth (RAY) reassessment results, when the youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is reveled. Five case management records were reviewed and contained documentation of an individual performance plan update/revision. Each update reflected the RAY reassessment results, newly acquired/revealed information, changes in the top three criminogenic risk factors, and progress and/or lack of progress towards completion of the youth's performance plan goals. Two case management records had several goals on individual performance plans which either needed to be end dated or dates extended to offer the youth adequate time to complete the goals. Four youth case management records were in transition and the individual performance plans were updated during the last sixty days of the youth's stay to prepare for the release notice process.

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

The program has a written policy and procedures in place regarding the completion and transmittal of performance summaries for each youth at ninety-day intervals, beginning ninety days from the signing of the performance plan or at shorter intervals when requested by the committing court. Five case management records were reviewed and contained a performance summary completed within ninety days of signing the initial performance plan and addressed the youth's overall progress, academics, and behavior. Youth were able to add comments on the summary regarding their progress and each summary was signed by the youth, treatment team leader, and facility administrator (FA). Supporting documentation indicated each applicable record contained a transmittal verifying a copy of each performance summary was forwarded to the committing judge, parent/guardian, and assigned juvenile probation officer (JPO). Five case management records were reviewed and four were applicable for youth who were in transition. In each reviewed youth case management record, documentation verified the original performance summary was forwarded, along with the Pre-Release Notification (PRN), to the JPO within forty-five days of the youth's planned release. Case management records documented copies of the performance summary and PRN were also forwarded to the committing judge and the parent/guardian. Each reviewed youth case management record contained the signed performance summary and none of the summaries were requested to be

forwarded in shorter intervals. Five youth were interviewed and stated they received a copy of their performance summary.

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

The program has written policy and procedures to provide parental involvement in case management services. The program makes efforts to include the parent/guardian in the assessment process, progress reviews, formal treatment team meetings, and transition planning. If parents are unable to attend the meeting in person, they are afforded the opportunity to attend by way of telephone, video conference, or give verbal or written input prior to the meeting. Five youth case management records were reviewed, and each contained documentation advising the parent/guardian of the date and time of the performance plan development and treatment team meetings. Observations of two treatment team meetings during the annual compliance review indicated the parents/guardians attended the meetings by way of telephone and were involved in the case management process. An interview with the facility administrator (FA) indicated the program encourages parental involvement in case management process by inviting them to treatment team meeting, during visitation, family day, and family sessions. Five youth were interviewed and each state their parent/guardian is involved in the case management process.

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

The program has a written policy and procedures which indicate treatment team members who consist of representatives from all areas of the program with an identified treatment team leader. The treatment team members consist of the youth, parent/guardian, juvenile probation officer (JPO), direct care youth counselor, clinical director, a member from administration, a representative from education, mental health therapist, recreational therapist, and the applicable Department of Children and Families (DCF) case worker. Each representative must participate in the case management process to ensure coordinated services are provided to each youth in the program. Five youth case management records were reviewed, and each contained documentation indicating the required treatment team members actively participated in the case management process. Four youth were applicable for transition and in each instance, the transition case manager was in attendance. Documentation also confirmed each youth's JPO participated by way of telephone. Observations of two treatment team meetings during the annual compliance review week verified all members of the treatment team participated in the case management process.

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

The program has a written policy and procedures for the intervention and treatment team to reference and/or incorporate other treatment plans into the youth's individual performance plan.

Five reviewed youth case management records validated the coordination of the youth's individual performance plan with educational plans, wellness plan, career education plan, and multidisciplinary interventions to coincide with mental health and substance abuse treatment plans through the treatment team process. One case management record documented a foster care youth with no other plan pertaining to the Department of Children and Families (DCF) need and assessment while in the program; however, case management records documented ongoing participation from the DCF dependency case manager to include coordinating living arrangements/placements for the youth upon release from the program.

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

The program has a written policy and procedures to ensure the intervention and treatment team conduct formal and informal treatment team meetings. Formal treatment team meetings are held every thirty days and informal treatment team meetings are held bi-weekly to review youth performance to include the youth's progress on their individual performance plan goals, behavior, and individualized treatment plan, as well as to review their Residential Assessment for Youth (RAY) reassessment results. Based on a review of documentation, formal treatment team meetings included the treatment team leader, case manager, health services, mental health services, direct care staff, education staff, a representative from administration, youth, juvenile probation officer (JPO), and parent/guardian. A review of documentation determined informal treatment team members consisted of the treatment team leader, youth, and one other treatment team representative. Five youth case management records were reviewed and confirmed each youth had a formal treatment team meeting at least every thirty days and an informal treatment team meeting bi-weekly with the required participants. Each of the five reviewed case management records contained formal and informal treatment team meeting documentation to include the youth's name, date of review, meeting attendees, comments from treatment team members, brief synopsis of the youth's progress in the program, and performance plan revisions. The youth's JPO, parent/guardian, and other pertinent parties were notified by letter and/or email and encouraged to participate in person, by telephone, or provide verbal or written input prior to the meeting. An interview with the lead teacher indicated information is shared with the treatment team in the weekly teacher's meetings, all-staff meeting, treatment team meetings, emergency team meetings when warranted, and town hall meetings. Five youth were interviewed, and each indicated during treatment team meetings, they can demonstrate the skills they have learned while in the program. Observations of two formal treatment team meetings during the annual compliance review week confirmed the program's practice. The youth were provided the opportunity to demonstrate what they have learned in the program by oral presentation during the treatment team meeting.

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

The program offers education services through the Broward County School District. The program offers Type 2 vocational programming. Three closed youth records were reviewed, and each record contained a sample completed employment application, a résumé, an appointment

with Career Source Center, and appropriate documents needed to obtain employment. Documentation indicated the youth's parent/guardian and assigned juvenile probation officer (JPO) were informed of the youth's vocational plans at the time of their release from the program. The career education programing includes communication, interpersonal, and decision-making skills. The program offers career education services and assessments to include Test of Adult Basic Education (TABE) placement test, General Equivalency Diploma (GED), interviewing skills, fork-lift operator certification, culinary arts, ServSafe certification, horticultural classes, software skills, customer service skills, résumé writing, field trips, chess and debate teams, and college and career preparation certifications. During the annual compliance review week, the Broward County School District hosted a career day at the program. Youth were given the opportunity to engage in conversation and ask questions pertaining to the different career opportunities. An interview with the facility administrator (FA) indicated the youth at the program are exposed to the various field trips and guest speakers from diversified career paths. Youth are introduced to the field of construction with the use of the program's forklift simulator. Youth eighteen years of age or older are provided an opportunity to participate in the forklift class at McFatter Technical College to receive a three-year Forklift Certification.

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 educational programs operate on a year-round basis and youth are required to participate in educational and career-related programming for 250 days of instruction which are distributed over twelve months, for a minimum of twenty-five hours of instruction each week. An interview with the lead teacher indicated youth are in class Monday through Friday from 7:30 a.m. to 12:45 p.m. A review of the school's instructional schedule, coupled with the program's daily schedule and a review of the facility logbook, indicated the youth received the required 250 days of instruction. Further review of the school's instructional schedule indicated teachers used ten calendar days for professional development or training. While participating in the program's education programming, youth receive credits for the participation and completion of both the educational and vocational training programs. Five youth were interviewed, and each stated there is not a lot of interruptions during school.

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

A review of three closed youth records indicated each youth had an individual education transition plan to prepare youth to successfully function as a member of the community once released from the program. Each plan included education goals which were developed upon admission and identified key personnel related to transition services included the youth, parent/guardian, education representative, and post-release staff. Each of the three closed records contained a transition plan which was developed with the youth, program staff, education staff, and aftercare staff for continuation of education and/or obtaining employment. The education transition plan included services and interventions based on the youth's educational needs, educational placement and specific monitoring responsibilities by individuals responsible for the reintegration and coordination of the provision of services upon release from

the program. Each of the three closed youth records included provisions for continued education and/or employment and a sample employment application, résumé, State of Florida identification card, and an appointment with a CareerSource Center near the youth's residence where he will reside. The case management records included evidence the youth's case manager and parent/guardian were aware of the plan documents and post-release discharge plans. An interview with the lead teacher indicated the services and interventions are addressed in the development of the transitional plans include and Individual Educational Plans (IEP) for Exceptional Student Education (ESE) students. Intermediate Alternative Plans (IAP) are based on the youth's educational assessment. Other services include post-secondary planning, completing financial aid and college applications, and completing résumé for 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.*	

The program has a written policy and procedures to ensure the program has a transition planning process which establishes transition activities to facilitate a youth's successful release from a residential commitment program and reintegration into the community. A review of three closed records indicated a Community Re-Entry Team (CRT) meeting was held prior to the youth's target release date. Each reviewed record confirmed a conference was held within the required time frame. The intervention team for each of the three conferences included the treatment team leader, facility administrator (FA), and other team members who signed the transition conference forms. Written input was also provided by the mental health and medical staff. The youth's assigned juvenile probation officer (JPO), parent/guardian, and education staff were invited and either attended by telephone or in person. During the CRT meeting, the team reviewed transitions goals and identified additional goals, as needed, with targeted completion dates for the responsible party. Each reviewed plan was signed by all parties and filed within the case management records.

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

The program has a written policy and procedures regarding the exit conference and exit portfolio for each youth. Three closed youth records were reviewed and each included copies of the youth's State of Florida identification card, Social Security card, birth certificate, and education records. Each of the three records contained a community calendar which identified

follow-up appointments the youth are required to attend upon release from the program. All exit portfolio information was discussed and initiated for the youth during the transition conference and exit conference. Each youth received a copy of the exit conference upon release. A United States Postal Service mail receipt indicated the program forwarded the exit portfolio to the youth's assigned juvenile probation officer (JPO).

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

The program has a written policy and procedures to ensure an exit conference is conducted to coordinate release procedures and prepare the youth for re-entry back to the community. Three reviewed closed youth records indicated each youth had an exit conference was conducted after the program notified the assigned juvenile probation officer (JPO) and conducted within fourteen-days of the youth being released. Further review of the exit conference validated the required parties attended the exit conference either in person or by way of telephone. In each of the three instances the admission and release dates coincide with the dates entered in the Department's Juvenile Justice Information System (JJIS). An exit portfolio for each of the three youth was provided to assist with their released back into the community. The program also forwarded a copy of the exit portfolio information to the youth's assigned JPO and documented.

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 clinician (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is employed full-time by the program and is on-site at least forty hours a week. The DMHCA is also available twenty-four hours a day, seven days a week in the event of a mental health or substance abuse emergency. A review of the DMHCA's license found it to be clear and active, with an expiration date of March 31, 2021. An interview with the DMHCA reflected they are responsible for ensuring the timely and accurate completion of the required assessments, evaluations, and treatment plans. In addition, the DMHCA ensures the treatment programming at the program complies with all requirements outlined in the program's contract. The program will utilize the regional clinical director, who is also a LMHC to provide coverage in the absence of the DMHCA for the program. A review of the regional clinical director's license found it to be clear and active and does not expire until March 31, 2021.

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

The program has one licensed clinician who is the designated mental health clinician authority (DMHCA) for the program. The DMHCA, who is a licensed mental health clinician (LMHC), provides oversight to all treatment services offered within the program. The program will utilize the regional clinical director, who is a licensed mental health clinician (LMHC) to provide coverage in the absence of the DMHCA for the program. Each of their licenses are clear and active, and do not expire until March 31, 2021. The program also contracts with Professional Psychological Consultants, Inc. for the provision of services from a psychologist, when applicable. The psychologist assigned by the contractor has a clear and active license., which expires on May 31, 2020. The program has not utilized psychological services during this review period.

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

The program has a written policy and procedures to ensure mental health and substance abuse staff have the appropriate credentials. The program currently has three non-licensed clinicians who provide clinical services to youth in the program. There was another non-licensed clinician who provided services for program youth from May through August of 2019. Reviewed documentation reflected schedules were staggered to ensure the program had clinical staff present seven days a week. Each of the non-licensed mental clinicians hold master's-level degrees in a relevant field of study. The program was able to provide documentation of twenty hours on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services for each of the applicable non-licensed clinicians. The reviewed documentation also validated the administration of five Assessments of Suicide Risk (ASR) or Crisis Assessments conducted in the physical presence of a licensed mental health professional, which allows the non-licensed staff to conduct an ASR and prepare them for approval by a licensed clinician. A review of direct supervision logs confirmed non-licensed mental health clinical staff were provided with at least one hour on-site face-to-face direct supervision by the designated mental health clinician authority (DMHCA) each week they worked, with no exceptions.

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

The program has a written policy and procedures which explain the program's comprehensive screening process conducted for each youth during the admission process. A review of documentation confirmed the program followed the procedures outlined in the policy. During each youth's intake, a case manager completed a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) on each youth as part of their admission process. The reviewed documentation in all five records confirmed the assessment was completed on the day of admission by a case manager who was trained to complete the MAYSI-2 and was entered into the Department's Juvenile Justice Information System (JJIS). The program would use a paper copy to complete the MAYSI-2 if JJIS was not available. Reviewed documentation also confirmed all available information was also reviewed to ensure staff got a clear picture of the youth's history. This was documented in each youth's case management record. The review reflected a review of the following commitment packet information, when available: Department external comprehensive evaluations, the youth's Face Sheet (to include alert information), the Community Assessment Tool (CAT), and any other available assessments. Four of the youth's MAYSI-2s indicated a need for further assessment, and each youth was referred for further evaluation through the completion of a new Comprehensive Mental Health/Substance Abuse Bio-Psychosocial Evaluation. One youth had a "hit" on the MAYSI-2 in the category for suicide ideation; however, the program conducts an Assessment of Suicide Risk (ASR) on each youth as part of their admission to determine if there are any concerns which may not have been identified through completion of the MAYSI-2. Interviews with the facility administrator and

designated mental health clinician authority (DMHCA) confirmed the program's admission screening process.

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

The program has a written policy and procedures ensuring each youth will receive a new Comprehensive Mental Health/Substance Abuse Evaluation upon admission to the program. Four of the five reviewed youth mental health records included a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), which indicated a need for further assessment upon entry to the program. The remaining youth had no concerns identified on their MAYSI-2. Even though the youth had no concerns on their MAYSI-2, the program's practice is to complete a new Comprehensive Mental Health/Substance Abuse Evaluation on all youth admitted to the program. During the admission process, the clinician will also complete a Substance Abuse Subtle Screening Inventory (SASSI), a Beck Depression Inventory II (BDI), a Suicide Probability Scale (SPS), and a Trauma System Checklist. This information, in addition to recommendations from the initial diagnostic psychiatric evaluation, is used to assist in the completion of each youth's Comprehensive Mental Health/Substance Abuse Evaluation. Each of the five reviewed records had a new Comprehensive Mental Health/Substance Abuse Evaluation completed within twenty-one calendar days of admission, which is the program's practice. Three of the evaluations were completed by a non-licensed clinician, and each had a review by a licensed clinician within one day of completion. Each reviewed assessment included the methods of assessment, identifying information, screening procedures, presenting problem, family history, history of abuse/neglect/trauma, behavioral observations, physical health, developmental history, mental health, mental status exam, substance abuse history and treatment, social history, sexual history, vocational skills, independent living skills, strengths, needs, abilities, transitional planning, Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) diagnosis, summary of clinical impressions, and treatment recommendations. The results of the Comprehensive Mental Health/Substance Abuse Evaluation were used to help develop each youth's individualized treatment plan.

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

Each youth in the program is assigned to a treatment team on the day of admission to the program. A review five mental health records found a signed acknowledgement form which notified each youth which staff were assigned to their treatment team on their day of admission. The review of treatment team documentation confirmed the team consisted of all required members. Five youth records containing mental health and substance abuse daily service progress notes were reviewed. The progress notes were documented on a form which contained all the information found on the Department's Group Progress Note form. Each of the

five youth received services as set forth in their individualized treatment plan, without exception. One of the five youth had a copy of a properly executed Authorization for Evaluation and Treatment (AET) form found in their individual healthcare record (IHCR). Three of the youth were eighteen years old at the time of the review and did not require an AET, and one other youth was under the custody of the Department of Children and Families and had a court order which included their treatment needs. Each of the five reviewed records contained a signed Youth Consent for Substance Abuse Treatment form, and a signed Youth Consent for Release of Substance Abuse Treatment Records form.

The program has a valid Chapter 397 license, which allows the non-licensed staff to provide substance abuse treatment services under the direction of the DMHCA. A review of all five youth's mental health and substance abuse daily service progress notes, as well as group sign-in sheets, determined substance abuse groups had no more than fifteen youth present during any group sessions. Any mental health groups held by the program did not have more than ten youth participating in groups at one time. An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health and substance abuse treatment groups, family counseling, individual counseling, and psychosocial skills training. The DMHCA indicated treatment groups are conducted seven days a week, individual counseling occurs no less than once a month for each youth, and family counseling is scheduled monthly for each youth, at a minimum. All five interviewed youth indicated they attend group treatment. Specific group curriculums mentioned by the youth were Living in Balance, relapse prevention, Impact of Crime, Thinking for a Change, and anger management. All five interviewed staff indicated direct care staff do not facilitate mental health or substance abuse treatment groups.

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

The program has a written policy and procedures addressing treatment and discharge planning. Five youth mental health records were reviewed and contained an initial treatment plan which was completed on the day of admission. All plans were completed on a form which contained all the elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan sample form and were signed by all treatment team members. Three of the five plans were completed by a non-licensed clinician, and these plans were reviewed by the designated mental health clinician authority (DMHCA) the same day of completion.

All five records also contained an individualized treatment plan which was completed within thirty days of admission. Each reviewed plan was signed by the treatment team, to include the non-licensed clinician who prepared the plan, and a review by the DMHCA within two days of being reviewed and signed by the treatment team. These were completed on a form which had all required elements found on the Department's Individualized Mental Health/Substance Abuse

Treatment Plan sample form. The individualized treatment plans included any psychiatric services required, including psychotropic medications and the frequency of monitoring by the psychiatrist, when applicable. All five reviewed youth were applicable for the completion of individualized treatment plan reviews every thirty days. Each reviewed youth had treatment plan reviews completed every thirty days without exception and each youth's progress notes confirmed the youth received group, individual, and family counseling, as specified in their individualized treatment plans.

Three closed records were reviewed for youth released from the program. There was evidence the program had completed a Mental Health/Substance Abuse Discharge Summary in each reviewed record. The plans were discussed and finalized at the exit conference for each youth. Reviewed documentation confirmed these plans were mailed to the parent/guardian of the youth upon their release. The review of documentation also confirmed a copy of the Mental Health/Substance Abuse Discharge Summary was emailed to their assigned juvenile probation officer (JPO) within five days of each youth's release from the program. The reviewed documentation also confirmed each youth received a copy of their Mental Health/Substance Abuse Discharge Summary in their exit portfolio, which was provided to them upon their release from the program.

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

The program's contract with the Department requires the program to provide substance abuse treatment overlay services (SAOS). A review of five individual healthcare records confirmed the program conducts urinalysis screening on each youth at admission. Additionally, the program drug screens at least three youth randomly each month, as required by contract. The reviewed documentation found these random tests were conducted by case managers using rapid screening test cups. Tests were previously completed by nursing staff; however, the job duty was reassigned approximately one month ago. The program provides individual, group, and family counseling to all youth within the program. Substance abuse groups are provided to all youth seven days a week. The designated mental health clinician authority (DMHCA) is on-site forty or more hours a week, at least five days a week, which meets the requirement of a facility operating under Chapter 397. Clinical staff are on-site seven days a week based on a staggered schedule. Individual and family counseling is offered by the therapists, as designated in each youth's individualized treatment plan, which was found to be at a minimum, on a monthly basis for each youth. Most of the family sessions are conducted by way of telephone to ensure compliance with their plan requirements; however, family members are welcome to participate in person if they can make it to the program.

The program utilizes a psychiatrist to provide medication management and address any other issues which may arise. The program's contract and SAOS requirements indicate the psychiatrist must be on-site bi-weekly to provide services to the youth; however, their agreement with the psychiatrist is for weekly visits. The psychiatrist is also available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist is providing services through weekly on-site visits, with one exception when the psychiatrist was not on-site for one week when the program had to relocate due to an approaching hurricane. Youth with co-occurring mental health disorders receive mental health treatment through their individual sessions with their assigned therapist. The group counseling ratio does not exceed

one counselor to fifteen youth during group sessions, as confirmed through a review of group sign-in documentation and observations of a relapse prevention group during the annual compliance review. The therapist caseloads are limited to no more than twelve youth each when the program is at capacity which is in the acceptable range for youth receiving SAOS and treatment.

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

The program has a contract with a licensed medical doctor (MD) to provide psychiatric services. The psychiatrist's license is clear and active in the State of Florida, with an expiration date of January 31, 2020. The psychiatrist's backup is another MD, whose license is clear and active, with an expiration date of January 31, 2020. A review of five youth records revealed three of the youth were admitted on psychiatric medications. Program practice is for each youth, regardless of whether the youth requires psychotropic medications, to be referred to the psychiatrist for an initial diagnostic psychiatric interview. A review of five youth records confirmed each youth was seen by the psychiatrist within seven days of admission. Each initial psychiatric diagnostic interview was completed using the program's initial psychiatric evaluation form, which contained all required elements, and incorporated page three of the Department's Clinical Psychotropic Progress Note (CPPN) form. One youth was referred to the psychiatrist during their stay. The youth was seen within thirty days of the referral, and had a psychiatric evaluation completed by the psychiatrist which included page three of the CPPN. All required medication management appointments were completed monthly for each of the four applicable youth, with two minor exceptions. Two of the five youth were seen five days late for one of their monthly medication management appointments.

The program's contract to provide substance abuse treatment overlay services (SAOS) indicates the program must have a psychiatrist on-site bi-weekly to provide services to the youth. The agreement with the psychiatrist indicates the psychiatrist will provide services on a weekly basis, and will be available twenty-four hours a day, seven days a week. A review of psychiatric service logs found the psychiatrist was on-site every week during the previous six-month period, with one exception. The psychiatrist was not on-site for one week when the program had to relocate due to an approaching hurricane. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the psychiatrist validated they provide services weekly and are available for consultation twenty-four hours a day, seven days a week. The psychiatrist indicated there is good communication with the program, and a meeting with nursing staff, who are a member of the treatment team, is held during each weekly visit. A review of documentation found detailed progress notes provided by the clinical staff for review by the psychiatrist during their weekly visits. The interview also revealed the psychiatrist meets face-to-face with the designated mental health clinician authority (DMHCA) and facility administrator (FA) on a monthly basis to discuss how the program youth are progressing. The psychiatrist further indicated there are no concerns currently with the healthcare or other services provided 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 suicide prevention plan detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide in the least restrictive means possible. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process. All elements required by the Department's Administrative Rule were included in the plan. The plan was reviewed and signed by the facility administrator and the regional clinical director on August 21, 2019 to meet the annual review requirement.

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

The program has a suicide prevention plan in place which outlines the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors. A review of five youth mental health and substance abuse records found each youth was screened for suicide ideation during their admission to the program. One of the five reviewed youth had a "hit" for suicide ideation on the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2); however, it is the program's practice to conduct an Assessment of Suicide Risk (ASR) on each youth during the admission process, regardless of whether any suicide risk factors were identified. Each of the five youth were evaluated during admission, confirming the program's practice. Each of the four youth without "hits" on the MAYSI-2 had an ASR administered by a licensed clinician on the day of admission, and each youth was maintained on standard supervision. The youth with an identified concern was placed on precautionary observation (PO) until he was seen by a clinician. This youth was seen by a non-licensed clinician for completion of an ASR and was stepped down to standard supervision. An alert was found in the Department's Juvenile Justice Information System (JJIS) to reflect placement on PO. This same youth was placed on PO on two separate occasions during their time in the program. The program provided one additional record for another youth who was placed on PO two times during their time in the program. In each of the four examples of the two youth being placed on suicide precautions subsequent to admission, this placement was authorized by the designated mental health clinician authority (DMHCA). These placements were due to staff observation, verbalization from the youth, or concerns from clinical staff. The reviewed documentation found an ASR was completed within twenty-four hours of placement for three of the instances, and immediately when statements were verbalized by a youth to their clinician for the other instance.

Notification was made to the youth's parent/guardian and their assigned juvenile probation officer (JPO), when applicable. In the one applicable example in which the youth was maintained on supervision beyond the initial ASR, the youth was seen each day for a Follow-up ASR until the youth was stepped back to standard supervision. A review of documentation also reflected a conference with a licensed clinician, when the ASR was completed by a non-licensed clinician, and the facility administrator/designee prior to reducing the level of supervision in each instance. This was clearly documented on each reviewed form, and the DMHCA signed the form the next time they were on-site, when required. During these youth's heightened placement, their supervision was documented using Suicide Precaution Observation Logs and Close Supervision Logs. No lapses in supervision were seen on the reviewed logs.

The program does not use secure observation. The program has one suicide response kit which was located in the supervisor's area. The kit was found to include a knife-for-life, wire cutters, and needle nose pliers. Interviews were conducted with five staff regarding what they are responsible for if a youth expresses suicidal thoughts. All five indicated they would notify mental health staff, place the youth on constant sight and sound, and document their supervision. Four of the staff indicated they would search the youth and room for sharp objects. One staff also indicated they would have the youth write a statement about what they were feeling. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

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 review of five youth records found one youth had been placed on suicide precautions which required the completion of Suicide Precaution Observation Logs. One additional applicable youth record was provided and reviewed. There were ten Suicide Precautions Observation Logs available for review for these two youth. All logs were maintained for the duration the youth was on suicide precautions, and the staff documented the youth's behavior observations in real time at intervals which did not exceed thirty minutes. No warning signs were noted after each youth's initial placement on supervision. Each of the reviewed Suicide Precaution Observation Logs also had all required reviews by supervisory staff and clinicians. The program prints the logs on yellow paper for easy identification by staff. Informal interviews were conducted with the two youth who had been on suicide precautions during the review period. Both youth indicated staff were with them always during this placement, and they were never left alone while on suicide precautions.

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's suicide prevention plan which addresses suicide prevention training. A review of five staff pre-service and five in-service training records found each staff received at least six hours of suicide prevention training. The program's mock suicide drills were reviewed for the first three quarters of calendar year 2019. Each of the reviewed drills included the time of the drill, the designated shift, name of the staff who conducted the drill, the nature of the incident, persons involved/function of each, type of medical of care given, type of mental health/crisis intervention provided, the outcome of the incident, the time of response, and any follow-up or corrective action needed. The review found suicide prevention drills were completed all three quarters, on all three shifts, without exception. The scenario for the mock suicide drill on the second shift during the third quarter was not in response to a suicide attempt and/or self-injurious behavior. The drill was in response to a youth hearing voices. The designated mental health clinician authority (DMHCA) indicated an understanding of the Department's Rule requirement and would ensure all drill scenarios follow the requirements of the Administrative Rule moving forward. A review of the completed drills against the program staff roster showed twenty-two staff were applicable for participating in mock drills semi-annually during the three reviewed quarters. Documentation supported fifteen staff completed two or more drills in the last three quarters, two staff participated in three, and four staff participated in none. The review of medical drills confirmed the program's practice of including cardiopulmonary resuscitation (CPR) and/or the use of the automated external defibrillator (AED) on quarterly basis.

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

The program has a crisis intervention services plan which establishes the goal of responding to youth in crisis in the least restrictive method possible. This is done to protect the personal safety of the youth and others while maintaining control and safety of the program. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis. All elements required by the Department's Administrative Rule were included in the plan. The plan was reviewed and signed by the facility administrator and the regional clinical director on August 21, 2019 to meet the annual review requirement.

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.	

Five youth records were reviewed, and one was applicable for requiring a crisis assessment. The program was able to provide crisis assessment documentation for one additional youth who required a crisis assessment during their stay. The youth from the original sample required two separate crisis assessments during their stay. In each instance, the two youth were seen within two hours of being determined to be in crisis. Each assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, recommendations of treatment, supervision levels, and follow-up or further evaluation. The two youth were stepped down to standard supervision upon completion of the crisis assessment. In the third instance, the youth was maintained on mental health alert status after completion of their assessment. Their supervision was documented on a Mental Health Alert Log. The youth was stepped down to standard supervision after completion of a follow-up Mental Status Exam. All three assessments were either completed by a licensed clinician or a non-licensed clinician, followed by a review by a licensed clinician within the required twenty-four-hour period and notification to the parent/guardian. All procedures found within the program's Crisis Intervention Services Plan were followed.

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 detailed emergency care plan which addresses mental health and substance abuse emergency care. The plan was reviewed and signed by the facility administrator (FA) and the regional clinical director on August 21, 2019 to meet the annual review requirement. The plan contains all the required elements outlined in the Department's Rule which includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training, and the review of each incident.

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

The program did not utilize a Baker Act or Marchman Act procedures during 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 maintains a written policy and procedures ensuring a health authority responsible for the provision of healthcare services. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) and provides overall clinical healthcare services to youth at multiple Sequel TSI of Florida, LLC programs, with an automatic annual renewal. The program also had a cooperative working agreement with a licensed medical doctor (MD) as a back-up to provide service in the event the DHA is on scheduled leave, emergency services, and vacations. The program does not utilize an advance registered nurse practitioner/advance practice registered nurse or physician's assistant. The program's DHA holds an unrestricted clear and active license to practice medicine in the State of Florida with specialty training in pediatrics, with a license expiration date of January 31, 2020. The DHA is a current member of the American Board of Pediatrics and maintains certificate of insurance with an expiration date of April 1, 2020. The DHA is scheduled to be on-site weekly for two hours. Reviewed physician logs for the past six months validated the DHA was on-site weekly for two hours, with the exception of two weeks. The two weeks in which the DHA was not on-site, the back-up MD, who has an unrestricted license expiring January 31, 2020, with specialty training in internal medicine, covered for the DHA. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical medications. An interview with the DHA supported their role includes performing Comprehensive Physical Assessments, monitor sick call/episodic care, periodic evaluations, off-site care, and reviews healthcare policies and procedures and nursing protocols.

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

The program maintains a written policy and procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported the facility administrator signed all healthcare policies and procedures on August 2, 2019, and the DHA and the psychiatrist signed healthcare policies and procedures on August 14, 2019. The program had two full-time and one part-time registered nurses (RN). The program had one new part-time nursing staff since the last annual compliance review. Documentation confirmed the new nursing staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures by the RN. The program maintains a nursing protocol manual developed and approved by the DHA on August 1, 2019. Reviewed training records for nursing staff confirmed training on the treatment protocols and healthcare policies and procedures in August 2019. Treatment protocols were reviewed by the DHA on August 1, 2019 and remained effective without change to include admission standing orders, non-licensed

medical and emergency protocol guide, body mass index protocol, and approved first aid kit content and designee.

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 to address the completion of Authority for Evaluation and Treatment (AET). A review of five youth healthcare records found three youth who subsequently turned eighteen years of age while in the program had a copy of an AET. Once the youth turned eighteen years of age, each youth signed a Release of Information form. One youth was in the custody of the Department of Children and Families (DCF) and the record contained court orders to administer medical treatment. One youth was under the age of eighteen and had a copy of the AET. There were no original AETs reviewed. There were copies of completed parental notifications maintained behind the AET for the one youth under the age of eighteen. An interview with the program's nursing staff reported all youth arrived at the program with a signed AET. If the youth is in DCF custody and parental rights have been terminated relating to medical decisions, then the program staff would contact the DCF case manager to obtain a court order. In the event, the youth AET is older than one year or break in custody then a new AET is obtained.

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

The program maintains a written policy and procedures ensuring notification to the parent/guardian of any significant changes regarding the youth's condition and obtaining consent when new medications and treatments are prescribed. Five reviewed youth healthcare records supported three youth were eighteen years of age or older. None of the reviewed healthcare records found a parent/guardian consented for vaccination/immunizations were needed. None of the five reviewed healthcare records were applicable for significant changes to existing medication and changes in condition and/or medication for youth identified with chronic condition. There were two applicable youth records of parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notifications were sent. One reviewed youth healthcare record was applicable for off-site emergency care and additional records were requested. The program staff reported there were only two off-site emergency care incidents since the last annual compliance review and reviewed documentation supported the parents/guardians were notified. One youth was in the custody of the Department of Children and Families (DCF) and had a valid court order for treatment. All notifications were sent, and consents obtained by the DCF case manager. The program had two youth applicable for a psychotropic medication being initially prescribed, discontinued, and/or a significant dosage adjustment being made since the last annual compliance review. Each applicable record contained documentation of the program obtaining consent prior to administering psychotropic medications. One reviewed healthcare record documented a telephone consent conducted by the psychiatrist and witnessed by the nurse and the other had a valid court order for psychotropic medication. The parent/guardian received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Copies of all

correspondence was maintained in the applicable youth healthcare record. There were no applicable reviewed healthcare records of the parent/guardian not consenting due to religious reasons. Nursing interviews indicated parental notifications are written and mailed out for signature within twenty-four hours of the written order and verbal consent is obtained.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission. Also, the program's policy ensures a healthcare admission re-screening will be completed each time the physical custody of the youth changes and they are subsequently returned or re-admitted to the program. A review of five youth healthcare records confirmed each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). None of the five reviewed healthcare records were applicable for a change in custody. The RN reported there were only two healthcare records applicable for a change in custody since the last annual compliance review. Both additional applicable youth healthcare records were reviewed. Each youth received a re-screening on the day the youth returned to the program and the program utilizing the FEPHS form. Both youth re-screenings were completed by an RN. An interview with the nursing staff reported a FEPHS form is completed by an RN upon re-entry to the program. If a youth arrives after nursing hours, the shift supervisor will complete the FEPHS form and notify the designated health authority (DHA). The RN will then review the FEPHS form within twenty-four hours.

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

The program maintains a policy and procedures to ensure all youth admitted to the program are oriented to the program's healthcare services at the time of admission. A review of five youth healthcare records found each youth received healthcare orientation on the youth's day of admission. The healthcare topics included how to access sick call, what constitutes an emergency and when to notify staff, medications process, and how to notify staff if they are having side effects from medication. Youth also receive healthcare orientation on what to do in case of sexual assault or attempted sexual assault, non-disciplinary role of the healthcare providers, and the right to refuse care and how to document. A review of the posted healthcare contacts confirmed the list was accurate with the healthcare staff information.

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

The program has a written policy and procedures requiring the notification of the designated health authority (DHA) for all newly admitted youth with known or suspected chronic conditions. A review of five youth healthcare records found one was applicable. The other four reviewed records reflected the youth did not have a chronic condition or needed an emergency response.

The RN reported there were no other applicable healthcare records for youth admitted with known or suspected chronic conditions since the last annual compliance review. Documentation confirmed the registered nurse (RN) contacted the DHA to advise of the one newly admitted youth with known chronic conditions and to provide information on the youth's medical condition. The RN documented the DHA notification on the Chronological Progress Note and the form was filed in the nursing chronological notes section of the healthcare record. The youth was placed on the list to be seen on the DHA's next visit to the program. The one applicable youth admitted with known chronic conditions was not identified as in-need of emergency response.

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

The program maintains a written policy and procedures ensuring nursing staff complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA) or at the same time as the CPA. A review of five youth healthcare records found a new Health Related History (HRH) form was completed within seven days of each youth's admission. All five completed HRH forms were completed by a registered nurse (RN). Reviewed documentation supported the designated health authority (DHA) reviewed each HRH form and documented a review of the HRH form on the completed CPA. An interview with the registered nurse (RN) determined the RN completes the HRH form immediately upon arrival of each youth. The HRH form is reviewed by the DHA within seven days of the youth arrival to the program.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation and the Department's Comprehensive Physical Assessment (CPA) form is used for all youth admitted into the program. The program also maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth healthcare records validated each youth received a new CPA within seven days of the youth's admission. The program uses the Department's CPA form. All five CPAs were completed in full by the designated health authority (DHA) and each documented the current medical grade. All sections were marked with an "O", an "X", or a line indicating no need. All five reviewed healthcare records indicated no youth refused any portion of the medical examination. The Department's Problem List was updated, as required. An interview with the nursing staff reported the DHA will complete a new CPA on all new admission and annually thereafter. The program's written policy and procedures require the screening of infectious diseases, including tuberculosis (TB), be conducted prior to any youth being placed into the general population. As part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening which is conducted on the day of admission for each youth. The five reviewed youth healthcare records validated each youth had at least one verified tuberculin skin test (TST) within the last year documented on the CPA and on the Department's Infectious and Communicable Disease (ICD) form to determine exposure to TB. There were no current youth admitted to the program during the review period with symptoms suggestive of active TB.

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

The program maintains a written policy and procedures outlining admission screening and medical evaluations for sexually transmitted infections (STI) and ensuring all youth at risk for human immunodeficiency virus (HIV) are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, if needed. A review of five youth healthcare records confirmed each youth was screened for STI at the time of admission utilizing the Department's STI screening form. The STI tests were completed and results were documented on each youth's Infections and Communicable Disease (ICD) form. All five records indicated there was further testing required. Each youth was referred to the designated health authority (DHA), who then ordered additional testing. The screening was documented on the ICD form, and results from the testing were in the laboratory section of the healthcare record. Five reviewed youth healthcare records confirmed each youth was offered HIV testing and counseling. None of the five youth refused testing. All five youth tested were given pre-test and post-test counseling by the program's registered nurse (RN), who holds a current 500/501 HIV training certification. Test results were found in each record and filed in a sealed envelope marked "confidential." All five interviewed youth indicated they could ask for a HIV test, if needed.

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

The program maintains a written policy and procedures for sick call requests/complaints to ensure there is a system in place to respond to complaints of a youth illness or injury of a non-emergent nature. The program's practice is to have youth complete a sick call request utilizing the Sick Call Request form and submitting them in the wall-mounted locked boxes located in designated areas in the program. The program's registered nurse (RN) check the sick call box two times a day. The program offers youth the opportunity to make a sick call request, seven days a week, two times daily, conducted by the RN staff. Sick calls are conducted seven days a week Monday through Sunday, 10:00 a.m. and 5:00 p.m., and as-needed. When a licensed healthcare staff is not on-site, the shift supervisor is required to check the sick call box every two hours and contact the RN for any complaint. A licensed healthcare staff is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. The program currently has all shift supervisors trained on the sick call process. Five youth healthcare records were reviewed and reflected each youth completed a Sick Call Request form at least once during their stay. Documentation confirmed the RN conducted all five sick calls reviewed. Sick call treatment and services provided are documented on the Sick Call Request form and maintained in each youth's healthcare record. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. All sick calls were documented on the Department's Sick Call Index and on the Sick Call Referral Log. Observations of a sick call found the RN inquired with the youth as to the nature of the complaint. The youth provided verbal approval for the annual compliance review team

member to observe the process. The youth was provided privacy and was instructed to sit on the examination table while the RN interviewed and assessed the youth. The youth care worker waited outside the clinic near the door. The RN followed the required procedures and the youth's confidentiality was maintained. Three interviewed youth indicated they can see the nurse immediately and two reported within one day of submitting a sick call request. Five interviewed staff reported the sick calls are conducted by the nurse.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Also, the program's policy and procedures outline episodic and first aid care. The program maintains one automated external defibrillator (AED) located in the supervisor's station, near the medical clinic, activity room, and cafeteria. The program's suicide response kit contained a knife-for-life, needle nose pliers, and wire cutters and was located in the medical clinic and master control office inside a mounted box. The first aid kits are checked weekly by the registered nurse (RN) and are replenished as needed. The AED is checked weekly to ensure batteries and pads are in working order. Observations found the program had listings of emergency telephone numbers, to include the Poison Control Information Center, which are accessible to all staff, but not in a location accessible to the youth. In the event a youth requires first aid during the time a licensed healthcare staff is not on-site, all non-healthcare staff are trained and maintain current certifications to provide the appropriate first aid care. During the annual compliance review, four first aid kits were inspected to include the two for transportation, and each contained the required items. Five reviewed healthcare records found three youth had at least one episodic event. Reviewed documentation supported each contained the date and time of the episodic care, nature of the complaint, findings of the person rendering care, treatment rendered, and plans for follow-up care, when applicable. None of the episodic care events were conducted by a non-healthcare staff during this annual compliance review period. All episodic care events were consistently documented on the program's Episodic Care Log. The program's Continuity of Operations Plan (COOP) requires emergency drills be conducted, at least quarterly, on each shift. A review of emergency drills found the program conducted quarterly emergency drill for each shift in the past six months. A review of five youth interviews indicated youth see a dentist, should they experience a toothache and reported they are able to see a doctor, if needed. Five interviewed staff reported they could personally call 9-1-1 when a youth has been identified with a medical emergency.

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

The program has written policy and procedures outlining off-site care and referral to ensure youth receive episodic and emergency care. Five healthcare records were reviewed, of which two required an off-site visit for medical. The program's registered nurse (RN) reported there were only two off-site care records since the last annual compliance review. Both youth were eighteen years of age or older and did not provide consent for parental notification. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation supported the designated health

authority (DHA) reviewed each completed Summary of Off-Site Care Form and discharge paperwork, by initialing and dating all off-site care findings and discharge instructions. One youth required follow-up care. Documentation confirmed the youth received services as prescribed. An interview with nursing staff indicated the RNs track follow-up testing, referrals, and appointments.

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

The program maintains a written policy and procedures ensuring youth who have chronic illnesses receive regularly scheduled evaluations with the required follow-up. A review of five youth healthcare records indicated four youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. Each youth was classified with a medical grade of two through five. There were two youth currently undergoing treatments for physical health conditions which included a body mass index greater than thirty. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name and chronic condition. Reviewed records supported each youth received periodic evaluations as required and as-needed follow-up care. Reviewed documentation supported each youth received periodic evaluations and documented which were maintained in each youth healthcare record. On-site evaluations were documented in the chronological progress notes. A review of the supporting documentation indicated there were no lapses in care or any missed periodic evaluations. The Department's Problem List was updated in accordance with the Health Services Rule 63-M. An interview with the designated health authority (DHA) indicated chronic conditions were monitored at least every ninety days and sick calls/episodic care provided by nurses but escalated to the doctor are seen during the weekly visits. An interview with the nursing staff indicated youth identified with a chronic condition are placed on the medical tracker to ensure the DHA followed-up and the registered nurse documented in the Chronic Care Log.

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

The program maintains a written policy and procedures to ensure youth medications are verified upon arrival. A review of five youth healthcare records indicated three youth were admitted into the program on prescribed medication. Reviewed nursing admission notes and Facility Entry Physical Health Screenings documented the youth's current medications in each instance. Each designated health authority (DHA) Notification of Admission form documented current prescribed medication and verbal notification by telephone to continue medication was also received. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation supported all medications had a current, valid order, and were given pursuant to a current practitioner's order. The program does not utilize restrictive housing. The medication was administered in accordance with the approved protocols and physician's order. The program utilized the standard Department's Medication Administration Record (MAR) to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and an attached copy of

current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. All three reviewed MARs supported the youth received the medications, as prescribed. Each youth's MAR clearly documented medication start and stop dates. The program's registered nurses (RN) initialed the MAR for each administered medication entry. Three reviewed youth healthcare records found each youth had a MAR outlining over-the-counter medications (OTC) approved through the AET form, and when applicable, the medication was administered in accordance with the approved protocols and physician's order. Observations found all medications securely stored in the medical clinic inaccessible to youth. All controlled medications were stored in a separate, secure box located in a locked medication cart. Oral medications were not stored with injectable or topical medications. The program maintains a locked refrigerator for medications requiring refrigeration. Four interviewed youth reported the nurse provides medication and one reported did not take medications. Five interviewed staff reported the nursing staff provide medication to youth and if nursing staff not available trained supervisors can administrate medication.

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

The program maintains a written policy and procedures outlining medication/sharps inventory and storage and ensuring all medication is inaccessible to youth at the program. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter medications were available to shift supervisor for when a licensed healthcare staff is not on-site. Narcotics and other controlled medications are securely stored in the medication cart. The program practice is to store the controlled medications in a locked box located in the locked medication cart. There were two applicable youth with controlled medications during the annual compliance review period. Both youth controlled medications were counted with the registered nurses (RN) and the count matched the ending inventory number. Oral medications were not stored with injectable or topical medications. The program maintains a locked refrigerator for medications requiring refrigeration. There were no medications requiring refrigeration during the annual compliance review week. The program securely stored sharps and syringes separate from medications. Reviewed documentation and nursing interviews confirm all medications included over-the-counter (OTC) are inventoried weekly using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist's license expires December 31, 2020. The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the RN to send back all expired medication, unused medication, disposal of narcotics, and other controlled substances to the pharmacy at the end of the month for proper disposal. The medication is placed in a bag and documented on the Disposal Log and on the Controlled Medication Inventory Record. Observations conducted during the annual compliance review week confirmed three youth prescribed medications inventories were accurate. Three OTC medications and three sharps were reviewed, and the inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. An interview with the nursing staff reported all medications are stored in a locked medication cart, OTC medications in the medication cart has

a perpetual inventory and counted daily. In addition, OTC medications stored in the locked cabinet are counted weekly and as removed or added. Prescribed medication is counted daily.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) regulations, and guidelines. The plan was reviewed and approved by the facility administrator (FA) and designated health authority (DHA) on August 1, 2019. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist's agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. There were no instances in which the local health department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease or youth/staff needing to be quarantined. However, the program has procedures in place to maintain a separate record for any exposed youth and/or staff. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The plan includes risk assessment and methods of compliance. Interview with the program's FA indicated the program's Exposure Control Plan/Infection Control Plan is located in the medical clinic office and the plan is reviewed with all staff annually or as needed.

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

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

Standard 5: Safety and Security

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

The program has a clear and specific written policy and procedures addressing the supervision of youth. The program promotes safety and security by keeping active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system (BMS). Youth and staff observations were conducted each day throughout the annual compliance review week and reflected during class, lunch, recreation time, and movement, staff were positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Observations made throughout the week included youth movement from classroom to cafeteria, dormitory, and to the outdoor recreation area. Youth-to-staff ratios were observed to be compliant with the program's contract of one staff for every eight youth during awake hours and one staff to ten youth during sleep hours. Informal interviews were conducted with supervising staff each day and reflected staff were aware of how many youths they were supervising and understood the program's procedures when there is a discrepancy in youth counts.

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

The program has a written behavior management system (BMS) approved by the facility administrator (FA) on August 12, 2019, which has not changed since the last annual compliance review. The BMS is clear and specific, and included in the youth handbook and manual which offers a detailed explanation of the program's system, program rules, expectations and teach youth alternative prosocial methods of dealing with problems. A review of five youth case management records confirmed each youth was oriented upon admission through the program's youth handbook, which includes a detailed outline of the BMS. Reviewed documentation reflected each youth signed the youth handbook to acknowledge their receipt of the handbook upon admission into the program. A review of five pre-service training records and five in-service training records confirmed each staff was trained in the program's BMS. The program provided training and sign-in sheet documentation of staff members from the Broward County School District receiving training on the program's BMS. Monitoring of the BMS reflected the program has postings of the BMS posted throughout the facility which is accessible to all youth and staff. A review of the program's facility operating procedures, coupled with an interview with the program's FA, confirmed fidelity checks are used during daily and monthly staff and treatment team meetings to monitor rewards and consequences/punishments to

ensure rewards outnumber consequences at a minimum ratio of four-to-one positive to negative consequences. Five staff were interviewed and all five understood how the BMS should be implemented, the point system used by the program, and could explain what type of rewards are given to youth. Five youth were interviewed, and each reported rewards include later bedtimes, extra telephone time, snacks, canteen, games, movies, personal hygiene items, and verbal praise.

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

The program has a specific and clearly written policy and procedures on the behavior management system (BMS). The BMS provides for positive and negative consequences in a ratio of four-to-one positive to negative consequences. The program does not utilize room restriction as a form of imposing sanctions for inappropriate behavior. The system makes provisions for staff to explain to the youth the reason for any sanctions imposed, youth to explain their behavior, and gives staff and youth the opportunity to discuss the behavior's impact on others. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and constantly imposed. All program infractions are reflected on the applicable youth's daily point cards. The BMS is not used to increase a youth's length of stay. A formal interview with the assistant facility administrator (AFA) coupled with a sample of randomly selected staff position descriptions were reviewed and reflected they specified implementation of the BMS as a job requirement. Reviewed documentation confirmed staff receive an initial ninety-day performance evaluation followed by an annual evaluation thereafter which includes an evaluation of the staff's implementation of the BMS. The program's AFA reported the BMS is monitored in the program's monthly meetings and performance evaluations to ensure it is being administered fairly and consistently. Program management provides updates and feedback on the staff's use of rewards and consequences regarding the BMS when noticed, during staff meetings, and during shift briefings. Five staff were interviewed, and each stated their supervisors provide feedback to staff regarding the implementation of the BMS immediately or when learning about a situation. Five interviewed staff each confirmed rewards include, later bedtimes, extra telephone time, snacks, canteen, games, movies, personal hygiene items, and verbal praise. Five youth were interviewed, and each confirmed they are never allowed to punish another youth. When asked how they would rate the program's BMS, one youth rated it as fair, one youth rated it as very good, and three youth rated it as good.

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

The program has a written policy and procedures regarding ten-minute checks. All staff shall 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. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically. The program utilizes a Ten-Minute Check Log to document the checks while the youth are in their sleeping quarters. A formal interview was conducted with the assistant facility administrator (AFA) and confirmed the program is equipped with thirty digital cameras to aid in ensuring security and facility control. The video system can store video recordings for up to thirty-days. Reviewed documentation of the program's Ten-Minute Check Log reflected staff documented the actual time of the room check and initialed on the Ten-Minute Check Log Sheets verifying who completed the room check. A review of Ten-Minute Check Logs from six randomly selected days and times from two different shifts were reviewed and compared with corresponding video recordings. Reviewed documentation verified checks were conducted at least every ten minutes by staff with fidelity and were documented accordingly in real time. Five staff were interviewed and each confirmed room checks are conducted every ten minutes.

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

The program has a clear policy and procedures in place to ensure youth are always accounted for through a system of physical counts at various times throughout the day. The program conducts, and documents youth counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations. 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. The program documents counts in the facility logbook. According to the program's policy and informal interview with assistant facility administrator (AFA), staff are to conduct counts of youth throughout the day. If

at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between youth counts and census information, the program reconciles immediately and takes follow-up action, stops all movement, and conducts a recount. A review of the facility logbooks and observations verified counts are conducted and documented, as required. Five staff were interviewed, and each confirmed the importance of emergency counts and how often those counts must be performed, which aligned with the program's policy. Observed counts throughout the annual compliance review week when youth moved to classrooms, lunch, or restroom indicated the staff performed the counts, as required. A review of the Continuity of Operations Plan (COOP) also confirmed the program is in compliance with the approved policy and procedures.

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

The program has a clear and specific written policy and procedures for logbook entries. Staff maintain a daily bound logbook with numbered pages and all medical and mental health alerts are written in red ink. The logbook documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), Florida Abuse Hotline, and supervisors can leave special instructions pertaining to the supervision of youth. A review of the facility logbooks for the past six months indicated all errors were struck through but were not consistently initialed by the staff correcting the error. All entries included the dates and times of the events, with the names of the staff and youth involved, a brief description of the events, and the names and signatures of the staff making the entries.

Further review of the facility log book found inconsistent documentation of times and dates youth were placed on precautionary observation. The Department's Rule requires both beginning and ending times, in addition to status changes, to be documented in the facility logbook. A review of five youth records of youth who were placed on precautionary observation coupled with the corresponding logbook reflected the beginning placement status was found for only one of the five youth in the facility logbook. The logbook documented four separate instances the youth was placed on precautionary observation. The first entry was made by the shift supervisor in the section for youth on current placement at the beginning of the shift, and not in the section for youth with a change in status. The shift supervisor also indicated the youth was placed on close supervision, when the youth was actually on one-to-one supervision. There was a correction made in the logbook by the designated mental health clinical authority (DMHCA) and an additional note regarding instructions during placement; however, there was no time documented to reflect when this adjustment was made. There was also no documentation in the logbook to reflect the time when the youth was stepped down from close supervision to standard supervision. All subsequent shifts also reflected the incorrect level of placement being documented for the one youth. Corrections and notes were made by the DMHCA; however, documentation did not reflect when these adjustments were made. Additionally, the facility logbook entries for the other three instances failed to provide clear instructions to staff regarding instructions for supervision and monitoring. There were also incorrect designations made regarding the supervision status for the other instance. Four youth had no beginning or ending times entered for their supervision within the logbook for either of their placements on precautionary observation. The program's shift supervisors verbally brief

incoming staff about the contents of the shift report and incoming staff review and sign the shift report. A random review of the shift reports verified this practice. Observations of staff briefings and a review of the program shift reports verified information is shared with incoming staff prior to the beginning of the shift.

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

The program maintains a written policy and procedures outlining the key control system. The system in place governs the control and use of keys which includes key assignment, restrictions on usage, inventory, tracking of keys, secure storage of keys and procedures addressing missing or lost keys damage keys and replacements. The program maintains a Key Log which indicates the name of staff and what type of key they are to be assigned according to their position. Each key ring has a tag indication the number of keys on the ring and a key reference number which can be cross-referenced to the master key inventory. When staff arrived to work they will submit their personal keys and receive a facility key. Staff sign the Key Log before and at the end of each shift. Personal keys are placed in the key box. Medical staff, case managers, and therapists are issued restricted keys which are kept in a separate locked key box inside the administrative assistant's office. Permanent keys are assigned at the discretion of the facility administrator (FA). Any staff who are issued permanent keys are required to sign an acknowledgment form indicating the key identification number and the number of keys issued. Reviewed documentation of the current key inventory was compared with the keys in use and the inventory matched the actual keys in use. A random check of three staff indicated none had personal keys in their possession. Five staff were interviewed and knew the program's key control policy. An informal interview with the assistant facility administrator (AFA) reported the program has not have any lost or missing keys within the last six months. The AFA reported if a key is missing or lost the program will notify the shift supervisor or assistant facility administrator immediately, the incident will be document in the logbook and a replacement will be issued.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program maintains written policy and procedures to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, incoming mail and outgoing mail, and youth. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The list includes sharp objects, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coins, and non-facility issued keys. Youth receive a youth handbook upon their admission to the program. Youth are notified of the unauthorized and illegal contraband and the consequences of possessing contraband. During this annual review, the contraband policy did not address consequence for staff who are found in possession of contraband in the program. This information was brought to the program's attention and the policy was updated while on-site. Any contraband found is documented on an incident reporting form and in the facility logbook which includes the method of disposal. A review of the facility logbooks, daily search reports, and the safety perimeter check inspection reports for the past six months verified searches and facility checks are conducted daily on each shift. Any illegal contraband will be handed over to the local police department. An interview with the assistant facility administrator (AFA) determined discovery of unauthorized contraband is confiscated and either discarded, returned it to the original owner, mailed to the youth's home, or stored and returned to the youth upon their release. An interview with the facility administrator (FA) indicated staff are to follow their facility operating procedures (FOP) should illegal contraband be found staff are to notify the Department's Central Communications Center (CCC) and illegal contraband is handled and disposed of in consultation with law enforcement.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

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

The program maintains a written policy and procedures in place to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code. Observed

youth searches before and after groups, after transports, after education (when moving from school to dorm or other area of the building). Program practice is for all searches to be conducted by staff of the same gender as the youth. Observations confirmed searches were conducted by male staff. Staff gave instructions and explained the reason and the extent of the search. Five interviewed staff were aware of the process for conducting searches and when to conduct a search on youth. Five interviewed youth knew when visual and full body searches are conducted. Observations of searches and full body visual searches determined searches were conducted in accordance with the Department's Protective Action Response (PAR) training policy.

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

The program maintains a written policy and procedures for vehicles and vehicle maintenance, ensuring vehicles are operated in a safe manner. The program utilizes two vehicles to transport youth at the program. Reviewed documentation relating to both vans reflected both have up-to-date maintenance, insurance, and registration documentation. Reviewed documentation for van one confirmed an annual inspection was completed on August 20, 2019 and documentation for van two had its annual inspection completed in August 22, 2019. Observations of both vans reflected the vehicles are equipped with safety screens separating the front seat compartment from the passenger's compartment. All safety equipment was in each van including fire extinguisher, window punch, an approved first aid kit, and a seatbelt cutter. One transport was observed during the annual compliance review and there were no issues identified. During the week of the annual compliance review, the program transported three youth to a local hospital to take Halloween baskets to the children at the hospital. All passengers were secured in seatbelts. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles were locked when not in use.

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

The program maintains a written policy and procedures to ensure appropriate minimum staff-to-youth ratio for the safety and security of youth, staff, and the community when youth are transported outside of the facility. Reviewed documentation, combined with an interview with the assistant faciality administrator (AFA), confirmed the program has a minimum of two staff for each transport. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate staff vehicles. The program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted on all staff upon hire. If designated as a transport staff, these staff's driver's licenses are checked monthly by the human recourse department. The program has two vehicles used to transport youth. Observations of both vans reflected the vehicles are equipped with a safety screen separating the front seat compartment from the passenger's compartment All safety equipment

was in each van including fire extinguisher, window punch, an approved first aid kit, and a seatbelt cutter. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles are kept locked when not in use. An informal interview was conducted with the AFA, youth custody worker, and the recreational therapist who explained the practice of the staff-to-youth ratio of one staff to every five youth is always maintained along with wearing seatbelts during all transports. Five staff were interviewed and indicated a cellular telephone is provided during transport and personal vehicles are not used to transport youth. A daily practice of checking staff personal vehicles in the parking lot was conducted and at no time were any vehicles found unlocked.

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

The program has a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's assistant faciality administrator (AFA) or designee is responsible for conducting safety and security audits every seven days. The program's policy meets all the requirements of Florida Administrative Code. The program ensures there is a clear process regarding the identifications tracking deficiencies are addressed by the program. Reviewed documentation of invoices reflected the AFA utilized the Department's Facility Security Audit and Safety Inspections form to document the weekly completions of audits. Records reflected this practice was consistently completed for a period covering the past six months. A formal interview with the AFA, combined with reviewed documentation, confirmed the AFA reviewed all weekly Facility Security Audit and Safety Inspections forms.

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 ensure youth do not use tools or equipment as weapons or security breaches. The procedures also address the issuance, inventory, control of equipment and tools, and staff shall report any discrepancy to the assistant facility administer (AFA) or designee for immediate follow-up action. The program prohibited tools such as machetes, bowie knives, or any long blade knives. The program policy also addresses missing/lost tool procedures. According to the AFA, the program identifies the maintenance manager as the designated tool control manager. The maintenance manager replaces and disposes of tools, as needed. Observations of tools found each was securely stored when not in use, marked for easy identification, inventoried prior to being issued for work and at the end of work. The program conducts the inventory of tools daily. A review of the daily inventory logs for the past six months verified this practice. A random review of the tools indicated the tools being stored is listed on the inventory sheet. Observations made of the tool storage area indicated it was organized. Reviewed training documentation indicated staff and youth are trained on the safety of tools. Five interviewed youth each confirmed they use mops and brooms and one said the use of a scrub brush.

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 composed strategy and methods to ensure youth use tools safely and are supervised appropriately to prevent injuries to themselves, other youth, and staff. The program maintains strict control of secure storage and the purchase of tools and sensitive items. All tools and sensitive items are under the control of the maintenance manager. The program's policy requires a minimum ratio of one staff for every five youth during activities involving tools, except in the case of disciplinary work projects involving tools, which require a minimum ratio of one staff for every three youth. The program completes a risk assessment on each youth at the time of their admission, and every thirty days thereafter. Youth are prohibited from using class A tools. Five youth records were reviewed, and each contained risk assessments and updated risk assessments. Observations made during the week of the annual compliance review reflected one youth performing daily cleaning activities of sweeping the lunch room floor. The youth was monitored directly by staff and searched after completion of the detail. Five staff were interviewed, and all stated youth are only permitted to use scrub brushes, mops, and brooms under staff supervision. Five youth were interviewed, and all stated they may use mops, brooms, and scrub brushes only.

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 to address outside contractors, which stipulates when an outside repairman or worker enters the program to perform a work project requiring the use of tools, those tools are inventoried. When a contractor comes on campus, they are provided a contractor agreement outlining the inventory of tools being used, signing in, and example of items not allowed in the program. Personal cellular telephones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. A review of five randomly selected work invoices along with the corresponding visitors sign-in logs indicated each contractor signed in on the visitors log once on-site and completed the required contactor agreement from. The facility administrator (FA) or assistant facility administrator (AFA) are the only persons responsible for providing approval/permissions if such items are required.

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

The program has a Continuity of Operations Plan (COOP) which states emergency drills will be conducted at random times and under varied conditions. The COOP was approved by the Department on May 16, 2019. Drills are documented and contain the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A random sample of the program's fire and safety drill forms for the past six months were reviewed. Drills were performed on varied shifts and included all staff on duty. An interview with the assistant facility administrator (AFA) reflected fire drills and COOP drills are to be completed monthly for each shift and unannounced. Five staff were interviewed and all five stated they participate in fire

drills, while four responded they have participated in escape drills, two responded hostage situation drills, while three staff responded chemical drills, three staff responded weather drills and two staff responded in bomb threat. Five youth were interviewed, and all stated they knew what to do in the case of a fire.

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

The program has a written Continuity of Operations Plan (COOP) which includes a coordinated disaster plan. The plan provides for basic care and custody of youth in the event of an emergency or disaster, while ensuring safety of staff, youth and the public. The plan outlines a procedure whereby critical identifying information and a current photograph of all youth are easily accessible to verify a youth's identity as needed, during their stay in the program and in the event of an emergency evacuation. The plan was approved by the Department on May 16, 2019. The COOP is located in master control, supervisor stations, and in the assistant facility administrator (AFA) office. The program has identified the various location within the program where staff, youth, and visitors can easily access the plan. The COOP addresses phases of a disaster plan, as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing should the program have to be vacated due to an emergency or disaster. A review of the administrative hard-copy file included the youth name, a photograph, Department identification number, admission date, date of birth, gender, and race, name, address, and parent/guardian contact information of name, address, telephone number of the person with whom the youth resides, and their relationship to the youth, person(s) to notify in case of an emergency.

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

The program maintains a written policy and procedures to ensure youth do not deal with toxic, combustible, of harmful chemicals and materials. The program assistant facility administrator and maintenance manager maintain a monitor system to ensure compliance with flammable, poisonous and toxic items. All flammable materials are stored in a metal fireproof safety secured locker in shed/storage. Toxic materials are kept in a shed/storage room located outside the facility. The program maintains a list of all staff who are authorized to handle the materials. A safety data sheet (SDS) binder is located inside the storage area with a picture of each material corresponding to the SDS. The program maintains chemicals used daily in a locked storage area inside the facility. The program also has a chemical daily usage log used to track all toxic materials when in use by authorized staff. Any chemicals used are signed out. Observation of

the storage area indicated it is clearly marked hazardous chemicals, securely locked, and has a posted list of authorized staff.

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

The program maintains a written policy and procedures to ensure youth do not deal with toxic, combustible, of harmful chemicals and materials. The maintenance manager keeps strict control of flammable, poisonous, and toxic items and materials. Youth do not use, handle, or clean-up dangerous or hazardous chemicals. An informal interview with staff reported youth do not use, clean, or dispose of any bio hazardous material, bodily fluids, or human waste. An interview with the assistant facility administrator (AFA) and staff indicated youth are not permitted to handle any chemicals. Five youth were interviewed, and all stated they do not use any chemicals and/or cleaning products. A review of the program's preventive maintenance Checklist confirmed the maintenance schedules and repairs were conducted, as required.

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

The program has a written policy and procedures for disposal of flammable, toxic, caustic, and poisonous items. The program's maintenance manager, facility administer (FA), and the assistant facility administrator (AFA) are responsible for disposing of unused flammable, poisonous, toxic materials to a local household hazardous waste drop-off site when needed. The program's disposal procedures of chemicals were created to be in accordance with Occupational Safety and Health Administration (OSHA) standards. The program maintains a disposal log sheet to track the disposal of such items. All material in need of disposal are taken to Broward County Household Hazardous Waste station. A review of the disposal log sheets indicated the program has not had any chemicals disposed of in the past six months. The program has a procedure in place in the event of a chemical spill. If a chemical spill occurs, the shift supervisor is notified, and the ventilation air handler is shut down. If necessary assistance from outside the facility is contacted. An informal interview with the AFA confirmed the program has not had a chemical spill within the last six months.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures in place for youth to have visitation and communication while in the program. Youth are informed of visitation during admission. The program encourages visitation from the parents/guardians by sending out a welcome letter upon each youth's admission, notifying the days and time of visitation, who can visit, and the corresponding rules for visitation. Visitation is held three days a week on Saturdays and Sundays from 1:00 p.m. to 3:00 p.m. and on Wednesdays from 6:00 p.m. to 8:00 p.m. to ensure family members who work on the weekends have an opportunity to visit. A random review of the logbooks and visitation sign-in sheets verified the program allows visitation for approved family members. The program provides stamps, envelopes, and writing material to youth who wish to correspond with approved family members by writing letter. The program has a practice of searching incoming mail and outgoing mail in the presence of the youth. Observations of staff passing out mail to youth confirmed this practice. During the program tour, the visitation

schedules were posted in the main lobby, master control, and youth living area. Informal interviews with staff and youth confirmed the program also allows alternative visitation arrangements with parent or guardian; however, it must be approved by the facility administrator or (FA) or assistant facility administrator (AFA). Five youth were interviewed, and each stated they are given the opportunity to communicate with family members by mail, telephone, and during visitation.

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

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

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

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

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

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

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

The program has a clear and specific written policy to conduct an on-going safety planning process for each youth. The safety plan shall be designed to identify stimuli which have both positive and negative effects on the youth. An informal interview with assistant facility administrator (AFA) confirmed copies of the safety plan are located in the supervisor station and AFA's office. A review of five youth safety plans, which were developed during admission, contained all the required topic areas and recommendations from collateral sources, and previous clinical assessments, and were reviewed monthly during treatment team meetings. All youth safety plans included warning signs, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Further review of the plans indicated they were updated, as needed. A formal interview with the AFA determined all youth receive an initial safety plan within fourteen days of admission. Reviewed documentation of five youth safety plan confirm the program is compliant with updating the form every thirty-days. Five youth were interviewed, and each stated they were involved in the development of their safety plan.