STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Pompano Youth Treatment Center
Sequel TSI of Florida, LLC
(Contract Provider)
3090 North Powerline Road
Pompano Beach, Florida 33069

Review Date(s): February 5-8, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Gary Mogan, Office of Program Accountability, Lead Reviewer (Standard 3)
Jeffrey D. Barrett, Office of Program Accountability, Technical Assistance Specialist (SPEP)
Teves Bush, Office of Program Accountability, Regional Monitor (Youth and Staff Interviews)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 1)
Carol Hickman, TrueCore Behavioral Solutions, Regional Compliance Manager, (Standard 2)
Peter W. Keelan, DJJ Office of Education, Education Coordinator (Standard 2)
Gabriel Medina, Office of Program Accountability, Regional Monitor (Standard 4)
Shandria Striggles, DJJ Residential Services, Government Operations Consultant III (Standard 5)

Program Name: Pompano Youth Treatment Center
Provider Name: Sequel TSI of Florida,LLC.
Location: Broward County / Circuit 17
Review Date(s): February 5-8, 2019

MQI Program Code: 1290
Contract Number: 10112
Number of Beds: 24
Lead Reviewer Code: 149

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **2** # Case Managers
- **3** # Clinical Staff
- **1** # Food Service Personnel
- **3** # Healthcare Staff
- **NA** # Maintenance Personnel
- **3** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **2** # Other (listed by title): **Regional Director, Manny Alvarez, Sequel TSI**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Limited
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Failed
2.10	Performance Plan Revisions	Limited
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	Limited
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Failed
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	Limited
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The 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 mental health and substance abuse overlay services, case management services, healthcare services, gender-specific programming, psychiatric services as applicable, diagnostic evaluation services, educational services, and vocational services. In addition, the program fosters each youth by providing evidenced-based services through the Impact of Crime (IOC) curriculum, Thinking for a Change (T4C), New Freedom/Phoenix Resource delinquency intervention along with Talk's My Father Never Had, 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 clinical 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 all 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). In addition, the program has a licensed psychiatrist, psychologist, pharmacist, and a dietician to manage the food service. 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 Board in portable structures contained within the perimeter fence. At the time of the annual compliance review, the program had seven vacant positions; five youth care workers (YCW) , one maintenance staff, and one food service. The layout of the program includes a single secure structure with an electronic 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 spacious dining area in the main day room, medical clinic, and the administration office area and a conference room. The supervisor's and manager's offices are located outside of the secure area. Within the secure perimeter fence is a recreation area, with a basketball court, which allows space for youth to perform other large muscle activities such as football, soccer, or running. 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, only four cameras were operational. The program indicated due to technical issues affecting the video and recording capability, the camera system was not functioning properly.

Strengths and Innovative Approaches

- The horticulture program is based upon a youth progress in the behavior management system (BMS). Youth planted several types of vegetables, flowers, and plants for not only the value and reward of consuming the vegetables they grow but for the beautification of the outside area of the program. The program offers hands-on training and the identification, maintenance and growing of shrubs, flowers, and vegetables. Youth further learn the use of various tools and equipment unique to horticulture and landscaping.

- The program established various reward incentives for youth recognition such as the good citizen raffle, a monthly award ceremony, and a positive culture raffle and award. The youth provide input in the program through the resident advisory council, weekly town hall meetings, and weekly debate instruction. The program established an anti-bullying culture by having youth sign an anti-bullying contract. Youth participate in restorative justice and community service activities such as food drives, collect and donate toys to local shelters, and decorate Easter baskets which are donated to a local child's center.

- For personal benefit of the youth to apply a specific skill upon discharge, the program is participating in the Trauma Responsive and Caring Environment (TRACE) program, where youth become more aware and sensitive to the needs of those who suffer from trauma. Youth are also able to participate in cardiopulmonary resuscitation (CPR) training working towards earning a certification in this lifesaving procedure. The program has also been afforded the opportunity to team up with the Dan Marino Foundation (DMF) with the Virtual Interactive Training Agent (VITA) program. The virtual software and curriculum offers youth the opportunity to develop social skills to overcome barriers related to employment and to practice and refine job interviewing skills.

- The program established a partnership with a local fitness center to allow up to five youth at one time to visit the fitness center and take advantage of the exercise equipment. The recreation therapist incorporated this fitness regime on top of the usual large muscle activity youth are afforded daily.

Standard 1: Management Accountability

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

The program has a policy and procedures in place addressing the program's initial background screening requirements. A background screening is conducted for all Department employees, volunteers, contract provider, and grant recipient employees with access to youth. During the annual compliance review, eleven staff members records were reviewed for an initial background screening through the Department's Background Screening Unit (BSU). Each reviewed staff record had a background screening completed prior to their initial hire date. The program has two volunteers who were also cleared through the BSU. During this annual compliance review period, there were no exemptions granted by the Department prior to hiring staff who were rated ineligible for employment by the Department's Office of Inspector General (OIG). The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the OIG BSU on January 01, 2019, meeting the annual requirement.

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

The program has a policy and procedures in place maintaining the five-year rescreening requirement calculated from the agency hire date. During the annual compliance review period, there were no applicable staff, volunteers, or mentors eligible for a five-year rescreening. According to the business manager/human resource personnel, the program continues to monitor the upcoming screening due dates on an excel spreadsheet, which is reviewed monthly.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse.*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*

The program has a policy and procedures in place addressing the provision of an abuse-free environment for youth, staff, and others to feel safe and secure while not threatened by any form of abuse and/or harassment. During a tour of the program, the annual compliance review team observed the posting of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers. Reviewed documentation indicated all staff are required to adhere to a code of conduct. A review of five incidents reported since the last annual compliance review indicated one out of five was substantiated in relation to physical, psychological, emotional abuse. Five youth were interviewed and each stated they feel safe in the program and staff are respectful to youth. All youth responded they never had to place a call to report abuse and staff will allow them to place a call, if necessary. An interview with the facility administrator (FA) indicated the code of conduct represents a list of professional expectations for all employees. Five staff were interviewed and all five stated they are to notify their supervisor if a staff and/or a youth wants to call the Florida Abuse Hotline. All five staff further stated they are to notify the program director (PD) and then allow the youth and/or staff to place the call. Three of the five staff responded the supervisor makes the call. The program's operating procedure outlines youth are to have unimpeded access to call the Florida Abuse Hotline.

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 in place to address management's response to allegations of abuse. A review of five incident reports since the last annual compliance review reflected management took immediate action to address each of the incidents. Internal documentation identified applicable corrective action was taken by management for follow-up to allegations and substantiated incidents of abuse or neglect. An interview with the facility administrator (FA) added a progressive disciplinary process would be taken towards an

individual who violates the code of conduct by committing physical abuse, threats, or profanity towards youth. These actions include, but not limited to oral warnings, coaching notes, written disciplinary write ups, suspension, and terminations. The one substantiated incident related to physical, psychological, and emotional abuse led to the termination of the staff involved. Additionally, the FA reported all staff are trained during pre-service and annual in-service training on the process of making calls to the Florida Abuse Hotline. The calls are tracked and discussed during daily morning meetings, weekly management team meetings, and during monthly reporting process. They are also tracked on the weekly management reports submitted to corporate office.

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

The program has a written policy and procedures in place addressing incident reporting. When a reportable incident occurs, the program's practice is to notify the Department's Central Communications Center (CCC) within two hours of the incident. A review of five CCC incident reports found the program reported the incident within the two-hour time frame. A further review of the reports for the past six months to determine compliance with reporting procedures found the program did not experience an increase in the number of reportable incidents to the CCC from the same time frame as last year's annual compliance review. n interview with the facility administrator (FA) indicated staff follows the CCC reporting guidelines when required to report an 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 has a written policy and procedures in place to address Protective Action Response (PAR) and physical intervention rating in accordance with the Florida Administrative Code (FAC). However, A review of the program's PAR logbook for the last six months found no documentation to indicate staff used any physical intervention techniques such as countermoves, control techniques, takedowns, or application of mechanical restraints during the scope of the annual compliance review; however, an interview with the assistant facility administrator confirmed a PAR control technique was used in October 2018. An interview with the facility administrator (FA) reported PAR incidents are discussed during daily morning meetings and monthly reports which are submitted to the corporate office, and monthly trend analysis of all PAR related incidents. The program's PAR plan was approved by the Department on January 16, 2019. The program's PAR rate during the annual compliance review period was 0.25, which is below the statewide residential PAR rate of 1.47.

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

The program has a written policy and procedures to address pre-service training. The program has an orientation training plan approved by the Department's Office of Staff Development and Training on January 30, 2019. The pre-service training is conducted through the Department's Learning Management System (SkillPro) and instructor-led courses. Five staff training records were reviewed for pre-service and certification training. All reviewed records found each staff completed a minimum of 120 hours of pre-service training, instructor-led and web-based in the areas listed in Florida Administrative Code (FAC) 63H-2.003(1b) and completed the required essential skills for Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, professionalism, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA).

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

The program has a written policy and procedures to address in-service training where staff complete twenty-four hours of in-service trainings, including mandatory topics specified in the Florida Administrative Code (FAC) 63H each calendar year, and effective the year after pre-service/certification trainings are completed. Supervisory staff are further required to complete eight hours of supervisory training. The in-service training plan was submitted and approved by the Department's Office of Staff Development and Training on January 17, 2019. A review of seven staff training records confirmed staff completed the mandatory twenty-four hours of training. Supervisors received eight hours of annual training in management, leadership, personal accountability, employee relations, communication skills, and fiscal as part of the twenty-four hours required for all staff. Reviewed documentation verified the training instructor for the Protective Action Response (PAR) recertification requirement was qualified to provided training for PAR, first aid, and cardiopulmonary resuscitation (CPR). All completed training was documented in the Department's Learning Management System (SkillPro). It was reported, on occasion, the assistant facility administrator (AFA) and recreation therapist may supervise youth and may be considered into the youth-to-staff ratios. The AFA and the recreation therapist are both PAR certified. The Broward County School District teachers are not PAR certified and may not supervise youth without a direct care staff present.

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

The program has a written policy and procedures in place regarding the internal grievance process. All staff are trained on the youth grievance process and procedures during pre-service training. The grievance process is explained to the youth during orientation and grievance forms are placed throughout the program. A review of five applicable staff training records confirmed staff received the required training for the grievance process. The program's grievance process includes an informal phase, formal phase, and appeal phase to the facility administrator (FA) and/or designee. Five youth were interviewed and each indicated they are aware of the three phases of the grievance process. The youth further stated they may ask for and receive assistance when filling out the grievance forms. Five staff were interviewed and all five indicated they were aware of the steps in the grievance process. The FA confirmed staff understand the program's grievance process and the three phases the system is designed around. The program had one applicable grievance filed within the last six months. A review of the grievance confirmed staff followed the grievance process and the issue was resolved favorably as reflected by the youth's signature on the form. The program maintains a separate file of all grievances and findings for a period one year.

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

The program has a written policy and procedures regarding staff training and delinquency interventions. The program provides delinquency interventions through evidence-based practices. The program utilizes Thinking for a Change (T4C), New Freedom/Phoenix Resources, and Impact of Crime (IOC) as the delinquency intervention models with each youth placed in groups according to their identified individual needs. An interview with the facility administrator (FA) confirmed this practice and indicated the clinical director, assistant facility administrator (AFA), and the management team collaborate to ensure staff have the necessary experience, education, and skills when working with youth prior to assigning job duties. The FA further reported youth in the program are matched with staff, counselors, and case managers based on the pre-classification meeting. A review of five applicable staff training records ensured staff completed the appropriate training in specific interventions. The review of five applicable staff personnel records revealed staff have the appropriate education and work experience to provide specific interventions. Five youth records were reviewed and each confirmed youth were participating in an evidenced-based delinquency intervention, promising practice, or a practice with demonstrated effectiveness. A review of the program's activity schedule reflected youth are provided structured programming activities at least sixty percent of their awake hours. Documentation of group sign-in sheets confirmed delinquency interventions are being consistently delivered.

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

The program has a written policy and procedures in place to ensure staff provide interventions or instructions focusing on developing life and social skill competencies in youth. The program provided youth with life and social skills intervention services specifically addressing communications, interpersonal relationships and interactions, non-violent conflict resolutions, anger management, critical thinking, problem-solving, and decision-making. The program's activity schedule listed daily life skill groups. A review of group sign-in sheets verified youth involvement. A review of five staff training records confirmed three of the staff job duties include implementation of life skills training. Five youth records were reviewed and the youth are receiving services, as outlined in their individualized treatment and performance plan. Five youth interviews indicated they are offered opportunities to practice the skills learned in the groups. The youth gave examples such as learning how to better control their anger, learning better coping skills, and thinking first before reacting.

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 has a written policy and procedures in place to provide youth restorative justice awareness. The program provides activities to increase youth awareness of and empathy for crime victims and survivors, and increase personal accountability for youth's criminal actions and harm to others. Reviewed documentation substantiated the program teaches youth about the impact of crime on victims, their families, and their communities. The program also provided opportunities for youth to plan and participate in restitution activities intended to restore victims and by exposing youth to the victim's perspectives thorough victim speakers. The program previously had two cohorts of the curricula which took place for five sessions from July 31, 2018 through December 5, 2018 and from January 13, 2018 through February 25, 2018. There were no additional groups held during the annual compliance review period. Sign-in sheets confirmed the Impact of Crime (IOC) curriculum is being delivered as designed when comparing to the daily activity schedule. A review of three applicable staff training records confirmed staff completed the appropriate training to deliver the services. An interview with the facility administrator (FA) reported groups are held two times a week. Youth also participate in community services activities where they feed the homeless, make Easter baskets for a local woman's shelter, and help with local toy drives for children.

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

The program has a policy and procedures regarding gender-specific programming which designs its services and service delivery system based on the common characteristic of youth and responsivity to the interventions or treatment. The program is currently teaching parenting classes to applicable youth, utilizing the Parenting Wisely Program and Talks My Father Never Had with Me. An interview with the facility administrator (FA) reported all youth assigned to the

program participates in the evidence-based curriculum called Talks My Father Never Had with Me, which addresses the needs of the targeted youth gender group. A review of the program's activity schedule determined gender-specific programing is provided at least twice a week.

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 produces in place to address internal alerts and alerts in the Department's Juvenile Justice Information System (JJIS). The program uses an internal alert system easily accessible to program staff to keep them alert regarding youth who are a security, and/or a safety risk, youth with health-related concerns including food allergies, and special diets. When risk factors or special needs are identified during or after the classification process, the program immediately enters this information into the JJIS. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth alerts status. Reviewed documenting confirmed alerts are identified, updated and communicated to employees by the appropriate staff. Youth are screened and identified during the intake classification process for medical, mental health, and security issues. A review of the program's internal alert list matched all alerts for youth maintained in the Department's JJIS database. There were no noted discrepancies. Five interviewed staff indicated they were informed of the youth alerts during daily debriefings, and the alert board located in the program's assistant facility administrator's (AFAs) office and in the kitchen. An interview with the facility administrator (FA) indicated the program has an internal alert system which reflects all safety and security alerts in addition to medical, dietary, and mental health. The alert roster is updated daily by the medical department and circulated to all necessary parties.

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 in place addressing youth records. The program maintains an official case management , healthcare , and mental health and substance abuse record, each labeled as "confidential." Reviewed documentation verified each individual record was divided by separate file tabs. The front of each reviewed record contained the youth's name, Department identification number, date of birth, county of residence, and committing offense. Observations of the records confirmed official records are secured in a locked file cabinet marked "confidential" in a locked room.

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

The program has a written policy and procedures in place addressing youth input. The formal process the program utilize is through a youth advisory board and program surveys. Five youth were interviewed and each stated they have the opportunity to provide input into the program by the youth advisory aboard. An interview with the facility administrator (FA) reported they are conducting weekly meetings to obtain youth input to make recommendations for resolutions to improve conditions and enhance the quality of life for staff and youth in the program. The FA further reported youth provide input through the resident advisory council which meets at a minimum of once a month with upper level management. The program also has a Speak Out form system, which enables all youth to share their thoughts and feelings about a topic. The program has weekly town hall meetings which provide a forum for youth to provide input.

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

The program has a written policy and procedures in place for an advisory board. The program has a community support group and an advisory board meeting which meets at least quarterly. Reviewed documentation of sign-in sheets, agendas, and quarterly advisory board meeting minutes confirmed the program's participation. Meeting invite letters were mailed to the board and community advisory members of the scheduled meeting dates. An interview with the facility administrator (FA) confirmed the program actively solicits or recruit's community partners such as a judiciary representative, local school district, law enforcement, community and local business, victim, victim advocate, and religious and community outreach representatives. During the annual compliance review week, a board member listed on the active advisory board members was contacted by telephone. The board member operates a local engraving company who was reported to have conducted business for the program when engraving services were being sought by the program. When contacted by telephone, the individual denied being a board member. In addition, the provided list of community advisory board members listed a representative from law enforcement with the Broward Sheriff Office (BSO). The officer's signature was not present on the sign-in logs for the past twelve months. However, the officer listed was no longer employed with the BSO for the past eleven years and was promoted to the Chief of Police for the City of Fort Lauderdale in June 2008.

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 outlining the practice of recruiting, training, and maintaining staff. The facility administrator (FA) is responsible for providing staff information pertaining to program operation as well as providing an opportunity for staff to offer feedback and input in the staff meetings. According to the FA, formal staff meetings are conducted at a minimum of once a month. In special circumstances meetings may be organized on an as needed basis to review concerns and/or planning of special events. A review of supporting documentation for staff sign-in sheets and the agenda's validated meetings are taking place at a minimum of once a month as reported for the past six months. The FA adopted internal practices to help reduce staff turnover by addressing employee moral with an employee of the

month award, a positive culture award, peer recognition award of a gift card, staff appreciation ceremony, special meals and/or a barbeque prepared by management with a raffle for a television or electronic speakers provided by the corporate office. According to the FA, surveys are forwarded to parents/guardians for their feedback for possible improvements and suggestions. Five staff were interviewed and three responded staff meetings occur on a monthly basis, while two responded meetings take place weekly. Three staff replied they are provided with annual compliance reports, Comprehensive Accountability Reports (CAR), and parent/guardian surveys. Two staff responded they are not provided with such information. Staff interviews reflected information on the subject matter of the meetings which varied from policy and procedures, new admissions, upcoming events, dress code, training issues with youth, accolades for staff, positioning of staff, completing proper paperwork, and a review of the behavior management system (BMS).

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 in place regarding employment position descriptions specific to the job staff are hired including performance standards and evaluations. A review of five staff personnel records validated each contained a specific job position description outlining the title of the position, educational requirement, work schedule, position summary, essential function, skills, and abilities, and a requirement for staff regarding the implementation of the behavior management system (BMS). Delinquency interventions for the youth care worker (YCW) positions and other related positions working directly with youth also addressed the BMS. A review of five staff performance evaluations for ninety-days, six-months, and annual evaluations found all staff followed a twelve month calendar from the staff date of hire. A review of the provider's contract found the program was utilizing all staff positions as outlined including a full-time recreational therapist. An interview with the facility administrator (FA) indicated staff receives an annual evaluation from their direct supervisor on the anniversary of their hire date. The employee evaluation process rates staff on a variety of specific job functions.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures addressing parents/guardians should be notified by telephone within twenty-four hours and written notification to the parent/guardian or the Department of Children of Families (DCF) within forty-eight hours of a youth's admission into the program. The policy also has the assigned juvenile probation officer (JPO) and judge will be notified in writing within five-days of the youth's admission into the program. A review of five youth case management records found all five reviewed records reflected telephone notification were made within twenty-four hours of admission to either the parent/guardian and/or the DCF case manager, with written notification within forty-eight hours. The selection of five youth case management records further found all had written notification made to the JPO, post-residential services counselor, and the committing judge within the initial five-day time frame. One admission letter written to the DCF case manager reflected the incorrect youth's name in the body of the letter.

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

The program has a written policy and procedures addressing the formalized process for youth orientation to the program on the day of the youth's admission. The five reviewed youth case management records reflected each youth had orientation on the same day they were admitted to the program. Upon admission all received orientation of the daily schedule, expectations and responsibilities, overview of the program's behavioral management system (BMS), a copy of the youth handbook, availability of and access to mental and mental health services, access to the Florida Abuse Hotline, and a list of contraband including illegal and prohibited items. Each youth was also oriented to the performance planning process involving the development of goals, dress code and hygiene practices, procedures for visitation, anticipated length of stay and expectations for release to include successful completion of goals and objectives, community access, grievance process, emergency procedures to include evacuation drill procedures, physical design of the facility, and assignment to a living unit and treatment team. Five youth were interviewed and all five confirmed they participated in an orientation process within twenty-four hours of admission. The youth interviews further reflected the orientation process included program rules, procedures, schedules, and other pertinent information.

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

The program has a written policy and procedures to address obtaining consent for youth admitted to the program who is eighteen years of age at the time of admission or obtaining written consent on their eighteenth birthday as they proceed through the program. Three youth case management records were applicable. One youth was eighteen years of age at the time of admission and signed the written consent to release information form during the orientation process. Two additional youth signed upon their eighteenth birthday while in the program. The program's written consent of youth eighteen-years-old or older consent form did not provide the name or address of the person the information was being released to. The form did not provide an option for the youth to choose not to consent.

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

The program has a written policy and procedures identifying staff who assigns the youth's room placement. The current practice is a system to ensure the youth are placed appropriately and staff members are aware of the alerts and risks to consider at the time of the youth's admission. The initial classification form used by the program included areas of physical characteristics, age and maturity level, identified special needs, history of violence, applicable gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified or suspected suicide risk factors. Five reviewed youth case management records reflected each had an initial classification form present. A review of the Department's Juvenile Justice Information System (JJIS) alerts found there were instances where the youth had open alerts which were not included on the individual youth's initial classification form. There were three youth who had open medical alerts not addressed in the medical section or the alert section on the initial classification form. One alert was for psychotropic medications, one for double mattress for back pain, and one for a special diet. The program policy and procedures stated the facility administrator (FA) and education representative will attend the classification meeting; however, the review of five youth case management records found the participants were the transition service manager (who is the team lead), both case managers, and the mental health therapist. There was no evidence to indicate the FA along with an education representative attended the classification staffing. Reclassification forms were routinely completed based upon the youth's behavior and when room changes occurred. Reassessments for activities were present for all youth each month for on-campus tool use and activities. The program also utilizes an off-campus risk assessment for off campus activities.

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

Three youth were identified in the Department's Juvenile Justice Information System (JJIS) with gang alerts who were still residing at the program at the time of the annual compliance review. The youth case management records indicated each youth had notification made to both the local and home county law enforcement agencies at the time of intake. One of the three youth did not have an alert entered into JJIS until two months after the youth's intake into the program took place. Observations made throughout the week of the annual compliance review found the program was free of gang graffiti.

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 did not provide a specific policy addressing the interventions identifying the gang strategies to be utilized by the program but did provide the New Freedom/Phoenix Curricula for gang interventions with a total of twenty-one lessons. The program does utilize an assessment for gang identification. The program provided documentation indicating the current gang group cohort utilizing the New Freedom/Phoenix Curricula started on January 20, 2019. The program completed two groups since January 20, 2019 prior to the annual compliance review. All applicable youth individualized performance plans (IPP) included a goal for gang related intervention strategies.

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

The program had a written policy and procedures to address the utilization of the Residential Positive Achievement Change Tool (R-PACT) assessments and reassessments. A review of five youth case management records found all had the initial R-PACTS completed within the thirty-day time frame and were maintained in the Department's Juvenile Justice Information System (JJIS). The selection also required the R-PACT reassessments to be completed, all of which were completed within ninety-days from the initial R-PACT assessment. All assessments were maintained in the youth's confidential official case management record.

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

The program has a written policy and procedures to address the Youth Needs Assessment Summary (YNAS) for each youth to be completed within thirty-days of admission. A review of five youth case management records found each contained a YNAS. Four out of the five reviewed records reflected all but one had a YNAS completed within the required thirty-days of admission. All five YNAS were maintained in the Department's Juvenile Justice Information System (JJIS). One youth record did not have the YNAS marked as completed by a supervisor.

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

The program has a written policy and procedures addressing the individual performance plan (IPP), which shall be developed based upon the Residential Positive Achievement Change Tool (R-PACT) assessment along with completing the Youth Needs Assessment Summary (YNAS). The policy also addresses the IPP will be completed within thirty-days of the youth's admission and forwarded to the youth's parent/guardian and/or the Department of Children and Families (DCF) case manager, juvenile probation officer (JPO), and committing judge within ten-days. Five reviewed youth case management records reflected the IPP was developed by the treatment team members and youth within thirty-days of the youth's admission. Documentation further indicated each youth was provided a copy of their IPP. The transmittal letters reflected the IPP was sent to the parent/guardian or DCF case manager, JPO, and committing judge within the required ten-day time frame. The IPP addressed the time frames for the completion of goals, the person responsible to accomplish the goal, the frequency, and a target date for completion. The IPP addressed the youth would attend Impact of Crime (IOC) or Thinking for a Change (T4C) as a delinquency intervention. The youth requiring gang interventions did have a gang intervention outlined on the IPP. There were two youth records which did not address the top three criminogenic risk factors identified in the YNAS, without supporting documentation to reflect why they were not addressed. None of the five reviewed youth records addressed the targeted court ordered sanctions. The IPP had the same intervention in each reviewed youth plan giving the appearance each youth's IPP was not individualized. Further, the five youth records reviewed did not consistently address transition interventions for each goal. Two youth records were missing two goals with transition interventions, two youth were missing transition interventions for one goal and the last youth was missing transition interventions on five of the goals. The program did provide documentation to support the youth's IPP transition goals were

updated during the annual compliance review . Five youth were interviewed and four responded they were provided a copy of their IPP, while one youth responded they did not receive a copy. A follow-up question to the youth who responded as why they did not receive a copy of their IPP indicated the youth was unsure as to why.

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

A review of five youth case management records indicated four of the five youth individualized performance plans (IPP) required revisions based upon the outcome of their Residential Positive Achievement Change Tool (R-PACT) reassessments. All five reviewed youth records reflected multiple reassessments requiring revisions. One of the R-PACT reassessments completed for one youth did not require changes to be addressed in their IPP. The remaining four youth had a total of six reassessments in which the top three criminogenic risk factors changed and were not addressed with an updated IPP. Two of the selected youth records also required adjustments based upon behaviors which warranted adjustments to their IPP with either time frames being extended on the goals and objectives to afford the opportunity to practice the skill learned or with additional goals or interventions to address the displayed behaviors. The program did provide a coaching session which was delivered by the clinical director on January 18, 2019, to address the issue of updating the IPP with revisions.

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 to address the completion of performance summaries at ninety-days from the completion of the youth's individual performance plan (IPP) and the development of a release summary at least forty-five days prior to the youth's release from the program. The policy and procedures further outlined the performance summaries are distributed within ten days of completion. Four of the five case management records selected for review were applicable to have performance summaries completed with two youth requiring multiple performance summaries based upon their length of stay. The performance summaries were all completed in ninety-day increments and were all transmitted to the required parties within ten days of completion. The performance summaries reviewed the youth's status of each performance plan goal, overall treatment progress, grades, behavior, level of motivation/readiness to change, interaction with peers and staff, overall behavior adjustment to the program, negative and positive events, and the signature of the staff preparing the summary, treatment team leader, the facility administrator (FA) and/or designee, youth signature and date. Although it was reported by the case manager (CM), youth have the opportunity to review and add comments to the summary, none of the reviewed four records reflected youth comments. Two of the performance summaries maintained in the confidential

records were copies as opposed to the originals. There were five youth interviewed and four youth stated they received a copy of their performance summary while one youth responded they did not. However, case notes maintained in the youth records reflected all the summaries were given to the youth at the conclusion of the meeting. There were three release summaries reviewed and each was completed within forty-five days prior to the youth's release. There were two youth who did not have written notification to the youth's parent/guardian of planned release upon receipt of the approved Pre-Release Notification (PRN).

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

The program encourages and facilitates involvement of the youth's parent/guardian in the case management process through providing invitations to the participants by telephone or in written format for the individual performance plan (IPP) meeting, formal treatment teams, as well as transition and exit meetings. The program provides an opportunity at exit conference through survey monkey for the parent/guardian to provide feedback to the program. The program invites families to the graduation of youth whom attended school as well as quarterly family days. A review of five youth case management records reflected letters and/or e-mails, and telephone calls documented in the youth's case notes indicating program staff were making an effort to include the parent/guardian, the Department of Children and Families (DCF) case manager, and the juvenile probation officer (JPO) to participate in the treatment team meetings. The case notes documented the participation of the parents/guardians and to the extent of the involvement whether by telephone or other means. An interview with the facility administrator (FA) reflected parents/guardians are invited to participate in all treatment team meetings and is reinforced when case managers call the parents/guardians on a weekly basis. Parents/guardians receives written communication regarding their youth's progress and are always encouraged to participate in counseling sessions.

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 to identify the treatment team representatives and their respective responsibilities. The policy outlines the youth, the program administration (PA) and/or designee, the residential living unit staff or supervisor, therapist, case management, nurse, juvenile probation officer (JPO), education, youth care worker (YCW), and the clinical director are all responsible for providing or overseeing the provision of intervention and treatment services. Observations of treatment teams as well as a review of five youth case management records reflected all members of the treatment team signed off on the formal treatment teams, transition meetings, and exit conferences. Observation of three treatment team meetings found the recreation therapist was not in attendance for each meeting; however, provided written input as it related to each youth's progress in their treatment. The living unit representative did not provide verbal feedback during the three observed treatment team meetings; however, was present and actively engaged..

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 review of the program's written policy and procedures to address performance plans reflected staff are required to ensure inclusion of the individual mental health and substance abuse treatment plan and the youth's individual academic or exceptional plan in the individual performance plan (IPP). A review of five youth case management records validated the coordination of the youth IPP with educational goals, and multidisciplinary interventions through the treatment team process. The youth would work to complete their individual goals in cooperation with other disciplines within the program to include education, mental health, and substance abuse. Although the program had two youth in the custody of the Department of Children and Families (DCF) residing in the program at the time of the annual compliance review, it was reported by the case manager, DCF has not provided any supporting records such as a case and/or care plan.

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

The program has a written policy and procedures addressing the individual performance plan (IPP). The IPP is reviewed formally within the first thirty-days and every thirty-days, thereafter. The policy further addresses the youth's IPP is informally reviewed with the youth and case manager, biweekly. A review of five case management records found all reflected informal reviews occurring consistently biweekly and formal reviews were conducted regularly every thirty-days. The formal treatment teams had a cover page followed with an attachment detailing the input forms for all departments. With exception of the recreation therapist, all members were present during observation, although the recreation therapist still signed the sign-in sheets to indicate attendance after the meetings concluded. The recreation therapist did provide written input which was not reviewed during the treatment team meetings. All formal IPP reviews were found in the youth record inclusive of all signatures and reviewed all items to include the Residential Positive Achievement Change Tool (R-PACT) reassessment results, progress on the IPP plan goals, prioritized needs, positive and negative behavior, including behavior resulting in physical interventions. The program completed informal reviews, review of the youths' plan at least one time a month to include the case manager, and reviewed the progress and assignments of the IPP or each goal. The treatment team gave the youth the opportunity to demonstrate what they learned by oral presentation during the treatment team meeting. Reviewed documentation validated the juvenile probation officer (JPO) and parent/guardian were attempted to be contacted in each treatment team review either by telephone and or written notification. The invitation to the parent/guardian offered an opportunity for them to submit any recommendations back to the program by mail. Participation was included in the case notes and by signature on the treatment team signature page to reflect by telephone or

unable to contact updates. A review of the Department's Juvenile Justice Information System (JJIS) reflected all youth have an anticipated release date and is updated as the youth progressed with completion of goals. Five youth participated in an interview and four responded they are given an opportunity to demonstrate the skills learned in the program while one youth responded they were not given an opportunity. The follow-up question to the youth who responded they were not given a copy of his IPP resulted in an unsure response by the youth.

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

The program offers a Type 2 educational program which is conducted and supervised by the Broward County School District. The programming includes, but not limited to, instruction of interpersonal communication skills, decision making skills as well as literacy and financial awareness skills being both age and intellect appropriate to the targeted youth. This programming is aimed to create appropriate preparation and work habits for future successful employment. The youth with employability identified as a goal in their individualized performance plans (IPP) were introduced to and completed employment résumés and sample employment applications which were included in the youth's individual exit portfolios. Also included in the youth portfolios were copies of documents needed for actual employment, driver's license or a State of Florida identification card, a social security card, and a birth certificate. Prior to the release from the program, the transitioning youth receives a calendar of appointments which includes dates or appointments with the youth's assigned juvenile probation officer (JPO), a meeting with a representative of Career Source for introduction to employment services, a meeting with a representative from a transitional organization such as Project Bridge or Project Connect, as well as the medical or mental service organization, if needed. The youth's residential counselor, a representative from the education program, the youth's parent/guardian, and the youth's JPO are all fully aware of the youth's intentions and post-release goals. A review of documentation within three closed case management records confirmed the program practices.

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

The program requires youth 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. A review of the program's daily academic schedule documents the hours of instruction begins at 7:30 a.m. and concludes at 12:45 p.m., Monday through Friday. A review of the school's annual schedule indicated the youth are receiving the required 250 days of instruction and the teachers are able to use ten calendar days for professional development or training. While participating in the program's education programming, youth are able to receive credits for the participation and completion of both the educational and vocational training programs for the forklift simulator and the culinary arts programs. A review of the master control logbook and the youth interviews, it was evident the education program was following a formal schedule with minimal interruptions.

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

The program has a written policy and established procedures addressing the youth's transition and discharge. Three closed youth case management records were reviewed and each confirmed the youth had an individual education transition plan developed upon the youth's post-release goals. The services provided during the program stay and services, as well as interventions implemented upon release were identified within the plan. The educational transition plan incorporates each youth's goals to be completed in the program prior to release and recommended educational placement within the youth's home community. The plan also included specific monitoring responsibilities by clearly identifying individuals for the reintegration and coordination for the provision of support services. As part of preparing the youth for transition from the program, the education program involves the youth with employment as a transition goal, along with appropriate coaching in creating résumés, completing sample employment applications, and exploration of appropriate interviewing techniques. Three closed youth case management records were reviewed and all three indicated the completion of the required transition objectives, including the specific target dates, the individuals and their roles in meeting such goals. The recognition and acceptance of each individual plan included the signature of the youth, the youth's parent/guardian, a representative of the educational program, the transitional representative, the youth's juvenile probation officer (JPO), and other individuals directly involved with the youth's post-release guidance.

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 address transition meetings. The policy outlines a meeting will take place at least sixty-days prior to the individual youth's projected release from the program. A review of three closed youth case management records found all contained transition plans and chronological notes stating the case manager attended the community re-entry team meeting sixty-days prior to the youth's anticipated release date. The transition plans included supporting documentation the treatment team leader and facility administrator (FA) or designee were present at the meeting. There was documentation to support the other team members submitted their input prior to the conference. The transition goals were on the transition plan with targeted discharge dates and persons responsible identified. However, one youth did not have transition interventions included in their individual

performance plan (IPP) to carry over to their transition plan. The program did not consistently obtain the community re-entry team notification from the juvenile probation officer (JPO) as only one out of three reviewed records contained all the required items.

2.20 Exit Portfolio	Limited 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 initiated an exit portfolio during the transition meeting as indicated by a check box on the transition plan. The exit portfolios were also reviewed at the time of the exit conference as indicated by a check of "yes" or "no" on the exit conference form. Each youth signed they received a copy of their exit portfolio. A review of three applicable closed youth case management records found each had mail receipts indicating the youth records were sent back to the assigned juvenile probation officer (JPO). The records supporting information further reflected the education staff forwarded the exit information to the receiving school district unless the youth obtained their high school diploma at the exit conference. The portfolios contained transcripts showing the youth was enrolled in Customer Serve, a component of the culinary arts program and Blueprint Professional Success, along with each also having certificates for employability skills. The three closed youth records found the exit portfolios did not contain the required contents. Three youth were missing a State of Florida issued identification (ID) card, two youth were missing social security cards, all three youth were missing birth certificates, one was missing a calendar with dates/times and locations of upcoming appointments, and all three youth records did not contain the vocational certificates earned while in the program. Two of the three exit portfolios indicated the youth's exit portfolio was verified at the exit conference, and the third was not verified.

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 address exit conferences. A review of three applicable youth case management records found the program conducted an exit conference fourteen days prior to the youth's release documenting the dates and signatures of the individuals present and the names of those in attendance by telephone. The release dates were documented on the exit conference matched the information in the Department's Juvenile Justice Information System (JJIS) database. The exit plans did finalize items which were assigned at transition. The exit conference was held outside of the transition and community re-entry team meeting.

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 license mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA). A review of the DMHCA license indicated it was clear and active to practice in the State of Florida with an expiration date of March 31, 2019. The DMHCA is full-time, working Monday through Friday from 9:00 a.m. to 5:00 p.m. The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health and substance abuse overlay services at the program. An interview with the DMHCA indicated the responsibility of the DMHCA is for overseeing the quality of services provided at the program including fidelity checks of groups, supervision of clinical staff, facilitating training, making recommendations for youth expressing suicidal thoughts and/or crisis interventions. A review of the position description indicates the DMHCA acts as the program's mental health and substance abuse authority. The DMHCA provides at least one hour of clinical supervision each week for each of the three non-licensed mental health therapists, along with weekly supervision to the clinical staff. An interview with the DMHCA indicated the program offers mental health counseling and substance abuse overlay services. Services are provided through group counseling sessions and individual counseling sessions twice a month.

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 full-time licensed mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA). The program also has an independent contractor agreement with a State of Florida board-certified licensed psychiatrist. The psychiatrist is scheduled on-site for a minimum of two hours weekly and is on-call twenty-four-hours a day, seven days a week for consultation. The reviewed personnel records demonstrated the DMHCA and the psychiatrist works within the scope of their licensure, experience, and training. Reviewed documentation supported each licensed staff maintains a position description and/or agreement identifying the position expectations and essential functions. The DMHCA and the psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes to provide outpatient treatment substance abuse services with an expiration date of October 25, 2019.

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 three non-licensed therapists. Each of the three non-licensed therapists are master's-level with degrees in social work or human services, working under the direct supervision of the designated mental health clinician authority (DMHCA) and receives at least one hour of face-to-face direct supervision from the DMHCA each week. The reviewed documentation found the clinical supervision log included all required elements as outlined in Chapter 397, Florida Statutes. The form utilized by the program to document the direct supervision includes all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log (MHSA 019). The reviewed forms reflected the DMHCA review of the clinician's caseload, clinical services provided, documentation, comprehensive evaluation, miscellaneous directions, instructions, and recommendations. Training records for the three non-licensed staff validated each completed the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 022).

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 addressing each youth's mental health and substance abuse needs, which are identified through a comprehensive screening process. Immediately upon the youth's admission to the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. A key component of the initial intake process is the physical health screening conducted by the nursing staff. The Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) is subsequently administered by a trained staff member on the Department's Juvenile Justice Information System (JJIS). A review of five youth mental records found each indicated staff reviewed all available information included in each youth's commitment packet regarding mental health and substance abuse histories documenting the review on a records review form. The information collected identifies prior inpatient mental health and substance abuse treatment services, outpatient mental health and substance abuse treatment, treatment with psychotropic medications, emergency evaluations, suicide risk, self-injurious behaviors, drug and alcohol use or possession, emotional stability, history of significant trauma, and history of mental illness in the family. The form also identifies protective and risk factors. Each reviewed record indicated the therapist completing the forms signed and the licensed mental health therapists documented their review of the

information by signing the form. Reviewed documentation supported each youth received a MAYSI-2 on the day of admission which was completed in the JJIS. A review of staff training records validated each staff completing the MAYSI-2 were properly trained. It is the program's practice to conduct a further evaluation on each youth admitted regardless of the MAYSI-2 results. All five reviewed MAYSI-2 assessments supported each youth required a referral for further evaluation. No youth indicated an elevation in suicide risk; however, all five youth received an Assessment of Suicide Risk (ASR), as this is the program's practice for each youth to be assessed upon admission. All reviewed records contained the Youth Consent for Substance Abuse Treatment form which were obtained during the admission screening process. The youth were also provided information on client rights and responsibilities and on what a youth needs to know about sexual assault, harassment, and abuse. The youth and case manager signed the forms acknowledging the information was shared with the youth and the forms were filed in the mental health and substance abuse record. The youth were also provided a list of telephone contacts identifying the Florida Abuse Hotline, Department's Central Communications Center (CCC), Department of Children and Families (DCF), and the Rights Advocacy program. The program's practice is to assess each youth upon admission utilizing the ASR. All reviewed ASRs indicated each youth was placed on standard supervision. In addition to the MAYSI-2, each youth is assessed upon admission utilizing the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-2), Symptom Checklist-90R, and Beck Depression Inventory.

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 maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. As part of the evaluation process used to assist in the development of the youth's individualized treatment plan, a comprehensive mental health and substance abuse bio-psychosocial evaluation is completed. The bio-psychosocial evaluation is completed with the youth, the parent/guardian, if applicable the Department of Children and Families (DCF) family services counselor, and/or others involved in the youth's care. The comprehensive mental health and substance abuse services use emotional and behavioral functioning, social roles, and identify other areas impacting the youth's overall level of functioning. The youth's primary therapist is responsible for the completion of the bio-psychosocial evaluation and must be completed within thirty-days of the youth's admission. The evaluation can be expedited should a youth pose a safety risk to self, other youth, and/or staff. Each therapist completing a comprehensive mental health and substance abuse evaluation is trained to complete evaluations/assessments and the licensed mental health counselor (LMHC) verified the training completion and competency. The program's designated mental health clinician authority (DMHCA) is responsible for the review of each comprehensive mental health and substance abuse bio-psychosocial evaluation and indicate a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review. The DMHCA is also responsible to provide a diagnosis and sign the evaluation within ten-days of completion. A review of five youth mental health and substance abuse records found each youth had a mental health and substance abuse bio-psychosocial evaluation completed within the required thirty-day time frame. Each reviewed bio-psychosocial evaluation contained all required elements, as outlined in Florida Administrative Code 63N-1. All completed evaluations were

conducted by a LMHC or non-licensed master's-level clinician and was reviewed by the LMHC. The program is licensed through the DCF in accordance with Chapter 397.

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

The program has a written policy and procedures related to multidisciplinary intervention and treatment team. A review of five youth mental health and substance abuse records reflected each youth was assigned to a multidisciplinary treatment team upon admission. The multidisciplinary intervention and treatment team is comprised of the youth, the parent/guardian, the juvenile probation officer (JPO), case managers, case manager director, education staff, medical staff, and the residential living unit staff. A review of the youth progress notes indicated each reviewed youth received treatment services as indicated in their treatment plan. Observation of a treatment team meeting confirmed this practice. Each reviewed youth received mental health and substance abuse clinical services and had a properly executed Authority for Evaluation and Treatment (AET) stamped, "copy." Each youth also had a signed Youth Consent for Substance Abuse Treatment form, and a signed Consent for Release of Substance Abuse Treatment Record. Group attendance sheets confirmed group therapy for mental health is limited to ten or fewer youth and group therapy for substance abuse is limited to fifteen or fewer youth. Observation of groups confirmed this practice. All substance abuse groups are provided by therapists who are qualified to provide the groups based on their education. An interview with the designated mental health clinician authority (DMHCA) indicated the type of specialized services provided by the program are substance abuse treatment overlay services and mental health and substance abuse groups being provided daily. Five staff were interviewed and none of the youth care workers (YCW) were trained to facilitate mental health and/or substance abuse groups.

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

A review of five youth mental health and substance abuse records validated on the date of admission, each youth received an initial treatment plan, which included all the elements required, including psychiatric needs. Each initial treatment plan was signed and dated by the youth and all multidisciplinary treatment team members. Reviewed records further supported

each youth had an individualized treatment plan completed within thirty-days of admission. All reviewed plans where signed and dated by all treatment team members who participated in the development of the plan including the parent/guardian. In addition, the program staff consistently completed treatment plan reviews every thirty-days following the development of the individualize treatment plan. A review of three youth mental health and substance abuse closed records confirmed each had a mental health and substance abuse treatment discharge summary outlining ongoing services including any possible upcoming services needed for the daily maintenance of positive skills made for youth in the program, along with the continuum of treatment within the community. Reviewed documentation indicated each discharge summary was discussed with all the applicable parties, including the youth's parent/guardian and the assigned juvenile probation officer (JPO).

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 is contracted to provide comprehensive substance abuse overlay services to youth in the program. A review of five youth mental health and substance abuse records, along with an interview with the designated mental health clinical authority (DMHCA) confirmed the ongoing provision of the comprehensive clinical services for youth with a diagnosis of substance abuse and/or dependency. An interview with the facility administrator (FA) indicated youth receive substance abuse treatment services seven days a week. Services provided includes mental health and substance abuse evaluations, treatment planning, daily group therapy session, individual sessions which are conducted twice per month, monthly family therapy, substance abuse therapeutic activities, mental health crisis intervention, on-site weekly psychiatric services if applicable twenty-four hours a day, seven days a week crisis intervention, therapy services, and suicide prevention.

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.	

The program has an independent contract agreement with a license psychiatrist for the provision of psychiatric services to all applicable youth in the program. The psychiatrist is on-site weekly and provides psychiatric evaluations, medication management, and regular consultation with the program's designated mental health clinician authority (DMHCA). Reviewed logs and sign-in sheets supported the psychiatrist was on-site weekly, on Sundays. The psychiatrist is on-call for consultation twenty-four hours a day, seven days a week. A review of five youth records indicated three youth qualified for psychiatric services. An evaluation was completed by the psychiatrist and documented on the Department's Clinical Psychotropic Progress Note (CPPN). The psychiatrist also reviews and signs the youth treatment plans and review youth records who are prescribed a medication regimen. A review of documentation and observation of a treatment team meeting confirmed the psychiatrist is a part of the monthly treatment team meetings as evidenced by the signature of psychiatrist on the treatment plan signature page. An interview with the psychiatrist indicated there is a weekly meeting with the DMHCA and the facility administrator (FA) to communicate the youth's clinical information and treatment. A

review of five youth mental health and substance abuse records found three youth were referred at admission to the psychiatrist for evaluation. Youth on psychotropic medications are evaluated on a monthly basis. The psychiatrist also contacted each youth's parent/guardian to obtain permission or discuss issues, as needed. An interview with the psychiatrist confirmed this practice.

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

The program has a written policy and procedures regarding suicide prevention. The plan was reviewed and signed by the designated mental health clinical authority (DMHCA) on December 1, 2018. The program's plan detailed suicide prevention procedures, and included all required elements outlined in Florida Administrative Code 63N-1. The plan included referral process, communication, notification, documentation, immediate staff response and a review process. An interview with the facility administrator (FA) indicated mock drills including emergency response to suicide attempts are conducted monthly.

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.*	

A review of five youth mental health and substance abuse records indicated each youth were screened utilizing the Assessment of Suicide Risk (ASR) with one applicable youth being placed on precautionary observation (PO). The one applicable youth remained on constant supervision until a follow-up ASR. An ASR was conducted by a licensed staff and the youth was determined to be placed on close supervision and stepped down to standard supervision. Reviewed alerts indicated they were entered into the Department's Juvenile Justice Information System (JJIS) at the time the youth was placed on PO and removed when placed on standard supervision. A review of the program logbooks verified the information was documented to include the beginning and ending times the youth was placed on PO. The program does not utilize secure observation (SO). A review of the non-licensed staff training records confirmed the required twenty-four-hour training was completed along with the observation of five assessments. Five staff were interviewed and all indicated if a youth expresses suicidal thoughts they notify the designated mental health clinician authority (DMHCA), search youth and room, place youth on constant sight and sound supervision, and document the supervision. Four interviewed staff replied the program's suicide response kits are kept in medical and the supervisor's office, three responded they are kept in master control and one staff responded they are kept in the dormitory area.

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 one applicable youth mental health and substance abuse record during the annual compliance review period revealed the suicide precaution observation logs were maintained for the duration the youth was on suicide precautions. There were no applicable warning signs documented. All suicide precaution logs were reviewed and signed by each shift supervisor and mental health clinical staff. All suicide precaution logs were in compliance with the documentation of the safe housing requirements. During the annual compliance review, there were no youth being observed 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.	

A review of five staff training records found each staff member received a minimum of six hours of annual training in suicide prevention and implementation of suicide precautions. The program provided suicide prevention training to every new employee and annually, thereafter. The suicide training is documented in the Department's Learning Management System (SkillPro). A review of the documentation reflected staff receive pre-service and in-service instructor led suicide prevention training including mock suicide drills. A review of the mock drills log indicated the program conducted quarterly drills on each shift in accordance with their continuity of operations plan (COOP) plan requirement and provided follow-up training for staff who were not present for the quarterly drills were provided follow-up training as evidenced by supporting records maintained in the suicide prevention training notebook.

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

The program has a written policy and procedures to respond to youth in crisis in the least restrictive methods possible. The program maintains a written crisis intervention plan which was reviewed and signed by the designated mental health authority (DMHCA) on February 7, 2019. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, youth self-referrals, communication, supervision, documentation and review process. It is the practice of the program to immediately refer youth to the mental health clinical staff for crisis intervention assessment, counseling, and any youth demonstrating acute emotional, psychological distress or behavioral issues.

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

The program has a written policy and procedures to assess youth in crisis. A review of five youth mental health and substance abuse records found none were applicable for crisis assessments. The program did not have any applicable youth for crisis assessment since the last annual compliance review. The program has internal procedures addressing crisis assessments. The program utilizes the Department's Crisis Assessment (MHSA 023) form pursuant to Rule 63N-1 to conduct crisis assessments. The assessments are inclusive of the reason for the assessments, mental status examination and interview, determination of danger to self or others, initial clinician impressions, supervision recommendations, treatment recommendations, follow-up or further evaluation, and notification to the parent/guardian of follow-up treatment. The program's protocol for crisis assessment is conducted by a license mental health professional or by a non-license mental health clinical staff working under the supervision of a licensed mental health professional. The program's designated mental health clinician authority (DMHCA) and the facility administrator (FA) are notified of the crisis assessment for concurrence or non-concurrence of the mental health crisis alert placement and level of supervision.

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

The program has a written policy and procedures in place regarding youth in need of emergency mental health and substance abuse services. A review of the program's emergency care plan indicated the plan was approved and signed by the facility administrator (FA), designated mental health clinician authority (DMHCA), and the corporate officer on December 11, 2018. The plan contained all the elements required by Florida Administrative Code 63E-7 and 63N-1. An interview with the DMHCA indicated there were no youth applicable for emergency mental health and/or substance abuse services for this review period. The plan outlined transport for non- emergency mental health evaluation and treatment as well as emergency substance abuse assessment. Joe DiMaggio Children's Hospital in Hollywood, Florida is identified as the receiving facility. For all emergency situations the emergency medical services (EMS) 9-1-1 number is to be utilized. The plan also indicated all staff are certified in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). A review of five staff training records verified first aid, CPR, and AED training was provided and completed as outlined.

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

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

Standard 4: Health Services

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

The program has policy and procedures in place regarding the designated health authority (DHA) which was approved, signed and dated by the facility administrator (FA) and the DHA on January 22, 2018. The program maintains an agreement for professional services with a physician licensed in the State of Florida. The DHA holds an unrestricted license and meets all requirements for independent and unsupervised medical practice. The DHA is responsible for the overall clinical healthcare services provided to youth in the program. The medical doctor's education and specialty training is in pediatric emergency care medicine. The DHA is scheduled to be on-site, two hours each week. A review of the sign-in and out logs validated the DHA was on-site weekly, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. At no time was there more than nine days passing between on-site visits. According to the agreement for professional services, the DHA is on-call twenty-four hours a day, seven days a week for consultations or emergencies and is responsible for communication with the nursing staff regarding youth medical needs. An interview with the DHA confirmed their role in the coordination and implementation of the program's medical services. The program also maintains a separate agreement with a State of Florida licensed medical doctor to serve as a backup when the DHA is on scheduled absences or vacation. The back-up medical license was reviewed and found active and in good standing with a background in internal medicine with an expiration date of January 31, 2020. Reviewed documentation supported the DHA and back-up medical doctor maintain current certificates of liability insurance. The program also maintains an agreement for professional services with a State of Florida licensed psychiatrist who provides psychiatric services to youth including the prescription of psychotropic medications. In addition, the program maintains an agreement for professional services with a dentist to provide comprehensive dental services to youth and another agreement for professional services with a State of Florida licensed optometrist who provide eye care services to the youth.

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 facility operating procedures (FOPs) for all health-related procedures and protocols utilized. The program's facility administrator (FA) conducted a review of all health-related policies and procedures on December 4, 2018. The previous FA conducted a review on January 22, 2018. Reviewed documentation supported the DHA signed all healthcare policies and procedures on January 22, 2018. A review of the policy and procedures for psychiatric services found the psychiatrist approved and signed on January 28, 2018. The program maintains a training requirement whereby all healthcare and program staff will have access to the health-related FOPs. Nursing staff sign and date a cover page of all FOPs, treatment protocols, and other procedures. New policies or changes in policies made during the year are reviewed, signed, and dated by each member of the nursing team. A review of the documentation confirmed the DHA and both registered nurses (RNs) signed the FOP acknowledgement form. The program maintains a nursing protocol manual developed and approved by the DHA on January 3, 2019. Reviewed training records for the nursing staff

supported the staff completed training on the treatment protocols in January 16, 2019. There were no new healthcare personnel in the program since the last annual compliance review. All program policies, procedures, and protocols ensure they outline the healthcare services provided.

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 written policy and procedures in place regarding the Authority for Evaluation and Treatment (AET) form. Each youth must have an AET form signed by the parent or legal guardian who serves as informed consent for non-invasive medical procedures or for minor ailments requiring over-the-counter (OTC) medications which can be treatment by healthcare staff. A review of five youth individual healthcare records (IHCRs) revealed three contained a copy of the AET and two youth in the custody or the Florida Department of Children and Families (DCF) contained court orders to administer medical treatment. The three reviewed AETs were not an original; however, the word “Copy” was clearly stamped on the AETs. Each reviewed AET and/or release of information form was filed in each youth’s IHCR in the appropriate section. In three additional applicable records reviewed, the program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the form and to whom the information can be released.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth’s condition and to obtain consent when new medications and treatments are prescribed. A review of five youth individual healthcare records (IHCRs) indicated all parental notifications were completed when required and in four cases the parent/guardian were notified for over-the-counter (OTC) medicines beyond those covered by the AET. Two youth were in the custody of the Department of Children and Families (DCF). There was one applicable reviewed healthcare record of a youth requiring off-site emergency care. The reviewed documentation supported the parent/guardian was notified. In the two records of the youth in the custody of the DCF, the court provided the appropriate court order for the youth to receive treatment while in the program.

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

The program maintains a written policy and procedures ensuring the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of five youth individual healthcare records (IHCRs) validated two youth were prescribed psychotropic medications. A review of both applicable youth healthcare records found the parents/guardians were notified of psychotropic medication changes through the Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN). The program’s policy indicates parental consent shall be obtained prior to the initiation of new psychotropic

medications and/or changes in a psychotropic medication regimen. All efforts to contact the parent/guardian is documented in the youth's healthcare record. A review of the youth healthcare records supported both required parent/guardian consent. Both applicable youth requiring parent/guardian consent documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parent/guardian received a written follow-up of a copy of the CPPN outlining the medication prescribed and reasons for the medication with the CPPN.

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

The program maintains a written policy and procedures ensuring an immunization history shall be obtained for each youth admitted. The registered nurse (RN) in charge nursing manager shall ensure each youth receives the proper immunizations while in the program. A review of five youth individual healthcare records (IHCRs) validated nursing staff review each youth's electronic commitment packet to determine whether it contains a complete history of immunizations. Nursing staff utilize the Florida Shots Florida Certification of Immunization to determine if the immunization history is missing or incomplete. All five reviewed youth IHCRs reflected each healthcare record contained a Florida Certification of Immunization. Reviewed documentation supported the vaccinations were verified on the youth's date of admission, meeting the thirty-day requirement. None of the reviewed healthcare records indicated there were no applicable youth requiring additional immunizations or had a completed religious exemption from immunization form filed in the healthcare record. An interview with the nursing staff indicated the parent/guardian must provide the vaccination exemption form from their local health department if they wish to file a religious exemption.

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

The program maintains a written policy and procedures ensuring each youth is screened for health-related conditions at the time of admission to help identify any health concerns needing immediate action and/or referral for further assessment by healthcare staff. A review of five youth individual healthcare records (IHCRs) validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed on the date of admission by one of the two program's registered nurses (RNs). The program does not utilize licensed practical nurses (LPNs).

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

The program maintains a written policy and procedures ensuring the program has a medical alert system in place and all staff are made aware of a youth's medical and mental health problems, which may require emergency responses while ensuring preservation of the youth's privacy. A review of five youth individual healthcare records (IHCRs) as well as the program's

daily internal alert system validated youth identified with medical, dietary, physical limitations, or healthcare complications were updated accurately, as required. A total of ten youth, including three youth on psychotropic medications with medical grades of five were placed on the program's medical alert system. The nursing staff ensures all alerts are verified, accurate, up-to-date, and placed on the medical alert roster and in each applicable youth individual healthcare record (IHCR). A review of the Department's Juvenile Justice Information System (JJIS) validated the alerts were updated and/or removed, as required. All communication regarding a youth's condition or risk shall be made on a "need to know" basis and conducted in a manner which best preserves the youth's privacy, while providing appropriate staff with the information they need to properly and safely supervise the youth. Observations completed during the tour of the program found the debriefing room contained a board with all youth pictured and the appropriate color-coded alert identified. The alert information is shared with staff during the daily shift debrief meeting.

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

The program maintains a written policy and procedures whereby all youth shall be oriented to the healthcare system within twenty-four hours of the youth's admission. A review of five youth individual healthcare records (IHCRs) validated each youth received a healthcare orientation on the day of admission or at the next available opportunity. Each reviewed IHCR contained a youth health education summary signed and dated by youth and a registered nurse (RN). Each youth receives an individualized health orientation/education packet outlining twenty-five health-related topics. Youth and nursing staff sign the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. Nursing staff also maintained twelve additional healthcare education topics youth receive from a registered nurse (RN) which are documented in each youth's Health Education Record (HS013). Reviewed healthcare records validated this practice.

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

The program has a written policy and procedures which was signed and dated by the facility administrator (FA) and the designated health authority (DHA) on January 22, 2018, ensuring all youth are screened for health-related conditions at the time of admission to help identify any health concerns. The program's practice is to notify the DHA or designee by telephone when a youth is admitted with a known or suspected chronic condition not requiring emergency treatment on admission or on prescribed psychotropic medications. The psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA and Psychiatrist Notification of Admission form. The nurse and the DHA signs the form at the next on-site visit. In addition, the nurse documents the notification in the nursing intake progress note. A review of five youth individual healthcare records indicated none of the youth required emergency care at admission. Only one additional youth record for the review period was reviewed for a notification to DHA. The notification was completed as required. Reviewed documentation validated the program was following the applicable policy and procedures.

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

The program maintains a written policy and procedures ensuring a healthcare admission rescreening is completed each time the physical custody of the youth changes and youth are returned or readmitted to the program. A review of five youth individual healthcare records (IHCRs) found none were applicable for healthcare admission rescreening. An interview with the program's registered nurses (RNs) indicated there were no applicable youth requiring a healthcare admission rescreening since the last annual compliance review. When applicable, the RNs complete the Department's Facility Entry Physical Health Screening (FEPHS) form.

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

The program maintains a written policy and procedures ensuring the standard Department's Health-Related History (HRH) form is used for all youth admitted into the physical custody of the program. The nursing staff shall complete the Department's HRH (HS 014) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCRs) found a new HRH was completed for each youth. An interview with a registered nurse (RN) indicated the program practice is to complete a new HRH for each admission. All reviewed HRHs were completed by a RN immediately upon admission to the program. The nursing staff and the designated health authority (DHA) documented their review of the HRH by signing the form. All the HRHs reviewed were completed before or at the same time as the CPAs.

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

The program maintains a written policy and procedures ensuring the standardized Comprehensive Physical Assessment (CPA) form is used for all youth admitted into the program. All youth admitted receive and/or have a current CPA. A review of five youth individual healthcare records (IHCRs) validated the program utilizes the Department's CPA form. All CPAs were completed by the designated health authority (DHA) within the first week of the youth's admission and yearly, thereafter. All sections of the CPA were completed in full utilizing an "O" or an "X". In two of the five reviewed records, youth were classified with a medical grade five, while the remaining three youth were classified as a medical grade one. All five reviewed CPAs indicated the youth refused a portion of the examination and each youth documented their signature of refusal on the CPA. A review of the documentation validated the Department's Problem List was updated when applicable for each youth throughout their stay.

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

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

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. The program's policy adheres to the requirements outlined by the Centers for Disease Control and Prevention (CDC) recommendations and with the Occupational Safety and Health Standards (OSHA). A review of five youth individual healthcare records (IHCRs) validated each youth had at least one verified tuberculin skin test (TST) documented within the last year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilized the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a Tier I tuberculosis screening. All Tier I tuberculosis screenings were conducted on the day of each youth's admission. A review of the documentation found the results of the TST was documented on the youth's Comprehensive Physical Assessment (CPA) and on the Department's Infectious and Communicable Disease (ICD) (HS 018) form. The program also maintains a record of all administered TST documented on the Department's Tuberculosis Testing Log.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and treated, when applicable for sexually transmitted infections (STI). Any youth who reports signs or symptoms consistent with an STI, or reports they are sexually active shall be referred to the designated health authority (DHA) for an evaluation screening with testing. The DHA shall then decide based on the evaluation which test to perform to prevent the advancement of possible infection and to decrease the risk of future transmission. A review of five youth individual healthcare records (IHCRs) found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening (HS 029) form. Each youth was referred to the DHA for further evaluation. Testing was ordered and was performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results was documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present.

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

The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. Testing is also offered to all youth after completion of an educational course in sexually transmitted diseases and HIV. A review of five youth individual healthcare records(IHCRs) validated each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific “Did You Know This About HIV” questionnaire. In addition, the program utilizes the Department’s HIV Antibody Test Youth Consent Form. Five interviewed youth indicated they can request an HIV test. Youth who consent receives counseling, testing, and signs the Department’s Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. One of the program’s registered nurse (RN) is authorized to provide pre-counseling, testing, and post-counseling, and HIV/AIDS HIGH RISK BEHAVIOR training to the youth in the program. A copy of the RNs HIV/AIDS 501 certificate was reviewed with an expiration date of December 31, 2020. Five reviewed youth records validated once youth receive pre-counseling, testing, and post-counseling, the youth’s health education record is updated in the IHCR. The results are placed in a sealed envelope marked ”Confidential” with the youth name documented on the outside of the envelope. All the tests were completed by a program’s RN. All five interviewed youth indicated they can request an HIV/AIDS test.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The program maintains a written policy and procedures ensuring all youth shall have the right to request the services of a health trained professional at any time. Non-emergency healthcare needs are addressed through the process of a nurses’ sick call. The youth will be provided unimpeded access to the designated health authority (DHA), if they feel proper treatment was not provided because of sick call. This also includes a referral to a specialist when indicated. The program maintains an agreement for professional services with Sunshine Dental Services in Pompano Beach, Florida, who provides a State of Florida licensed dentist to provide professional dental services to youth. The program also maintains an agreement for professional services with At Your Home Eyecare, Inc. in Plantation, Florida, to provide a licensed optometrist. The optometrist maintains a current professional liability insurance and a clear and active license in the State of Florida with a license expiration date of February 28, 2021. The program offers youth sick call seven days a week, two times daily conducted by registered nurses (RNs). Sick call is conducted at 10:00 a.m. and 5:00 p.m. daily. A review of five youth individual healthcare records (IHCRs) validated each youth completed a sick call request form at least one time during their stay. The RNs documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. However, program procedures outlined the healthcare staff will automatically refer the youth to the DHA or dentist for an evaluation and treatment. The dental sick call is incorporated into the healthcare sick call process. When a licensed healthcare staff is not on-site, all sick call request forms shall be turned into the shift supervisor for review. The shift supervisor or lead staff is required to review the sick call complaint promptly but no longer than

two hours after the request was submitted. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. All care provided is documented on the Department's Report of On-site Healthcare by Non-Healthcare Staff form. According to nurse interviews, there were no documented practice since the last annual compliance review of non-licensed staff addressing minor complaints. The nursing staff leaves an over-the-counter (OTC) box for the shift supervisor/lead staff when nursing staff are not on-site in case an OTC is required. The DHA developed and approved protocols for non-licensed staff to utilize when nursing staff are not on-site. Three of the five interviewed youth indicated they can see a nurse within one day of the sick call request. One youth indicated they can see the nurse immediately, and one youth did not respond as the youth informed they have never completed a sick call form.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The program maintains designated health authority (DHA) approved protocols for non-licensed staff to assist with healthcare situations and nursing protocols which were both dated January 3, 2019. The two registered nurses (RNs) documented a review of the approved nursing protocols on January 16, 2019. Nursing protocols included nursing assessment subjective, objective, assessment, and plan as well as an educational fact sheet for each complaint. A review of five youth individual healthcare records (IHCRs) found each youth submitted a sick call request form during their stay. Sick call is completed by the nursing staff when on-site. Procedures are in place for supervisory staff to review the sick call request form to determine if it requires immediate care. Completed sick call request forms are filed in chronological order in the nurses note section of the healthcare record. In addition, all sick calls are documented on the Department's Sick Call Index and the Sick Call Referral Log. Observation of a sick call found the nurse inquired with the youth as to the nature of the complaint. The youth provided verbal approval of the annual compliance team member to observe the process. The youth was provided privacy and was instructed to sit on the examination table while the nurse interviewed and assessed the youth. The youth counselor waited outside the clinic. Observation of a sick call practice with the youth's permission ensured the youth provided verbal approval of the annual compliance team member to observe the process. The RN followed the required procedures and the youth's confidentiality was maintained. n interview with a RN indicated the sick call is conducted in the program's treatment room inside of the medical office.

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

This program does not utilize room restriction/controlled observation; therefore, this indicator rates as non-applicable.

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

The program maintains a written policy and procedures ensuring the program has a process for the provision of episodic care and first aid. The program has a written plan to provide twenty-four-hour emergency care to youth including emergency medical services (EMS), as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment. The program's designated health authority (DHA) or the licensed psychiatrist will accomplish this through a screening examination. A review of five youth individual healthcare records (IHCRs) found all five required episodic and/or first aid care, and all the treatment services were provided by the program's registered nurses (RNs). The review of the records progress notes documented the services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. The program has an episodic/first aid/emergency care log where all documented incidents of care by date, name of youth, Department identification number, emergency, treatment provided, RN initials, and whether the youth was referred to the DHA. The program maintains one automated external defibrillator (AED), nine first aid kits, and two suicide response kits with each containing a knife-for-life, wire cutters, and needle nose pliers. In addition, the program maintains two epinephrine auto injectors located in the medical clinic. There were no youth prescribed an epinephrine at the time of the annual compliance review. The first aid kits and the AED are checked by the RNs, weekly. All five interviewed youth indicated they can see the doctor or the dentist, when needed.

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

The program maintains a written policy and procedures ensuring the provision of emergency care and/or facilitating an appropriate response to an emergency. The program provides for twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth individual healthcare records (IHCRs) found one youth requiring emergency care, episodic, and/or first aid care. Nursing interviews indicated there were no other applicable youth since the last annual compliance review. All emergency care services were provided by one of the two registered nurses (RNs). The nursing progress notes clearly documented the treatment services rendered. Nursing staff also maintained an episodic/first aid/emergency care log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, RN initials, and whether the youth was referred to the designated health authority (DHA). Reviewed documentation found the program conducted quarterly emergency drill for each shift, as required. The program has a list of emergency numbers accessible to staff posted throughout the program in the main office are, on the bulletin board in the main area day room, in the medical clinic, and the assistant facility administrator's (AFA) office. All five interviewed staff indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency.

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

The program maintains a written policy and procedures ensuring evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form (HS 033). The form is reviewed and signed by the designated health authority (DHA) and the nursing staff and filed in the youth individual healthcare record (IHCR). A review of five youth IHCRs and an interview with the registered nurses (RNs) found only one youth required off-site care and/or emergency care since the last compliance review. Reviewed documentation supported the Summary of Off-Site Care Form was completed for the applicable youth and was filed in the healthcare record. Reviewed documentation supported the DHA reviewed the completed off-site care form and discharge paperwork as evidenced by the youth's signature and date. When hospital orders or off-site doctor orders are received, the RN calls the DHA for a telephone order to continue or discontinue the order. The orders are then faxed to the pharmacy and transcribed to the Medication Administration Record (MAR). In addition, the parent/guardian is notified and verbal consent is obtained. The medication list is updated and the parent/guardian notification is mailed to the parent/guardian.

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

The program maintains a written policy and procedures ensuring youth who have chronic illnesses receive regularly scheduled evaluations with the required follow-up. The program maintains one uniform process to ensure staff receive the necessary information related to the youth's health and mental health conditions. Youth identified with a chronic condition receives regularly scheduled and as-needed follow-up care. A review of five youth individual healthcare records (IHCRs) indicated none were admitted with an identified chronic condition. An additional three applicable youth healthcare records were reviewed. One with a medical condition and two with high body mass indexes. The program conducts the Center for Disease Control and Prevention (CDC) Body Mass Index Percentile Calculator for Child and Teens for each youth during the admission assessment process. The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name and condition. Reviewed records supported each youth received periodic evaluations, as required. An interview with the designated health authority (DHA) indicated the youth is evaluated at a minimum of every ninety days. The psychiatrist indicated an evaluation is conducted every thirty days for youth prescribed psychotropic medications. There was no indication of lapses in care or missed periodic evaluations. The interviewed DHA indicated a diagnosis of the chronic condition is provided and a prescribed medication treatment plan is created. Approximately every ninety days, the DHA conducts a periodic examination of the youth, if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. The Department's Problem List was updated, as required. The program conducts a weekly meeting with the psychiatrist, mental health therapists, nursing staff, and facility administrator (FA) to discuss youth treatment.

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

The program maintains a written policy and procedures ensuring the accurate and safe administration of medication. The program has two registered nurses (RNs) who verify all medications arriving with a newly admitted youth and continue all currently prescribed medications. In the event a youth arrives from a detention center the medication is verified prior to arrival and recorded on the Department's Medication Receipt, Transfer, and Disposition form (HS 053). When the youth arrives from home, non-healthcare staff and a RN utilizes the Prescription Medication Verification Checklist form (HS 025) and places the completed form in the youth's healthcare record. All medications must have a valid pharmacy label and the pills are verified by the pharmacy. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s), as ordered. A review of five youth individual healthcare records (IHCRs) indicated two youth were admitted to the program on prescribed medication. The program provided an additional applicable healthcare record of a youth entering the program on prescribed medication, meeting the minimal sample size for review. Reviewed nursing admission notes documented the youth's current medications and the notification of the designated health authority (DHA) and psychiatrist was documented during the youth's admission screening process. There were no instances when a youth's medication could not be verified and was returned to the youth's parent/guardian. When youth are admitted to the program and the RNs are not on duty, the facility operating procedures which were developed by the DHA are followed by the trained non-healthcare staff.

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

The program maintains a written policy and procedures ensuring the accurate and safe administration of medication. Each youth receiving medication shall have a current, valid order and are given pursuant to a current prescription or practitioner's order. The current medications prescribed prior to admission shall be renewed or refilled for the life of the prescription(s) if there are no changes in the total dosage or route. A review of five youth individual healthcare records (IHCRs) validated three youth were applicable for medication management and each documented a current and valid prescription order. Each reviewed youth IHCR indicated the prescribed medication was continued, discontinued, changed or a new medication was ordered. Each time the doctor's order sheet clearly documented the medication and dosage.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications were securely stored in the medical clinic, inaccessible to youth. All non-controlled medications were stored in a separate secure locked medication cart. Narcotics and other controlled medications were observed securely stored in a locked box within the secured

medication cart. The program had one controlled youth prescription secured in the locked box during the annual compliance review week. Oral medications were not stored with injectable or topical medications. The program maintains a refrigerator for medications requiring refrigeration. The program did not have medications requiring refrigeration at the time of the annual compliance review. The program securely stored sharps and syringes separate from medications. The program maintains a written process for the disposal and destruction of expired and/or discontinued medications. All controlled medications are disposed of by the consultant pharmacist and witnessed by the registered nurse (RN). The program's disposal practice is to utilize the Rx Drug Buster and document the disposal on the Consultant Pharmacist Monthly Inspection form.

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

The program maintains a written policy and procedures ensuring all medication and sharps are securely inventoried. All instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Syringes and sharps are counted and verified through a weekly sharps perpetual inventory. The program contracts with Polaris Rx Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires on September 30, 2019. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator (FA), health services administrator (HSA), designated mental health clinician authority (DMHCA), and consultant pharmacists. Agenda and minutes are maintained highlighting administration, medication storage, pharmacy services, consultant pharmacists report, controlled substances, stock medication and expiration dates of medications, and continuous quality improvement event summary. The program maintains written procedures for the disposal of narcotics and other controlled substances and has a controlled medication inventory record in place. The program's practice for the consultant pharmacist and the registered nurse (RN) is to dispose of the medication by utilizing the RX Drug Buster. All disposed medications are documented on the Consultant Pharmacist Monthly Inspection form. Copies are maintained in the medical clinic. Observations conducted during the annual compliance review supported three youth prescribed medication inventories were accurate. Three over-the-counter (OTC) medications were reviewed and the inventories were accurate. Three sharps were reviewed and inventories were accurate. The program had one youth prescribed a controlled medication and the inventory was also accurate. The inventory was documented on the Department's Controlled Medication Inventory Record. A review of the program's counts from the past six months validated no discrepancies were identified with the counts.

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

The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Florida

Administrative Code 63M-2.024, 63M-2.026 requirements. The program maintains a Modified Institutional Class II Type B License with an expiration date of February 28, 2021. All controlled substances are maintained in the securely locked box within the securely locked medication cart located in the medical clinic. Observations found the medications are procured through Polaris Rx Pharmacy in Fort Lauderdale, Florida and the program utilizes a local Walgreens Pharmacy as a back-up. The medications are delivered in blister packs documenting the number of pills in each prescription order. Procured controlled medications are administered only by nursing staff. The youth's individual controlled medication inventory record is updated after each administration.

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

The program maintains a written policy and procedures ensuring accurate and safe administration of medications shall be provided pursuant to a physician order written in the youth's individual healthcare record (IHCR). Medications should be administered within one hour of the scheduled times, unless specified by the designated health authority (DHA), psychiatrist, or as required by medication instructions. The person administering the medication will document their initials on the Medication Administration Record (MAR). A review of five youth individual healthcare records (IHCRs) found two youth were admitted to the program on prescribed medications. An additional applicable youth healthcare record was reviewed to meet the sample size requirement. The program utilizes the Department's Medication Administration Record (MAR) form (HS 019) 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 a current picture of the youth. The three reviewed applicable youth IHCRs supported the MAR documented the youth received the medication(s) as ordered. The MAR clearly indicated the medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center (CCC) reports validated there was one incident of missed medications during the annual compliance review period and the registered nurse (RN) called the CCC within the required two-hour time frame. Nursing staff documented side effects monitoring on the MAR daily each time medication was administered. Refusals were clearly documented on the MAR and nursing staff completed the Department's Refusal of Treatment form when a youth refuses a medication dosage. All five interviewed staff and all five interviewed youth indicated the RNs provides medication to youth.

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

The program maintains a written policy and procedures ensuring authorized prescribers, including consultants, shall utilize the prescribed formulas when providing appropriate healthcare to youth. Prescribed medication is administered only by order of the consulting physician, designated health authority (DHA), or psychiatrist. A review of five youth individual healthcare records (IHCRs) validated two youth were prescribed medications. One additional applicable youth healthcare record was reviewed to meet the required sample size. There were no youth which required parenteral medication at the time of the annual compliance review;

however, procedures are in place for only the licensed registered nurse (RN) to administer the medication. Reviewed Medication Administration Records (MARs) for each youth as well as the prescription, validated the youth received the medication as ordered and at the scheduled time frames. Refusal of medications were clearly documented on the MAR and the Refusal of Treatment form was also completed and filed in the youth's healthcare record. Observations of medication administration by RN indicated the medication was administered in accordance with the six rights of medication administration, the right youth, right medication, right route, right dosage, right time, and right documentation. The RN blocked the door to the clinic with the medication cart, the youth approached one at a time, identified themselves and informed the RN the medication prescribed, the purpose of the medication, the side effects, and whether the youth was experiencing side effects at the time of medication administration. The youth care worker (YCW) stood behind the youth when the medication was administered. The RN then checked the youth's mouth to ensure the medication was swallowed and had the youth cough to ensure it was swallowed. The YCW also checked the youth's mouth and had the youth cough to ensure the medication was swallowed. The RN did not pre-pour the medication from the blister pack prior to administration. The medical clinic and working space was observed to be clean and well organized. The observed process was structured and interactive.

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

The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained staff. Non-licensed staff shall provide self-administration medication only when a licensed healthcare staff is not on-site and only if they have been trained to assist in the delivery of oral medications. Reviewed documentation supported the registered nurse (RN) trained the seven non-healthcare staff to assist in the delivery of over-the-counter (OTC) medications to youth. The designated health authority (DHA) has developed and approved non-healthcare staff protocols to utilize when nursing staff are not on-site. The protocol identified the use of OTC medications for constipation, and minor complaints of pain. A review of three applicable youth individual healthcare records (IHCRs) indicated the trained non-healthcare staff provided OTC medications. Each OTC medication was documented on the current MAR for each youth. Each youth and staff initialed the MAR indicating the dosage was provided and the RN followed-up with the youth the next day. Observations by the annual compliance review team validated this practice. Reviewed MARs supported the RN conducted side effect monitoring daily.

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

The program maintains a written policy and procedures ensuring there is a comprehensive system in place for medication management for youth diagnosed with a mental disorder and is prescribed medication. All psychotropic medication is provided pursuant to a physician's order. All staff administering medications have knowledge or have been informed of the common side effects and precautions of prescribed medications. The program maintains an agreement for

professional services with a State of Florida licensed psychiatrist who maintains professional liability insurance. The psychiatrist is scheduled to be on-site two hours each week, on Sunday from 2:00 p.m. to 4:00 p.m. The program's practice is to refer youth to the psychiatrist for an initial psychiatric evaluation within fourteen days of admission, if they were admitted on psychotropic medications. The program's psychiatrist utilizes the Department's Clinical Psychotropic Progress Note (HS 006). The initial psychiatric assessment/evaluation contained all required elements as in the Department's Clinical Psychotropic Progress Note (CPPN) form. A review of five youth individual healthcare records (IHCRs) validated two youth were prescribed psychotropic medications. One additional youth healthcare record was reviewed to meet the required sample size. Each youth was assessed by the psychiatrist and prescribed psychotropic medications. Reviewed documentation supported medication monitoring is conducted by the psychiatrist at least monthly. The monthly psychiatric evaluation was documented on the CPPN. In addition, the psychiatrist completed a Physician Communication Form (Psychiatric) to document the overview of the youth's behavior for the previous thirty-days. The form is signed by the assigned therapist and the psychiatrist. All three required monthly Tardive Dyskinesia monitoring and the reviewed documentation supported the practice was completed, as required. The program did not have standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. The psychiatrist does not provide the program with pro re nata (PRN) order for psychotropic medications.

4.34 Infection Control – Surveillance, Screening, and Management	**Satisfactory Compliance**
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program maintains a written policy and procedures ensuring there is an approved plan for infection control which includes the types or categories of diseases. The infection control plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal regulations and guidelines. The infection control plan is combined with the program's exposure control plan. The plan was reviewed and approved by the facility administrator (FA), designated health authority (DHA), and the registered nurse (RN) in charge on January 23, 2019. The infection control 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 outlined outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorists agents, chemical exposures, and 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. The program currently maintains a service agreement subcontracted with Bio-waste Medical Waste Management in Fort Pierce, Florida. The program documents a transport log for monthly medical waste pick-up through Bio-waste Medical Waste Management. The program maintains a current operating permit through the Department of Health (DOH) for biomedical waste – juvenile correctional facility with an expiration date of September 30, 2019. The program received an inspection by the County Health Department on August 30, 2018 with satisfactory results. There were no instances in which the Broward County Health Department ,

Center for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. Nursing interviews indicated the infection control plan is only located in the medical clinic.

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

The program's control of infectious and communicable diseases plan included staff training during the pre-service phase and in-service training, annually. The program documented in-service training was conducted on January 17, 2019. A review of five staff training records found each staff received the required training. A review of five youth individual healthcare records documented on the health education record form and five staff training records, validated all received training on infection control to include hand washing techniques, universal precautions, prevention of transmission of communicable diseases, vaccinations, and the Center for Disease Control and Prevention (CDC) guidelines for infection control.

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

The program maintains a written exposure control plan addressing risk assessment, methods of compliance, engineering and work-place control, and training requirements to provide a safe environment for youth, staff, and visitors. The infection control plan is combined with the program's exposure control plan. The plan was reviewed and approved by the facility administrator (FA) and the registered nurse (RN) in charge on January 16, 2019 and by the designated health authority (DHA) on January 23, 2019. The program provided training to all staff on the infection control and exposure control plan on January 17, 2019. The program's exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910). The exposure control plan included a comprehensive process for needle stick post-exposure evaluation and the plan is available to all staff. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. There were no documented instances of staff experiencing a facility or occupational exposure since the last annual compliance review.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures addressing the supervision of youth. Youth and staff observations were conducted each day during the annual compliance review week, at various times and during various activities. A review of the staff schedule and observations indicated the program adhered to the contractual compliance for the program's staffing ratio of one staff to every eight youth, during the awake hours of operation. Staff were aware of the youth under their supervision and provided appropriate daily total youth counts when asked. Observations during the annual compliance review reflected staff were taking positions where youth were always in sight and sound view with the exception of one instance. One youth was observed to be sitting alone in the dining area for approximately ten minutes unsupervised completing school work assignments. An informal interview with staff confirmed staff were aware of the program's ratio requirements. Staff were able to explain the process when youth counts are not reconciled. Youth were supervised at all times during the annual compliance review. The program's behavior management system (BMS) was implemented when applicable and the program had a daily activity schedule which was followed, as required.

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

The program has a clearly written behavior management system (BMS) approved by the facility administrator (FA) on November 29, 2018, which has not changed since the last annual compliance review. An interview with the FA indicated the program's BMS utilizes a cognitive behavioral strategic model designated to decrease unwanted behaviors and increase desired behaviors through reinforcements. The program has annual in-service training and pre-service training on the BMS for all staff. A review of five staff training records for in-service and five pre-service training records verified each staff completed the required BMS training during the first 180 days of hire and annually, thereafter. The BMS outlines weekly and monthly incentives to include responsibilities, expectations, and level advancement. A review of five youth case management records indicated the youth orientation and youth handbook included a review of the program's BMS. Rules governing the conduct of positive and negative consequences for behavior are posted on the bulletin board in the main area and in the youth handbooks. 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 was able to explain the program's level system and how to progress to the next level. During the annual compliance review week, staff were observed

interacting positively with youth. Staff were observed counseling youth regarding their behavior and offering verbal praise for accomplishments.

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 clearly written behavior management system (BMS) which utilizes a cognitive behavioral strategic model designated to decrease unwanted behaviors and increase desired behaviors through positive reinforcements. 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 consistently imposed. The program does not utilize room restriction as a form of imposing sanctions for inappropriate behavior. Five staff were interviewed and each stated youth are informed of consequences when they attend treatment team meetings. Five youth were interviewed and each stated they have never been sent to their room for punishment and are not allowed to punish other youth. An interview with the facility administrator (FA) indicated youth progress through the level system by an evaluation system of the total number of points each youth earns. Youth are provided incentives based on maintaining their weekly point average. Youth who receive numerous incident reports or critical incidents are referred to the emergency treatment team to immediately address the behavior. Observation of staff implementing the BMS indicated staff interaction with youth was positive, addressed the four-to-one positive-to-negative consequences, and negative consequences were in direct relation to the inappropriate behavior. Five youth were interviewed and each were aware of the consequences for inappropriate behavior.

5.04 Ten-Minute Checks (Critical)	Failed 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 in place to conduct and document ten-minute room checks. The program has a total of thirty cameras on-site and four of the thirty cameras were operational during the time of the annual compliance review. An informal interview with the assistant facility administrator (AFA) confirmed the program stores video recordings for up to thirty-days; however, during the compliance review, both digital video recorders (DVRs) were not operational due to technical difficulties. The available coverage to view ten-minute checks were January 1, 2019 through January 11, 2019 and January 28, 2019 through January 29, 2019. The program documents the room checks in real time at ten-minute intervals or less on

the room check forms with staff initials. Room checks were compared to the documented room check forms to confirm the program's practice. A review of randomly selected surveillance videos for various shifts and dates found staff conducted ten-minute room checks within the required time frame with some exceptions. Staff on one out of six various reviews of security video were observed not completing an actual room check; although staff documented on the form they had completed the room check. Additionally, staff conducting the ten-minute checks was not always the staff completing the forms. According to the program's policy and procedures, each check will be recorded on a specific form by the staff conducting the check. Due to these discrepancies in documentation, the program reported these findings to the Department's Central Communications Center (CCC). A review of the program's camera system also found the program camera skips at times due to inactivity. This was never reported on the programs weekly safety and security audit form which is submitted to the Department on a weekly basis. Five staff were interviewed with responses of conducting room checks at least 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 practicable after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a written policy and procedures to track the daily census. Youth are always accounted for by formal head counts and random head counts. Both formal and random head counts are documented in the facility logbook. A random review of the facility logbooks for the past six months revealed documentation of youth counts at the beginning and end of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. Observation of youth count during the annual compliance review indicated prior to any youth movement a formal head count is conducted. Five staff were interviewed and stated youth are counted every hour, between movements, and during emergencies. Counts were observed being conducted throughout the annual compliance review anytime youth movement occurred such as youth moving to classrooms, lunch, or restroom.

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 written policy and procedures for logbook entries. Staff maintains a bound logbook with numbered pages. 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. Errors are struck through but were not consistently initialed by the staff correcting the error. A random sample of fifteen errors were reviewed and found three were initialed by the staff correcting the error. Reviewed documentation found there were pages in the briefing report which needed to be reformatted to make the wording legible. A random sample of thirty shift briefing reports indicated five out of the thirty reports did not consistently list the staff name for the incoming shift and/or were not consistently signed and dated by the staff. The staff name is written in on the form by either the staff or supervisor conducting the staff briefings. The program also conducts staff briefings prior to the beginning of each shift. Incoming staff are briefed on the previous shift. Observation 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 has a written policy and procedures for key assignment, inventory of keys, tracking, and storage of keys. The program has a daily key log to track keys. The log indicates the name of staff and the type of key staff are assigned according to their position. Keys are bound on a tamper resistant ring which includes a brass colored tag with the initials of the staff positions, a tracking number, and the number of keys on the ring. When staff arrive to work, they gain access to the facility through the main entrance. Staff 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). Staff who are issued permanent keys are required to sign an acknowledgment form indicating the key identification number and the number of keys issued. A random check of three staff indicated none had personal keys on their person. Five staff were interviewed and all was aware of the program's key control policy. A random interview with youth indicated they do not have access to facility keys.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a written policy and procedures which identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor sign-in sheets verified a list of the required unauthorized items not permitted to include personal cellular telephones, devices capable of taking photos, and/or audio/video recordings. The program conducts contraband searches of the youth rooms at least once a day and findings are documented on the program's room search checklist. The assistant facility administrator (AFA) is responsible for reviewing and signing the search report forms. An interview with the facility administrator (FA) indicated staff are to follow their facility operating procedures (FOPs) should illegal contraband is found. Any contraband and/or illegal contraband discovered by staff are to notify the Department's Central Communications Center (CCC). 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 has a written policy and procedures in place addressing searches and full body visual searches. Searches are conducted upon admission, after visitation, when youth return from any type of off-site activity, and movement to and after class. Observations during the annual compliance review verified the program's practice of full body visual searches following movement from group, school, and transportation to ensure the safety of youth and staff in a controlled environment. The searches and full body visual searches were conducted in accordance with the Department's Protective Action Response (PAR) training policy. All searches are conducted by staff of the same gender as the youth. 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 expressed knowledge of when visual and full body searches are conducted.

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

The program has two vans which are used to transport youth. All safety equipment in each van included a fire extinguisher, window punch, an approved first aid kit, and a seatbelt cutter. One youth transport was observed during the annual compliance review and there were no issues identified. All passenger seatbelts were operational. A review of records from van one, dated December 18, 2018 indicated it was inspected and there were recommendations for a few repairs, which were completed. There was an electrical short circuit in the fuse box causing a voltage shortage to fully power the battery, whereby the lifespan of the battery would be shortened. The front brakes pads needed replaced and the front brake rotors were machined to fit the new pads. The repairs for van number one were completed on December 18, 2018. A review of records for van number two, dated November 29, 2018 indicated it was inspected and after a free multi-point performance inspection there were no recommendations for repairs. Interviews with staff who transport youth validated seat belts for both youth and staff are mandatory.

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

The program utilizes two vans for youth transportation which were found to be secured during the annual compliance review. One van does not have a partition between the youth and the driver. All interior doors youth have access are unable to be opened from the inside. Staff driver's licenses are monitored on a monthly basis by the human resource director. The recreation therapist transports youth to approve off-site community outings, while shift supervisors and/or case managers have been identified as transportation staff. Staff indicated when youth are transported, two staff are on the transport. A review of staff records assigned to transport youth found each had a valid driver's license. Five staff were interviewed and indicated a cellular telephone was provided during transport and personal vehicles were not used to transport youth. A daily practice of checking staff personal vehicles in the parking lot was conducted and at no time there were no vehicles found unlocked.

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

The program has a written policy and procedures which outlines conducting weekly safety and security inspections in accordance with the Department's expectations and utilizes the

Department's approved safety and security instrument. The program's facility administrator (FA) or assistant facility administrator (AFA) of operations is responsible for conducting weekly security audits and safety inspections, as well as a review of the internal system to ensure deficiencies are corrected and existing systems are improved as needed in order to maintain compliance. The FA was interviewed and stated internal systematic and programmatic deficiencies are tracked daily during the daily management team meetings. Issues requiring notification to all staff are handled during monthly staff meetings. The FA reported the security audit results are e-mailed each week to the Department and to the provider's south regional director. The program indicated on October 31, 2018, a camera on the outside recreation yard needed repositioning and on December 12, 2018, camera two was not operational in the classroom. The program received a quote on January 3, 2019 which documented in addition to the reported issues identified camera number one would fade in and out while showing a fuzzy unclear picture. The time on both digital video recorders (DVRs) needed to be synchronized and a new power source to DVR number two was needed. On January 28, 2019, twelve out of sixteen cameras were no longer working on DVR number one. Interviews with the FA indicated the camera vendor was contacted and tried to troubleshoot the issue over the phone, which did not solve the issue. The Department's Central Communications Center (CCC) was contacted on January 28, 2019 to report these issues. The CCC was contacted again on February 2, 2019 to provide an update indicating four of the thirty cameras were operational; however, none of the DVRs were able to record. A work order was submitted and is currently in the approval process. The only issues reported on the weekly security audit submitted to the Department was a camera in need of repositioning, camera number two in the classroom was not operational, and a new power source being needed for one of the two DVRs. Although the weekly security audits were submitted to the Department as required, none included the issues with camera one until the week of the annual compliance review. Observation of the program's camera system during the annual compliance review found the camera system skips at times due to inactivity. This was also never reported on the programs weekly safety and security audit form which is submitted to the Department. A review of the daily management meeting minutes and agenda topics was conducted and found evidence facility updates were being discussed. The program maintenance position has been vacant since August 2018. The program currently uses the maintenance staff from Palm Beach Youth Academy (PBYA) which is another Sequel residential program. An interview with the FA indicated a "punch out" list is submitted to the PBYA FA and the Department in regard to the maintenance issues at the program and systematic maintenance issues to be addressed according to priority.

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

The program has a policy and procedures for the access, issuance, and inventory of the program's tools. The assistant facility administrator (AFA) is responsible for the inventory, storage, and usage of the tools. Mops, brooms, and dust pans are the only tools in the program and are kept in a locked storage room next to the kitchen. All other tools are kept outside the main building in a locked shed inaccessible to youth . Kitchen sharps are kept in the kitchen in a locked cabinet inside the kitchen storage closet and inventoried every day or after they are used. Five youth were interviewed and stated they can use mops and scrub brushes only. Broken tools are disposed of and replaced, if needed. Observation of tool storage area indicated it was clean, neat, and each tool was accounted for. Reviewed inventory reports for the past six months validated this practice. An interview with the FA and the assistant FA indicated youth

are not allowed to utilize class A tools. Review of staff and youth training documentation on tool use verified training is conducted.

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

The program has a written policy and procedures for youth using tools in the program; however, the procedures addressing searches did not outline youth searches at the conclusion of the handling of tools. According to the program's contract, a ratio of five youth to one staff is required when youth are using tools. A risk assessment is conducted prior to a youth handling tools. Only youth on level three or four of the program's behavioral management system (BMS) and have been trained are eligible to use class B tools. A review of five youth case management records verified youth who are eligible to handle tools receive a risk assessment and have been trained to use class B tools. Five staff were interviewed and all stated youth are only permitted to use scrub brushes, mops and brooms. Observations of youth using a broom after the afternoon meal reflected the youth was supervised by staff while the youth appeared to use the cleaning tool properly. 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 for outside contractors prior to beginning work projects in the program. Once a contractor arrives 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 facility. An interview with the assistant facility administrator (AFA) indicated when contractors are on-site, youth are not allowed near the work area. While the work is being performed, a program staff is assigned to the contractor to ensure the work is being completed and all tools are accounted for. A review of ten randomly selected work invoices along with the corresponding visitors sign-in logs indicated seven out of ten contractors did not sign in on the visitors log once on-site; however, the contractor agreement were signed in all ten contractor visits.

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. 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. The forms also included debriefing documentation and feedback for the drills performed which were maintained in a safety and security drill binder in chronological order for the past six months. Observation of the program during the annual compliance review indicated egress plans are posted throughout the facility. An interview with the facility administrator (FA) reflected COOP emergency drills are

conducted on a monthly basis, once per shift. Fire and medical drills are also conducted on a monthly basis, once per shift. Suicide and mental health drills are conducted on a quarterly basis. Five staff were interviewed and all five stated they participate in fire drills, while four responded they have participated in escape drills, two responded they participated in hostage situation drills, while one staff responded they participated in chemical drills. Four staff responded they participated in medical and/or suicide drills. Five youth were interviewed and all stated they knew what to do in 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.	

The program has a 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. The plan was forwarded to the Department for approval on January 16, 2019, approved and signed on the same date. Review of the plan indicated alternative housing if the program must be vacated due to an emergency or disaster. An interview with the facility administrator (FA) indicated a copy of the COOP is located in master control, operations office, and the FA's office.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous, and toxic materials. Toxic materials are kept in a 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 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 and securely locked.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, and toxic items and materials. The assistant facility administrator (AFA) maintains control over all flammable, poisonous, toxic items with limited access. Youth are not permitted to

clean any chemical spills, handle, or dispose of any person's biohazardous human waist. An interview with the AFA and youth care worker (YCW) indicated youth are not permitted to handle any chemicals. Observation of the chemical storage area indicated with posted signs restricting youth from handling chemicals. Five youth were interviewed and all stated they do not use any chemicals and/or cleaning products.

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

The program's assistant facility administrator (AFA) is responsible for disposal of unused flammable, poisonous, and toxic materials. All unused hazardous materials are kept in a locked storage area located outside the facility. All materials in need of disposal are taken to Broward County Solid Waste and Recycling Center. All liquid waste resulting from daily program details are disposed of in the utility sink located in the mop storage closet of the program. An interview with the AFA and kitchen staff indicated grease is not used for cooking. An interview with the facility administrator (FA) indicated the program has a Broward County approved disposal site located next door where the program' staff are able to dispose of flammable, toxic, caustic, and poisonous items.

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

The program provides a variety of recreation and leisure activities for youth in the program. Activities are planned to expose youth to a variety of recreation and leisure choices. The program has a full-time recreational therapist who is responsible for assessments, planning, development, provisions of clinically appropriate services, and provides treatment services and recreational activities to the youth in the program. A wellness goal is developed with the recreational therapist for each youth in the program based on their development levels and needs. Each wellness goal is incorporated into the youth's individualized performance plan (IPP) and reviewed during treatment team meetings. A review of five youth wellness goals and performance plans verified this practice. The recreational therapist conducts activities five days a week and each participating youth signs the recreational group sign-in roster which includes the date, time, and a description of the therapeutic activity. A review of the logbook for the past six months indicated the scheduled recreation with direct care staff is documented. The program has a youth advisory board which meets once a month to provide input regarding activities in the program. A review of the recreational group sign-in rosters for the past six months verified a variety of activities are provided to the youth including leisure and recreational activities to promote cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Five youth were interviewed and all responded they receive a minimum of one hour of physical and leisure activities a day. Football, basketball, board and card games were the consistent responses with other responses for pull-ups, gardening, movies, and corn hole toss bean-bag game.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures in place for youth to have visitation and communication with family members in order to re-establish family and community ties. Youth are informed of visitation during the orientation process. 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. Youth in the program who have children may have a special visitation with their child. A list of authorized visitors and correspondence is placed in each youth's case management record. Youth are provided writing materials and a self-addressed stamped envelope to send letters to family members. A review of five youth case management records indicated each record contained an approved correspondence, visitation,

and telephone log. The visitation and telephone schedules are visibly posted in the youth's living area. Five youth were interviewed and each stated they are given the opportunity to communicate with family members by mail, telephone, and during visitation.

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

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

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

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

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

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

Program Name: Pompano Youth Treatment Center
Provider Name: Sequel TSI of Florida, LLC
Location: Broward County / Circuit 17
Review Date(s): February 5-8, 2019

MQI Program Code: 1290
Contract Number: 10112
Number of Beds: 24
Lead Reviewer Code: 149

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.04 Classification Factors, Procedures, and Reassessment for Activities	2.09 Performance Plan Development, Goals and Transmittal*
2.10 Performance Plan Revisions	5.04 Ten-Minute Checks*
2.20 Exit Portfolio	
5.06 Logbook Entries and Shift Report Review	
5.12 Weekly Safety and Security Audit	