STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Pompano Youth Treatment Center

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

Review Date(s): October 27-30, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Rondarrell George, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Teves Bush, Office of Accountability and Program Support, Regional Monitor (Standard 5 and Interviews)
Carol Hickman, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Gabriel Medina, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Shakela Minns, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Sharon Wong, Office of Accountability and Program Support, Regional Monitor (Standard 2)

Program Name: Pompano Youth Treatment Center
Provider Name: Sequel TSI of Florida, LLC
Location: Broward County / Circuit 17
Review Date(s): October 27-30, 2020

MQI Program Code: 1290
Contract Number: 10112
Number of Beds: 24
Lead Reviewer Code: 179

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.08 Specialized Treatment Services*	5.13 Tool Inventory and Mangement

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
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Non-Applicable
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*	Limited
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 *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

* 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).

Program Overview

Pompano Youth Treatment Center is a twenty-four bed program, for male youth ages thirteen to eighteen, located in Pompano Beach, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides substance abuse treatment overlay services (SAOS), mental health services, case management services, healthcare services, gender-specific programming, psychiatric services, as applicable diagnostic evaluation services, educational services, and vocational training. In addition, the program fosters each youth by providing services through the Impact of Crime (IOC) curriculum, Thinking for a Change (T4C), along with Talk's My Father Never Had with Me, a gender-specific intervention. Additional treatment services provided includes group counseling, individual, family therapy, and recreational therapy. Program administration is comprised of a facility administrator (FA), assistant facility administrator (AFA), designated mental health clinician authority (DMHCA), director of nursing (DON), business office human resource manager, food service manager, and an administrative assistant (AA). There are two full-time case managers and two non-licensed master's-level therapists, a transitional services manager, and a recreational therapist working under the direct supervision of the DMHCA, who is a licensed mental health counselor (LMHC). The program has a contract with a licensed medical doctor (MD) to serve as the designated health authority (DHA). The program also has a licensed psychiatrist, psychologist, and pharmacist as well as a dietician to manage food services. There are two full-time registered nurses (RNs), one which serves as the DON. The medical clinic is staffed seven days a week on a rotating schedule from 8:00 a.m. to 6:30 p.m. Educational services are provided by the Broward County School District in portable structures contained within the perimeter fence. At the time of the annual compliance review, the program had eleven vacant positions which included a facility administrator, assistant facility administrator, one group leader, and eight youth counselors. The assistant facility administrator from Palm Beach Youth Academy was serving as the interim facility administrator at the time of the annual compliance review. The layout of the program includes a single secure structure with an electronically operated security main entrance. All services are conducted within the main secure building, which includes a dormitory area for the twenty-four beds, a recreation and honors dorm room, laundry room, a kitchen, a dining and living area in the main day room, medical clinic, and the administration. The supervisor's office is located within the day room area. Within the secure perimeter fence is a basketball court and grassy recreational space which allows for youth to engage in other large muscle activities such as football or soccer. 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, twenty-six were operational. The program was able to provide copies of the work order to have the four non-operational cameras repaired.

Standard 1: Management Accountability

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

The program maintains a written policy and procedures to ensure all newly hired staff and volunteers receive an initial background screening. The program had a total of nine new staff hired since the last annual compliance review. A review of background screenings verified each staff received an initial background screening. Each new staff received a background screening prior to their start date and completed a pre-employee eligibility assessment with a passing score. The program also reviewed the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS), and the Florida Department of Law Enforcement (FDLE) results for each newly hired staff prior to hiring. The program had no volunteers at the time of the annual compliance review. The Annual Affidavit of Compliance with Level 2 Screening Standards was signed on December 13, 2019, meeting the annual requirement. The program and Broward County School Board completed and submitted the Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU)/Clearinghouse on June 25, 2020. There were no new teachers hired since the last annual compliance review.

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

The program maintains a written policy and procedures to ensure all staff and volunteers receive a background rescreening every five years from their initial date of employment. The program had no staff applicable for a five-year rescreening during this annual compliance review. The program had no volunteers or interns during the annual compliance review period.

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

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

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

The program maintains a written policy and procedures ensuring the program provides an abuse free environment. The facility operating procedures for abuse and neglect reporting along with the program's manual, addresses the code of ethics. Staff are required to sign an acknowledgment form indicating they reviewed the required information. A review of five staff personnel records reflected all staff reviewed the program's code of ethics. Observations during the annual compliance review week indicated staff displayed pro-social behavior for youth throughout the day. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were also observed to be posted throughout the program. A telephone located in the day area has been designated for youth to contact the Florida Abuse Hotline or the CCC if youth feel they have been abused or neglected. At the time of the annual compliance review, there were twelve incidents reported to the CCC for physical, psychological, or emotional abuse since the last annual compliance review of which six was substantiated for the use of physical abuse. There was no human trafficking instances reported by the program. There were no Prison Rape Elimination Act (PREA) investigations nor any open Department of Children's and Families (DCF) investigations, law enforcement, or Office of the Inspector General (OIG) investigations pending. An interview with the interim facility administrator (FA) stated Pompano is participating in the Trauma Responsive and Caring Environment (TRACE) program. This program allows the program to become more aware and sensitive to those who suffer from trauma. In addition, the TRACE program also focuses on the needs of staff who work with those suffering from trauma. The TRACE program is designed to become more sensitive to both youth who suffers from trauma and how to better support the staff who work with those youth. Achieving business results by illegal acts or unethical conduct is not acceptable and will not be tolerated. Each supervisor and manager are responsible for assuring all personnel they supervise or manage are performing ethically and in conformance with applicable laws, regulations, and the code of ethics. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues related to their jobs and for

seeking appropriate advice regarding such issues. At all times, the program takes all allegations seriously and all charges are investigated with interviews of all involved including witness statements, video reviews, and other resources available where the allegations were stated to have happened. The staff is removed from contact with the youth. When necessary, the Department of Children and Families (DCF) and the Department will be contacted. Five staff were interviewed and each stated never observing a co-worker denying a youth to make an abuse call or hearing staff intimidate or humiliate a youth. One staff stated hearing staff use profanity. The information was brought to the interim facility administrator's attention and indicated it will be addressed at the next all-staff meeting. Five youth were interviewed and each stated they feel safe in the program and staff are respectful when speaking with them. Five youth were interviewed and three youth stated never hearing staff use profanity when speaking with youth. One youth stated occasionally.

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

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

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

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

Communications Center (CCC) within two hours of the incident or knowledge of the incident. The FA also stated all program residents have unimpeded access to a direct dial telephone connects to the Florida Abuse Registry. All incidents requiring notification to the Florida CCC registry are made within the two-hour reporting time frame, as expected. All allegations of abuse by a program resident or if an employee suspects some form of abuse may have taken place a call is made to the Florida Abuse Registry for residents under the age of eighteen. For those over the age of eighteen, a call is made to the Departments CCC.

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

The program maintains a written policy and procedures related to Protective Action Response (PAR) including the use of verbal and physical intervention techniques and mechanical restraints. A review of the program's PAR binder indicated there were four PAR incidents in the past six months. The program has a current PAR plan approved by the Department's Office of Staff Development and Training on February 17, 2020. The program's PAR rate during the annual compliance review period was 0.15, which is below the statewide Residential PAR rate of 2.23. An interview with the interim facility administrator (FA) regarding the process for monitoring PAR incidents and use of force found all PAR incidents are monitored by the FA and all reports and witness statements are read along with a review of video footage. The FA indicated the program makes sure to interview any witnesses to the incident along with making sure the youth is seen by medical. All PAR-related incidents are reviewed on a case-by-case basis when they take place. Additionally, the program tracks PAR data by discussing the data during the management team meetings and monthly all-staff meetings. Furthermore, the program tracks PAR data trends by shift and incident nature on a month-to-month basis. Lastly, this data is tracked at the corporate level and is a component reviewed when looking at key performance indicators. The program also uses these incidents as training for staff members.

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

The program maintains a written policy and procedures outlining the pre-service training requirements for newly hired staff. The program's policy specifies all newly hired full-time and part-time staff will receive a minimum of 120-hours of training which are computer-based and/or instructor-led topics and shall be completed within 180-days of employment. An annual training plan for pre-service training was approved by the Department's Office of Staff Development and Training on January 13, 2020. The plan outlines the program's required training hours, training objectives, course names, and descriptions for any instructor-led training. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. An informal interview with the interim facility administrator (FA) indicated youth care workers are Protective Action Response (PAR) certified direct care positions and are included in the staff-to-youth ratios. All supervisors, the FA, assistant facility administrator (AFA), medical staff, mental health staff, case management staff, and maintenance staff are PAR certified and are qualified

to supervise youth in special circumstances when they are not working in their current role. A review of five staff pre-service training records confirmed each staff completed all required pre-service training requirements within 180-days of employment to include suicide prevention, emergency procedures, child abuse reporting, professionalism, ethics and standards of conduct, cardiopulmonary resuscitation (CPR), first aid, emergency procedures, Prison Rape Elimination Act (PREA) trainings, and human Trafficking. None of the reviewed staff positions required any specific training indicated by the contract. All reviewed pre-service training was entered in the Department's Learning Management System (SkillPro).

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

The program maintains a written policy and procedures outlining the in-service training requirements for program staff. The program has an annual training plan approved by the Department's Office of Staff Development and Training on February 17, 2020 to include all Departmental required trainings, as well as the program's required internal trainings. According to the program's contractual requirements, specific training is required for different position classifications such as management, case managers, mental health, and direct care staff. A review of five staff in-service training records indicated all staff had supporting documentation to reflect their automated external defibrillator (AED), cardiopulmonary resuscitation (CPR), and first aid trainings were up to date. Each reviewed record also verified completed training in human trafficking, active shooter training, suicide prevention, ethics, Protective Action Response (PAR), communications skills, professionalism, as well as the contract required training elements of Facility Entry Physical Health Screening, Residential Assessment of Youth (RAY), Massachusetts Assessment of Youth Screening Instrument (MAYSI), and the Department's Juvenile Justice Information System (JJIS). Two supervisory staff training records were reviewed and indicated each supervisory staff completed the required eight hours of management training. All trainings were found to be documented in the Department's Learning Management System (SkillPro).

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

The program maintains a written policy and procedures which outline the three phase grievance process which consists of informal, formal, and appeal phases. Youth are informed of the grievance process at the time of admission into the program. Grievance forms are available and accessible to youth in the day area located in a file holder next to the locked grievance box at the program. Youth who have difficulty completing the form may receive assistance by staff on the instructions, preparing, and submittal of a grievance. The program had a total of six grievances submitted during the past twelve months. All grievances were maintained in a

designated binder for one year. The six grievances were observed in the designated binder. A review of the submitted grievances validated each youth was provided the proper form and each grievance was resolved at the formal phase. A review of five staff training records verified grievance training was provided. An interview with the interim facility administrator (FA) indicated the grievance process has three phases to include informal, formal, and appeal phases. If a youth feels they are being treated unfairly, they will use the informal phase and speak to the staff they are having problems with and try to work it out. If the problem cannot be resolved during the informal phase,, the youth will file a written explanation of their grievance on a youth grievance form. Grievance forms are available next to the grievance box mounted to the wall in the recreation room. According to the FA, the facility grievance officer will review the grievance within twenty-four hours of receipt and meet with the youth with the possibility of a resolution agreed upon by the resident facility grievance officer. The facility grievance officer will get back with the youth and provide an opportunity to process the situation. The facility grievance officer and youth will sign the grievance form verifying acknowledgement of the grievance. If the youth is not satisfied with the supervisor's response, the youth may request a review by the FA. The FA will review the grievance and meet with the youth within forty-eight hours of the request for review of the facility grievance officer's decision. The FA will provide the youth with their findings and both will sign the grievance form verifying whether the grievance has been satisfied. The FA will review the prior two steps and responses and will submit a decision in writing. Once the FA has presented their decision, this decision is final. Both the youth and the FA will sign the decision. Five staff were interviewed and were knowledgeable of the program's grievance process. Five youth were interviewed and were able to explain the program's grievance process and stated they can receive assistance if they need complete a grievance.

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

The program offers treatment and interventions services which incorporates evidence-based models, cognitive-behavioral which is based upon social learning theory and highlights skills and modeling of anti-criminal attitudes and behaviors. The curricula used by the program include Thinking for Change (T4C) and Impact of Crime (IOC). The program has the designated mental health authority and two non-clinical staff trained in facilitating evidence-based, promising practice, and/or practice with demonstrated effectiveness groups. Each clinical staff holds a master's-level degree and the case managers have a bachelor's-level degree. A review of the program's activity schedule, group sign-in sheets, and the contract indicated groups were held seven days a week and conducted by the appropriate counselor, as scheduled. A review of five youth performance plans verified a goal identified the need for youth to participate in at least one of the required group trainings. During an interview, the interim facility administrator (FA) reported a staff's education and work experience is taken into consideration while also considering the strengths of each staff along with their life experiences when groups are assigned. These groups are coordinated by the clinical director. Five youth were interviewed and each stated they are participating in groups.

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

The program's treatment services include the use of social and life skills curriculum including Talks My Father Never Had with Me, Thinking for Change (T4C), A review of the program activity schedule and group sign-in sheets verified groups were held, as required with a majority of the youth's time spent in structured, therapeutic activities, with a minimum of one hour of each youth's day devoted to the delivery of treatment services targeted to address identified risk, criminogenic, and treatment needs. The program has a total of Five staff trained to deliver life skills training groups. Reviewed training records supported this practice. Five youth were interviewed and were able to describe the new skills and behaviors they have been taught. Each of the five youth also stated they practice the skills outside of group such as how to control their anger, able to process what the situation is, and/or walking away from the confrontation.

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

The program utilizes the Impact of Crime (IOC) curriculum and Thinking for Change (T4C) which has some aspect of restorative justice, to assists the youth to accept responsibility for the harm their criminal actions have caused in the community. The program provides opportunities for the youth to participate in activities intended to restore victims and communities such as volunteering at food banks. An interview with the interim facility administrator (FA) indicated the program utilizes the IOC curriculum where youth are exposed to victim's statements by way of video tape, written material, and victim speakers to learn of the impact of being a victim of a crime. Youth participate in on-site and off-site community service work projects to heal some of the harm they caused. Group sessions are held on Monday and Tuesday by staff trained to provide the service. A random review of youth performance plans and group sign-in sheets coupled with the program's activity schedule, verified the practice. A review of staff training records indicated staff providing the service are trained in the curriculum.

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

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

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

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

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

The program maintains a written policy and procedures for record management. The program maintains individual records for healthcare, case management, and substance abuse and

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

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

The program maintains a student council to promote a formal process for youth to have constructive input regarding the program issues. Student council members are chosen by way of a youth voting process along with input from staff. Student council meetings are held quarterly and address issues initiated by the youth in the program. Agendas, sign-in sheets, and minutes are maintained in a designated binder. A review of the binder verified meetings are held, as required. Youth can also utilize the “Speak Out” form system which allows the youth to share their thoughts and feelings about a specific issue within the program. The program also conducts town hall meetings with the youth at least monthly to discuss any issues within the program which is the largest forum for youth to voice their opinions. Each youth is encouraged to share any issues and concerns along with suggestions to the staff. An interview with the interim facility administrator (FA) indicated the youth advisory board meets regularly with the FA and/or designee. The student council represents the residents in the program and provides a voice to share ideas on how the program can improve and best cater to their needs. The FA also indicated each youth is provided the opportunity to submit additional ideas and/or complaints during the informal and formal treatment team meetings. Five youth were interviewed and each indicated the program has a student council and conducts town hall meetings for youth to provide input about what happens in the program.

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

The program has established a community advisory board which meets at least every ninety to 120 days to serve as a support to the program and a link to the community. The facility administrator (FA) solicits and maintains a collaborative partnership with the Department and local stakeholders in the community. Partnerships consist of letters of support, community service projects, participation in community board meetings, and public service events. A review of the program’s 2020 community advisory board roster consisted of education, faith community, medical, victim advocate, parent/guardians, judge, and law enforcement. A review of the advisory board agendas, minutes, and sign-in sheets for December 19, 2019, March 20, 2020, and September 30, 2020 verified meetings were held at least quarterly. The program conducted a conference call advisory board meeting on June 30, 2020. An informal interview with the interim FA indicated the program has actively solicited board members. The FA indicated advisory board meetings are held quarterly at the program. The board makes suggestions during the meeting and sometimes meet with the student council to find out what they would like to see different in the program and what can be improved. The FA actively

solicits members and maintains a list of those who have been solicited. Invitations are mailed for all meetings. As a result of the COVID-19 pandemic, the program has been facilitating advisory board meetings through conference calls. After the completion of each call, the program sends each member a copy of the minutes to keep them abreast with in the status of the program and what transpired during the call.

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

The program maintains a written policy and procedures to establish and utilize effective channels of communication among the program staff, corporate leaders, other agencies, stakeholders, and between youth and staff. The program recognizes staff who demonstrate teamwork, leadership, and positive culture through the “Employee of the Month”. The program also incorporates staff outings, monthly birthday celebrations, and “Team Spirit” Friday’s when staff are allowed to wear their favorite athletic team shirt. The program developed a staff moral committee to create different ideas to reduce staff turnover and provide for a healthy work environment. An interview with the interim facility administrator (FA) indicated outside of traditional turnover, the program has not had any major issues with turnover or morale. The program has a morale committee which schedules a variety of morale related events throughout the year. These events include but are not limited to employee luncheons, employee of the month celebrations, birthday celebrations, and holiday celebrations. The program also has a full-time human resource manager to oversee various initiatives geared toward improving morale and retention. Youth and parent/guardian surveys are conducted during the weekly visitation and upon the youth’s release from the program. A review of the surveys found they included feedback for case management, mental health, food, and medical services. An interview with the interim FA indicated the information received from the youth and parent/guardian surveys are reviewed by the FA during management meetings, all-staff meetings, and incorporated into the program’s planning process. The topics which are discussed in the meetings are safety and security, youth behavior, operations updates, behavioral management system (BMS), alerts, and drills. Five staff were interviewed and two stated they are briefed on annual compliance reports, training, BMS, safety and security, and youth and parent/guardian survey reports. Three interviewed staff indicated they are not briefed on any of the reports. An interview with the interim FA indicated the Comprehensive Accountability Report and any other report published by the Department are shared with staff through monthly staff meetings. The FA also indicated the program conducts daily morning meetings and monthly all-staff meetings. Five staff were interviewed and validated this practice. Five staff were interviewed on how they believe the communication is amongst the staff in the program. Two staff stated communication is very good, one stated it is good, and two stated communication is poor.

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

The program maintains a written policy and procedures to ensure all staff receive a written performance evaluation. Every new employee is evaluated the first ninety-days of completed work and yearly thereafter on their job performances. A review of five performance evaluations verified new employees were evaluated during the first ninety-days of employment and yearly thereafter. Each new employee is provided feedback on their job performance and allowed to

comment. A review of program job descriptions indicated each specified the required qualifications, performance measures, and job duties to include the implementation of the behavior management system (BMS) and the delivery of specified interventions. A review of the program's contractual requirements indicated all specified key positions are filled and being performed as outlined in the job descriptions. An interview with the interim facility administrator (FA) indicated staff will be given the initial ninety-day probationary evaluation once employee have successfully completed the evaluation period, they will then be given an annual evaluation around twelve months from the date they were hired. The evaluation will be performed by the staff's immediate supervisor. There is a section on the evaluation where the supervisor is responsible for creating goals on the evaluation as part of the staff's growth and development. Five staff were interviewed on how often they have a formal evaluation of their performance. Four of the five staff stated evaluations are conducted yearly and two of the five staff indicated evaluations are conducted informally each month to provide performance updates.

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

The program maintains a written policy and procedures regarding recreation and leisure activities. The activities are geared to provide supervised and structured indoor and outdoor recreation activities for the youth and based on the developmental levels and needs of the youth in the program, as well as youth input about their preferences and interests in various activities. According to the program's original contract, the program is required to have a recreational therapist to provide treatment services and recreational activities to the youth by using a variety of techniques such as proper body mechanics, sports, music, arts and crafts, and community outings. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth; however, the program's recreational therapist positions was eliminated due to the reduction in the budget as part of the public health emergency related to the COVID-19 pandemic as outlined in the Department's amendment eleven. Prior to the budget reduction, the recreational therapist was maintaining a monthly calendar of indoor and outdoor recreation activities for the youth targeted to promote team building and leadership skills. A review of the program's activity schedule and facility logbook documentation reflected recreation activity is provided each afternoon for one hour. Observations of recreation during the annual compliance review, validated the activity listed on the recreational schedule was the activity being performed. A random review of five youth treatment plans verified each had a wellness goal, as required. Five youth were interviewed and each stated they are provided at least one hour of large muscle activity daily to include basketball, football, kickball, dominoes, cards, and board games. Five staff were interviewed and each stated youth receive a minimum of one hour of indoor and outdoor activity to include basketball, football, soccer, cards, board games, and movie.

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 written policy and procedures addressing the program's intake and admission process. The program's policy indicates the youth's parent/guardian will be notified by telephone and sent written notification of the youth's admission to the program. The policy further indicates the youth's committing court, juvenile probation officer (JPO), and post-residential services counselor will be notified in writing of the youth's admission to the program. A review of five youth case management records found supporting documentation indicated each youth's parent/guardian was notified by telephone within twenty-four hours of admission, and in writing within forty-eight hours of the youth's admission to the program. Each youth record contained a letter dated the day of the youth's admission which was sent to the court, JPO, and post-residential services counselor within five working days notifying each of the youth's admission.

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

The program has a written policy and procedures to provide each youth an orientation to the program rules, procedures, schedules, and services applicable to youth, to begin on the day of admission. A review of five youth case management records found documentation in each record reflecting the program provided an orientation to each youth within twenty-four hours of their admission. Each reviewed record documented a signed checklist orientation packet and information on the program's daily schedule, expectations and youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) number, contraband, dress code and hygiene procedures, community access, grievance procedures, emergency procedures, services provided, and assigned living units. The reviewed records also validated each youth received a copy of the youth handbook which outlined the program rules governing conduct and positive/negative consequences for behavior. The right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures. Each reviewed record contained a list of contraband and prohibited items, the performance planning process, dress code and hygiene practices, procedures on visitation, sending and receiving mail, telephone use, expectation for release from the program, community access, grievance procedures, emergency procedures, facility tour, and assignment to a living unit. Documentation supported each youth signature acknowledging receipt of the orientation packet. Two youth admissions were observed during the annual compliance review. The orientation included program rules, procedures, schedules and all other pertinent information, and each received their orientation on the day of admission. Five interviewed youth reported their orientation included program rules, procedures, schedules and all other pertinent information, and each received their orientation on the day of admission.

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

The program has a written policy and procedures which addresses obtaining written consent of youth who is 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. A review of five youth case management records found none were applicable for youth eighteen years of age or older. The program provided three additional applicable youth records and each was applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. The reviewed records contained the required signed consent of each youth who was eighteen years old.

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

The program has a written policy and procedures regarding screening each youth upon admission, all youth shall be classified to determine the most appropriate group placement and sleeping arrangements, and to increase staff awareness of classification issues. The program's policy ensures classification of youth is based on the premise youth are assigned rooms and groups to prevent threat or harm of violence to themselves or others and to maximum therapeutic gain. A review of five youth case management records found documentation indicating each contained an admission classification check list which identified physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, perception of vulnerability, and history of potential or human trafficking. A review of the Department's Juvenile Justice Information System (JJIS) confirmed a new Victimization and Sexually Aggressive Behavior (VSAB) was completed and entered prior to youth's room assignment as well as the alerts list for any issues affecting classification. The classification form also identifies risk factors such as suicide risk, medical risk, escape risk, and security risk. None of the five reviewed youth records were classified as being at risk for suicide or an escape risk. Three youth were classified as being a medical risk and two youth were classified as being a gang member. Further review of each youth record indicated the youth was classified for the purpose of being assigned to a living area, sleeping room, and group. The program maintains a continually updated internal alert system documenting any medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process. Five interviewed staff reported all program alerts are maintained and updated as needed on an alert board which is accessible to all staff. The program's policy and procedures addressing

reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other activities which involve the use of tools, and a youth's participation in any off-campus activities. Due to COVID-19 pandemic, there were no youth who participated in off-campus activities. An interview with the interim facility administrator (FA) reported the program has a pre-commitment meeting to discuss each youth prior to assignment of a bed placement. During the meeting the staff took into consideration when assigning the youth to a prospective therapist and case manager. It is the program's practice for the case manager to complete a monthly classification reassessment for each youth which is discussed with the multidisciplinary treatment team members. Reviewed documentation supported this practice.

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

The program has a written policy and procedures to screen youth during the admission and classification process to determine if they are a gang member or gang affiliated. A review of five youth case management records found one youth was applicable for identification as a gang member. Two additional youth records were reviewed for gang identification and notification. Reviewed documentation supported the law enforcement was notified in writing, of each youth's presence in the county and of each youth's gang affiliations. Prior to the annual compliance review, local law enforcement was notified by the juvenile probation officer (JPO) in each youth's home county. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS). The gang information is also shared with the educational staff at the program, the youth's JPO, and if applicable, the post-residential services counselor. Additionally, gang information pertaining to the three applicable youth was documented on the program's internal alert system.

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

The program maintains a policy and procedures which addresses gang prevention and intervention activities and procedures to ensure the youth have the opportunity, if they desire to disaffiliate from a street gang. The program maintains a gang binder to include information on youth documented as gang members or associated with a gang. If a youth is identified as a gang member or gang associate upon admission or post admission, the youth's Individual Performance Plan will include a gang prevention and intervention strategy. A review of five youth case management records found one youth was identified as a gang member or affiliated gang member. Two additional applicable youth records were reviewed. All three reviewed youth's performance plans had a gang goal indicating the youth would participate in the monthly gang groups. The program utilizes the Phoenix Gang and Impact of Crime (IOC) intervention groups as part of their gang prevention curriculum.

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

The program has a written policy and procedures to ensure the completion of the Residential Assessment for Youth (RAY) Assessment is completed on each youth within thirty days of admission. A review of five youth case management records indicated all records contained a completed RAY Assessment within thirty days of admission. The initial RAY Assessments were maintained in the Department's Juvenile Justice Information System (JJIS). Four youth records were applicable for a ninety-day RAY Re-Assessments. One record was not applicable since the youth was not in the program ninety days to receive a RAY Re-Assessment. All reviewed RAY Assessment and RAY Re-Assessments documentation were maintained in the youth's official case record. There were no other updates or reassessments deemed necessary by the intervention and treatment team.

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

The program has a written policy and procedures for the completion of the Youth Needs Assessment Summary (YNAS) within thirty days of each youth's admission to the program. Five youth case management records were reviewed and each contained a completed YNAS within thirty days of admission to the program. All YNAS were documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in the youth's case management record.

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

The program has a written policy and procedures addressing the intervention and treatment development plan. The multidisciplinary treatment team members including the youth, meet to

develop the Individualized Performance Plan (IPP) based on the findings of the initial assessment of each youth within thirty days of the youth admission. A review of five youth case management records revealed all IPP were completed after the completion of the initial assessment. Each youth record documented the plans were developed with the intervention and treatment leader, youth, administrative representative, living unit representative, treatment staff, education staff, and all parties who have significant responsibility in goal completion. Two reviewed youth records were applicable for the Department of Children and Families (DCF) participation and reviewed documentation supported the DCF case worker participated by telephone. Each reviewed youth IPP contained all required elements as outlined in Florida Administrative Code. A copy of all five youth's performance plans were sent to each youth's committing court judge, juvenile probation office (JPO), and parent/guardian within ten days of completion. Five interviewed youth found each was familiar with their IPP goals and were able to explain the treatment process. Each interviewed youth confirmed they received a copy of their IPP.

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

The program has a written policy and procedures addressing performance plan revisions. Five youth case management records were reviewed and each was applicable for a revision to the Individual Performance Plan (IPP). Documentation supported each IPP was revised based on the Residential Assessment of Youth (RAY) Re-Assessment results, newly acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and/or completing a goal. Documentation found each IPP was updated with recommendations from the treatment team. In addition, two closed youth case management records were reviewed and documentation supported each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

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 which addresses the completion of performance summaries and their transmittal. A review of five youth case management records revealed four were applicable for ninety-day performance summaries. All four applicable youth records contained a performance summary completed ninety calendar days following signing of the performance plan. All four applicable reviewed records contained performance summaries. Each summary contained information regarding the youth's status for each performance plan goal, youth's overall treatment progress, academic status and/or credits, behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. All four applicable

records contained documentation confirming the youth could read and add comments to their performance summaries. Documentation supported each youth received a copy of their performance summary and the original summary was filed in the youth's case management record. Each performance summary was signed and dated by the treatment team lead, staff member preparing the summary, facility administrator, and the youth. All four youth records contained documentation to support each performance summary was sent to the committing court, juvenile probation officer (JPO), youth, and parent/guardian within ten days of completion. Three closed records were reviewed for discharge and release summaries. Each record contained the original release summary which included the justification for the youth release from the program. All three records contained a Pre-Release Notification (PRN) which was completed forty-five days prior to the youth's release. All summaries and PRNs were signed by the appropriate parties and maintained in the youth closed case management record. All three records contained notification to the parent/guardian confirming the youth's release date once the program received the approved PRN from the committing court. Documentation supported each record contained a completed Exit Residential Assessment for Youth (RAY) Assessment. There were no youth applicable for the Sexually Violent Predator Program (SVPP) and the victim notification. All four records indicated the JPO was provided a copy of the performance summary and transition plan upon completion. Five interviewed youth each indicated they were provided with a copy of their performance summary prior to sending it to the court.

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

The program has a written policy and procedures to provide parental involvement in case management services. The program makes efforts to include the parent/guardian in the assessment process, participation in the development of the youth performance plan, progress reviews, formal treatment team meetings, and transition planning. Supporting case note documentation and copies of notification were forwarded to the parent/guardian by mail. If the parent/guardians are unable to attend the meeting in person, they are afforded the opportunity to attend by telephone, conference call, or provide verbal or written input prior to the meeting. Attached to the admission letter is a copy of the program's parent handbook which details the staff who will be working with their child, how the program works, treatment and performance team members, medical care, ways of communicating with their child, visitation, program level system, privileges, consequences for negative behaviors, transition planning, assessments, and the grievance process. A review of five youth case management records confirmed each youth had regular telephone contact with their parent/guardian. Each record contained documentation the parent/guardians were invited to participate in the youth's performance planning and treatment team meetings. An interview with the interim facility administrator (FA) indicated all parent/guardians are invited to take part in all aspects of case management. This includes completion of the need's assessment. The parent/guardians are encouraged to play a proactive role in the case management process as well as the treatment team process. Parent/guardians are also called weekly and provided with updates on their child's progress and are encouraged to communicate by mail correspondence. Parent/guardians are made aware of the program visitation schedule and are informed of any approved special visitation time outside of the normal visitation schedule. Five youth were interviewed and each stated their parent/guardian participated in their formal treatment team.

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 addressing treatment team and the members. The program assigns a representative from each program area to participate in biweekly informal progress reviews and formal reviews for each youth at least once every thirty days. At a minimum, the treatment team leader, youth, representative from the program's administration, living unit representative, education, juvenile probation officer (JPO), parent/guardian, and others responsible for providing or overseeing the provision of intervention and treatment services. Five applicable youth case management records were reviewed and each documented treatment team participation through signatures captured from the youth, case manager, medical staff, therapist, and education staff provided written input in all records. Parent/guardian participation was noted by telephone in some instances. Two applicable youth case management records documented invitations to the Florida Department of Children and Families (DCF) representative to participate in the meetings. Observations of a treatment team meeting during the annual compliance review week revealed active participation by all required staff and parties, as outlined in the program's facility operation procedures and Florida Administrative Code. The assigned juvenile probation officer participated by telephone.

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

The program has a written policy and procedures for the intervention and treatment team to reference and/or incorporate other treatment plans into the youth individual plan. Five reviewed youth case records validated the coordination of the youth Individual Performance Plan (IPP) with education plans, career education plan, and multidisciplinary intervention to coincide with mental health and substance abuse treatment plans through the treatment team process. The goals included the responsibility of the program staff in assisting the youth to successfully complete the goal(s). Two applicable youth have a current behavior support plan through the Department for Children and Families (DCF), which was incorporated in their IPP plan. The program had no applicable youth for involvement with the Agency for Persons with Disabilities.

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

The program has a written policy and procedures addressing formal and informal treatment team meetings. Five applicable youth case management records were reviewed. Documentation supported formal treatment team reviews were conducted at least once every thirty days. Each record was reviewed for informal treatment team reviews and documentation supported informal treatment team reviews were conducted at least once within thirty-days. The program utilized a Performance Plan Review form which included the youth's name, date of review, comments from treatment team members, brief synopsis of youth progress, behavior

positive or negative, and any Residential Assessment for Youth (RAY) Assessment revisions. Reviewed documentation confirmed treatment team meeting attendees included the youth, case management staff who act as the treatment team leader, clinical staff, education, and a program administration representative. Each youth's juvenile probation officer, parent/guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and RAY Re-Assessment results. Observations of a treatment team found all staff provided relevant input on the youth and agreed on how to proceed with the treatment plan. Five interviewed youth stated during treatment team reviews, staff review their performance to include progress on performance goals, positive and negative behavior, and treatment progress. Additionally, each youth stated they are given the opportunity during treatment team meetings to demonstrate any skills they have learned in the program.

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

The education program has in place a written policy and procedures addressing and ensuring the instruction of a career education curriculum. This program of study which is conducted and supervised by the Broward County School District is identified as a Type 2 career educational program. The course programming includes but not limited to instruction of interpersonal communication skills, personal accountability skills, and behaviors leading to appropriate work habits for positive post-release employment and living standards. This curriculum, which is age appropriate for the youth it targets, is also suitable to their learning and ability skills .The content of this programming provided an orientation to the broad scope of career choices based upon personal abilities, aptitudes, and interests. The youth participating in this course offering were introduced to and completed employment résumés and sample employment applications which were included in the youth's exit portfolios. Three closed youth case management records were reviewed and each contained résumés and employment applications. In addition, each youth record contained a post-release calendar which identifies the location of and contact information of a Career Source office either in or near the community in which they will reside upon exit from the program, as well as appropriate documentation to gain employment such as(a valid State of Florida identification card or license, a birth certificate, and Social Security card. Additionally, each youth record contained evidence identifying the youth's parent/guardian, juvenile probation officer, as well as the youth's program case manager were aware of the vocational plans as well as the post-release discharge plans of the youth. The program's interim facility administrator and the program's lead instructor, provided information regarding the instruction of the Career Education was present.

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

The program's educational component is directly managed and supervised by the Broward County School District. Reviewed documentation, as well as input from the program's lead instructor, indicated each youth was provided a minimum of 250-days instruction during the calendar year and each calendar week contained a minimum of twenty-five hours of classroom teaching. To provide teacher preparation/planning, ten days were incorporated into the calendar year. A review of the program's daily academic schedule indicated the school day starts at 7:30

a.m. and concluded at 12:45 p.m. A review of the program's logbook entries verified the classes were being conducted with minimal interruptions. Five interviewed youth indicated classes were being conducted on time and without interruptions. Additionally, due the COVID-19 pandemic, classes were conducted virtually with the aid of Google Classrooms and supplemental educational packets were also being incorporated into the curriculum delivery.

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

The purpose of the Educational Transition Plan is to formulate and provide to the youth, services and interventions based on the youth's assessed educational needs and post-release education plans created within the first ten days of the youth's entry into the program. In the absence of such document, evidence was collected from other resources to include the individual Electronic Educational Exit Plans, the program's Ninety-day Performance Summaries, and Exit Plans to ensure such planning had taken place. Upon the review of three closed youth case management records, it was evidenced each youth had in place a post-residential education plan which was derived from the aforementioned documents and were developed with the youth to include input from the program's education and aftercare staff and was based solely upon the youth's individual assessed needs, performance, and their post-release goals whether to include the continuation of education or employment. Each plan addressed key monitoring responsibilities and were acknowledged by individuals who are responsible for the re-integration and coordination of the provision of support services for the youth upon release from the program. Through signed acknowledgment, it was evidenced individuals were directly related to the plan's creation and implementation included, the youth, the parent/guardian, department and instructional personnel from the residential program, and personnel from the school district of which the youth would be returning to following release. The plan also included either a certified school counselor or others from the school district who are responsible for providing academic guidance services.

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 addressing transition planning, conferences, and Community Re-Entry Team (CRT) meetings. Three closed youth case management records were reviewed for compliance with transition planning and CRT meetings. All three

reviewed records confirmed each youth, treatment team leader, and designee had a transition conference completed by the program and held at least sixty days prior to the youth's targeted release date. All pertinent parties were invited to attend the transition conference through advanced notice and encouraged to provide written input if unable to attend. The transition activities and target dates were reviewed and all required signatures were obtained. Reviewed documentation confirmed completion of a CRT meeting prior to the youth's release. All three reviewed records had documentation the youth participated in the CRT meeting. A copy of the transition plan and conference was electronically sent to the juvenile probation officer (JPO) and each closed record contained an electronically signed copy of the form.

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

The program has a written policy and procedures outlining the program's process for the transition of the youth back into the community. The program develops an exit portfolio for all youth during the transitional phase of the program. A review of three closed youth case management records indicated an exit portfolio was discussed and started at or before the youth's transition meeting for each of the three records. A review of the exit portfolios indicated one youth was not applicable for a State of Florida issued identification card due the Department of Children and Family (DCF) case worker did not present documentation due to COVID-19 pandemic; however, two youth received a State of Florida issued identification card. All three youth received a copy of their transition plan and a calendar with dates, times, and locations of follow-up appointments in their home community. Two of the three exit portfolios contained a copy of the youth's original birth certification. The applicable DCF youth record did not due to the case worker not providing the information to the program. Three portfolios contained vocation certificates the youth earned in the program, educational documentation, school transcripts, résumé, and completed sample job applications. Documentation indicated each youth was provided a copy of the exit portfolio upon release. Youth were provided with completed forms and clear instructions on how to obtain relevant information, when applicable. Reviewed documentation confirmed educational staff forwarded information to the receiving school board. Program staff sent a copy to the juvenile probation officer (JPO) for all three youth.

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 in place outlining the program's exit process at least fourteen days prior to each youth's release. A review of three closed youth case management records supported each exit conference was conducted at least fourteen days prior to the youth's release. All three records contained the program's exit conference form with the date of the conference, signatures of participants, and a summary of the youth's pending transition goals. A review of the Department's Juvenile Justice Information System (JJIS) reflected the date of each youth admission and release date from the program was accurate. The multidisciplinary treatment team discussed the youth's transition activities established at the transition conference and finalized the plan for the youth's release. All exit conference forms were signed by the youth, education representative, treatment team leader, transitional services manager, and therapist. All three exit conference forms were either signed by the

parent/guardian and juvenile probation officer (JPO) or it was denoted they participated in the conference by telephone. The transition activities and target dates were reviewed and all required signatures were obtained. Reviewed documentation in all three exit conferences supported the treatment team leader, educational staff, youth, the assigned JPO participated by telephone or documented the attempted telephone contact with the parent/guardian, case manager, facility administrator, mental health staff, and medical staff participated.

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

The program has a written policy and procedures addressing the safety planning process for youth. The program maintains a safety plan for each youth which is located in a centralized location in the supervisor's office and accessible to all staff. Five interviewed staff were able to identify the location of all safety plans and reported they are reviewed daily and changes to the plan comes directly from the clinical director and are documented in the logbook. Five youth case management records were reviewed and all five records had safety plans completed within the fourteen days of arrival to the program. The reviewed records indicated the safety plan was jointly prepared by the youth, parent/guardian, case manager, and clinical staff. Youth confirmed they contributed to their safety plans which were applicable to be updated at least once every thirty-days. Documentation supported incorporating recommendations from the previous or current clinical assessments or screening instruments. Five interviewed staff stated the safety plans are reviewed daily and whenever youth are having a bad day.

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 written policy and procedures addressing the designated mental health clinician authority (DMHCA) which was reviewed, signed, and dated by the interim facility administrator (FA) and the DMHCA on August 3, 2020 and the psychiatrist on August 23, 2020. The FA is responsible for the administrative oversight and management of mental health and substance abuse services in the program. The program has a full-time licensed mental health counselor (LMHC) who serves as the program's DMHCA. The DMHCA is scheduled to work Monday through Friday, forty hours a week, and is on-call twenty-four hours a day; seven days a week. The DMHCA is responsible for the coordination and implementation of all the mental health and substance abuse services provided by the program, including fidelity checks of group therapy, ongoing and weekly supervision of clinical staff, facilitating training, making recommendations for youth presenting with suicidal ideation, and or crisis management. The DMHCA also provides clinical supervision to the program two master's-level non-licensed therapists in a face-to-face setting on a weekly basis and ensure the program clinical treatment programming complies with all requirements outlined within the substance abuse treatment overlay services (SAOS) specialized treatment services guidelines. An interview with the DMHCA confirmed the program offers SAOS treatment services to all youth in the program. The DMHCA confirmed being on call twenty-four hours a day and is scheduled to be on-site Monday through Friday for a minimum of forty hours each week. A review of the DMHCA's licensure reflected a clear and active licensed mental health counselor (LMHC) in the State of Florida as verified on the Florida Department of Health website. The current license expires on March 31, 2021. Reviewed documentation found the program utilizes the regional clinical director, who is also a LMHC to provide coverage in the absence of the DMHCA for the program. A review of the regional clinical director's license found it to be clear and active in the State of Florida expiring on March 31, 2021.

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

The program's policy, procedures, or contract does not require any other licensed clinical staff other than the individual serving as the designated mental health clinician authority (DMHCA); therefore, this indicator rates as non-applicable.

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 provides clinical supervision to ensure non-licensed clinical staff working under the supervision of the designated mental health clinician authority (DMHCA) are performing services they are qualified to provide based on education, training, and experience. The program has two full-time master's-level non-licensed mental health and substance abuse therapists. Both therapists received the required education, training, and experience to perform their assigned duties. The reviewed training records for the non-licensed therapists validated each completed the required twenty hours of training and five supervised assessments of suicide risk completed under the direct supervision and within the presence of the DMHCA. The program is licensed under Florida Statutes Chapter 397, by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services with an expiration date of January 14, 2021. The two non-licensed therapists conduct individual, group, and family counseling services, and any assessments as needed. The program's DMHCA assures the non-licensed clinical staff works under their direct supervision and qualified based on education, training, and experience. The DMHCA meets with the clinical staff weekly to provide clinical supervision, discuss youth-specific clinical issues, and to ensure documentation and deadlines are met. Reviewed supervision logs contained documentation of caseload reviews including a review of case history to include specific information related to youth progress, treatment needs and goals, caseload directions, instructions, and recommendations. The review of the direct clinical supervision log found the non-licensed therapists provide mental health and substance abuse services under the direct supervision of the DMHCA. In addition, non-licensed therapists participated in the treatment team meetings and received face-to-face clinical supervision. An interview completed with one of the program's non-licensed therapists revealed they received additional training throughout the year provided by the DMHCA.

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

The program has a written policy and procedures which explain the program's comprehensive screening process conducted for each youth during the admission process. The program ensures each youth's mental health and substance abuse needs are identified through the screening process which includes suicide prevention. All youth are assessed utilizing the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) conducted by a case manager during admission screening process to ensure the proper identification of mental health and substance abuse issues requiring immediate attention, assessment, and/or evaluation.

Each MAYSI-2 is administered by a trained case manager and the assessment is conducted in the Department's Juvenile justice Information System (JJIS). The program conducts further evaluation on each youth admitted regardless of the MAYSI-2 results. The program's clinical staff review all available information received in the commitment packet, records, reports, and

other documentation regarding the prior youth's mental health and substance abuse issues. The program's suicide risk screening process includes an initial evaluation of the youth at intake utilizing the Department's Assessment of Suicide Risk (ASR).

A review of five youth mental health and substance abuse records confirmed each youth received a MAYSI-2 on the day of admission completed in JJIS. Each youth also received an ASR on the day of admission and a new comprehensive mental health and substance abuse bio-psychosocial evaluation within twenty-one days of admission. The review of the youth's ASRs indicated each youth was placed on standard supervision. In addition to the MAYSI-2, each youth is assessed upon admission to the program utilizing the Adolescent Substance Abuse Subtle Screening Inventory (SASSI), the Suicide Probability Scale (SPS), the Beck Depression Inventory (BDI), the Trauma Symptom Checklist for Children (TSCC), clinical mental health and substance abuse intake screening, the Beck Depression Inventory, and the Adolescent Anger Rating Scale (AARS). An interview with the designated mental health clinician authority (DMHCA) explained a classification meeting is held for each youth upon admission to the program. Within the classification meeting, the findings of the MAYSI-2, records reviewed, Victimization and Sexually Aggressive Behavior (VSAB), ASR, and the initial interview process are reviewed. An interview with the interim facility administrator indicated beginning at intake, all youth are assessed for risk of mental health and substance abuse problems and suicide through the Department's ASR, SPS, BDI, the clinical mental health and substance abuse screening, and the MAYSI-2. In addition, each youth had a safety plan created at the time of admission to assess for history and preventive measures to avoid triggers.

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 plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the process by which all youth regardless of identified needs, are referred for the completion of a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. Due to the specialized population of youth admitted to the program and regardless of the outcome of their initial screening, the youth are automatically referred for a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. Following the admission process, if a youth exhibits behavior or need an in-depth evaluation, the assigned therapist initiates a referral for assessment documented on the Mental Health/Substance Abuse Referral Summary form.

The comprehensive bio-psychosocial evaluation is completed by the assigned therapist trained to complete evaluations, working under the direct supervision of a licensed professional with the youth, parent/guardian, applicable Department of Children and Families (DCF) case worker, and other parties involved in the youth's care. The assigned therapist obtains information through face-to-face interviews and records review processes. A review of five youth mental health and substance abuse records supported the program conducted an evaluation within thirty days of admission. The DMHCA is responsible to review each comprehensive mental health and substance abuse evaluation and review, approve, and document the treatment recommendations based upon the findings of the review. Each reviewed evaluation included demographic information, reason for the evaluation, relevant background information,

behavioral observations, mental status examination, procedures, discussion of findings, diagnosis impressions including the Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnosis, and recommendations. Each reviewed bio-psychosocial evaluation was inclusive of a substance abuse assessment.

The program is licensed under Florida Statutes Chapter 397, by the Department of Children and Families (DCF) to provide outpatient substance abuse treatment services with an expiration date of January 14, 2021. Each reviewed record contained the appropriate signed consent for substance abuse evaluation and treatment. An interview with the DMHCA and reviewed documentation indicated the program does not update any prior mental health and substance abuse assessment/evaluation; however, a new evaluation for each youth is completed.

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 maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. Each youth’s mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. The assigned therapist develops the youth’s individualized treatment plan through the coordination of the multidisciplinary treatment team based on identified needs and treatment is provided by staff trained to perform the services provided. The program provides on-site mental health and substance abuse treatment through the provision of substance abuse treatment overlay services (SAOS). The program’s treatment team is responsible for assisting in developing, reviewing, and updating the youth’s initial and individualized mental health and substance abuse treatment plans. An interview with the designated mental health clinician authority (DMHCA) and reviewed documentation reflected the program has not provided therapy sessions since March 4, 2020 due to the COVID-19 pandemic. All five interviewed youth confirmed their participation in family and individual counseling sessions in the program.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. All mental health and substance abuse treatment services are provided through the provision of substance abuse treatment overlay services (SAOS). The program identified the mental health and substance abuse needs of youth through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or identified as a possible suicide risk. Upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by the clinical staff to ensure the identification of the issues requiring immediate attention, and an initial mental health or substance abuse treatment plan is developed. The program also develops an individualized treatment plan for each youth and completes monthly revisions, reviews, and addendums to the individualized treatment plans when new problems or issues are identified.

The program provides SAOS treatment under the direct supervision of the designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC). Upon release from the program, all youth 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. The review of five youth mental health and substance abuse closed records found each reviewed record contained a complete discharge plan documented on the Mental Health/Substance Abuse Treatment Discharge Summary form, which was available during each youth's exit staffing. Each reviewed discharge summary documented the beginning and ending Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnosis with the presenting symptoms. There were no applicable youth released with an identified suicide risk alert. Each reviewed discharge summary contained clear recommendations for the continuation of the mental health and/or substance abuse treatment services needed within their home along with applicable referrals for continued services and documented youth and parent/guardian participation. The program's practice is to provide a copy of the discharge plan to the youth and parent/guardian upon release and provide a copy to the assigned juvenile probation officer (JPO).

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

The program has written policy and procedures regarding specialized treatment services which was reviewed, signed, and dated by the facility administrator (FA) and the designated mental

health clinician authority (DMHCA) on August 3, 2020. The review of the program's contract and clinical program description found the program provides substance abuse treatment overlay services (SAOS) to all youth. Treatment services is guided by an individualized mental health and substance abuse treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code.

The SAOS services include substance abuse assessments, treatment, and relapse prevention. All specialized mental health and substance abuse treatment services are provided by the DMHCA and the two master's-level non-licensed therapists. At the time of the annual compliance review, the clinical therapists were staffed in full in accordance with the current contract and applicable amendments. Each youth is assessed upon admission utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). A review of the contract amendments indicated the program provides each youth with group therapy services seven days a week. The program's contract outlines SAOS provided includes Aggression Replacement Therapy (ART), Cognitive Behavioral Therapy (CBT), Men's Trauma Recovery and Empowerment Model (M-TREM), Seeking Safety, and Living in Balance (LIB).

An interview with the DMHCA and the program's regional clinical director indicated the program had two non-licensed clinicians trained to deliver ART during the review period and at the time of the annual compliance review there was one trained clinician due to a resignation. The program has not conducted ART or Seeking Safety groups in the last twelve months. According to the DMHCA, youth with a history of anger control or a diagnosis participated in Anger Management for Substance Abuse and Mental Health group and there are two non-licensed therapists trained to deliver the curriculum.

The DMHCA indicated the program has not conducted M-TREM groups in the last twelve months. The DMHCA did indicate any youth with a history of trauma would receive trauma-informed care through individual therapy. The program's regional clinical director indicated all youth upon admission participate in LIB. A review of the LIB attendance logs supported all sixteen youth currently in the program participating in the group.

The program utilizes a licensed psychiatrist to provide medication management and an interview with the psychiatrist indicated they meet with the DMHCA and the FA weekly to exchange youth's clinical information, treatment, and to ensure sustainability. Clinical services provided by the program include substance abuse assessments/evaluations, including drug screening upon admission into the program including routine and random urinalysis drug testing with positive test followed by appropriate clinical intervention and sanctions. Individualized substance abuse treatment planning and daily treatment services are also provided. Each youth's individualized mental health and substance abuse treatment plan outlines individual and family therapy one time each month and group therapy seven days a week. The program provides crisis intervention therapy and management, suicide prevention services, mental health evaluation, and treatment for youth with co-occurring mental disorder. Therapists caseloads are twelve youth for each therapist. Youth are encouraged to practice pro-social skills, family involvement, and effective treatment team participation.

The program has an agreement for professional services with a contracted vendor for the provision of psychological services to the youth in the program, which is utilized on an as-needed basis. The psychologist assigned by the contractor has a clear and active license, which expires on May 31, 2022. The program has not utilized psychological services in the last twelve months. An interview with the DMHCA indicated the program did not have any applicable youth

requiring extreme measures to be implemented; however, the DMHCA created behavioral contracts and individualized treatment plans for applicable youth. An interview with the interim FA confirmed the program provides SAOS to youth with a comprehensive array of mental health and substance abuse services. The FA indicated each youth is admitted to the program given their substance abuse history and diagnosis, and all youth receive individual, group, and family counseling related to their individualized needs.

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

The program has an independent contract agreement with a licensed medical doctor who maintains a clear and active license in the State of Florida with an expiration date of January 31, 2022, for the provision of psychiatric services to all applicable youth in the program. The psychiatrist education is in child and adolescent psychiatry and scheduled to be on-site on Sundays for two hours each week and provides psychiatric evaluations, monitor medication management, regular consultation, and emergency consultation with the facility administrator and the designated mental health clinician authority (DMHCA). The psychiatrist is also available for consultation twenty-four hours a day, seven days a week. In the event the psychiatrist is on scheduled leave, the program maintains a contract agreement with a medical doctor licensed in the State of Florida to serve as the back-up psychiatrist. The back-up psychiatrist education is in child and adolescent psychiatry. According to the program, the back-up psychiatrist was not utilized during the annual compliance review period. The psychiatrist participates with the treatment team regarding youth needs and progress and provides psycho-pharmacological therapy to each applicable youth.

A review of the program's mental health and substance abuse profile and the psychiatrist's sign-in sheets validated the psychiatrist is on-call for consultation twenty-four hours a day, seven days a week. All youth receive an initial psychiatric evaluation and monthly comprehensive psychiatric evaluation completed on the Department's Clinical Psychotropic Progress Note (CPPN). The program's practice is to refer all youth for an initial psychiatric evaluation, regardless of medication status. The psychiatrist documented medications prescribed, medication name, dosage, frequency, diagnosis, side effects, and dosage range on each CPPN. An interview with the psychiatrist indicated they meet with the DMHCA and the FA weekly to exchange youth's clinical information, treatment, and to ensure sustainability.

A review of five youth mental health and substance abuse records found each youth was referred at admission to the psychiatrist for evaluation. Youth prescribed psychotropic medications are evaluated monthly. The psychiatrist and the DMHCA meet weekly to discuss and review each youth receiving psychotropic services, their progress, and follow-up treatment. Reviewed documentation found the psychiatric also contacted each youth's parent/guardians to obtain permission or discuss issues, as needed when prescribing psychotropic medications. Each reviewed mental health and substance abuse record revealed each contained a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis which included the youth's medical history, mental status evaluation, treatment recommendations, applicable prescribed medications, the explanation for the need of psychotropic medication, and

the frequency of monitoring medication. Each initial diagnostic was documented on the Department's CPPN and contained page number three of the CPPN, and clearly documented the treatment plan discussion with the youth and parent/guardian. Three of the five reviewed youth records supported the youth entered the program with prescribed psychotropic medication. Each applicable youth was seen by the psychiatrist at a minimum of every thirty days.

An interview with the psychiatrist confirmed this practice.. The program does not have a certified addition professional (CAP) or the assistance of a psychiatric advanced practitioner registered nurse (APRN). Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications.

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 maintains a written policy and procedures regarding a suicide prevention plan who is reviewed annually and was last reviewed, approved, signed, and updated by the facility administrator, designated mental health clinician authority (DMHCA), and the psychiatrist on August 23, 2020. The program's written plan detailed suicide prevention procedures and included identification, staff training, suicide precautions, levels of supervision, referrals, communication, notifications, documentation, immediate staff response, a review process, review of serious suicide attempt and self-inflicted injury, mortality review, and an emergency notification list, serious suicide attempt or serious self-inflicted injury review and mortality review, as outlined in Florida Administrative Code 63N-1. An interview with the DMHCA indicated the program provides suicide prevention training throughout the year and conducts monthly mock emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury.

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

The program maintains a written policy and procedures regarding suicide prevention services which was last reviewed, approved, signed, and dated by the facility administrator and the designated mental health clinician authority (DMHCA) on August 3, 2020. The program assesses each youth utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Assessment of Suicide Risk (ASR). Youth identified with an elevated suicide risk are placed on precautionary observation (PO) until they are evaluated by the DMHCA. Each

youth placed on PO remained on constant supervision until a Follow-Up ASR was completed and the youth was stepped down to close supervision. A mental status examination was conducted prior to stepping each youth down to standard supervision. The mental health therapist provided supportive counseling as documented on the reviewed Suicide Precaution Observation Logs.

A review of five youth mental health and substance abuse records indicated only one youth in the program was applicable for suicide prevention services in the program since the last annual program's compliance review. The applicable record indicated the youth was placed on precautionary observation (PO), the ASR was timely completed, the program's mental health staff provided supportive services, and a Follow-Up ASR was completed prior to the removal of youth from PO. The discontinuation of close supervision was documented in accordance with the program's suicide prevention plan, the youth's parent/guardian and the assigned juvenile probation officer (JPO) were notified. The review of the ASR found it contained all the required elements and was completed in the required time frame. An interview with the DMHCA, revealed the program does not utilize secure observation (SO). Observations during the annual compliance review confirmed the program had two suicide response kits; one located in the medical office and the remaining one located in sub-control. Both suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. The review of the program's suicide prevention plan confirmed the program has an established review process for every serious suicide attempt or serious self-inflicted injury, and a mortality review for a complete suicide.

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

The program maintains a written policy and procedures regarding suicide precaution observation logs to ensure youth placed on suicide precautions are maintained on one-to-one or constant supervision. The program's policy and procedures were last reviewed, approved, signed, and update by the facility administrator and the designated mental health clinician authority (DMHCA) on August 3, 2020. A review of five youth mental health and substance abuse records found only one youth in the program was applicable for the completion of the suicide precaution observation logs since the last annual compliance review. The review of the applicable youth record indicated the Suicide Precaution Observation Logs were maintained for the duration the youth was on suicide precautions. The review of the logs also confirmed the appropriate level of supervision and observations of the youth's behavior was documented in real time and in all the required time intervals. The reviewed logs documented safe housing requirements and were reviewed and signed by each applicable shift supervisor and reviewed and signed by mental health clinical staff.

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

The program has a written policy and procedures regarding suicide prevention training to ensure all staff who work with youth is trained to recognize verbal and behavioral cues

indicating suicide risk, suicide prevention, and implementation of suicide precautions. The program's policy and procedures were last reviewed, approved, signed, and dated by the facility administrator (FA) and the designated mental health clinician authority (DMHCA) on August 3, 2020.

Reviewed training documentation and an interview completed with the program's DMHCA, confirmed all staff receive intensive training on suicide prevention throughout the year. An interview with the DMHCA revealed all program staff receive training on suicide prevention which consists of a thorough review of the program's suicide prevention plan which includes techniques, behavioral cues, and recommended responses. All training sessions includes rapid identification, referral, screening, and assessment of youth having suicide risk factors upon their intake to the program. The training consists of a thorough review of the suicide prevention plan and include detection techniques, behavioral cues, and recommended responses. A review of five mental health staff training records indicated each staff completed the required six hours of annual suicide prevention and implementation of suicide precautions training. Training was conducted face-to-face by the DMHCA, as well as online in the Department's Learning Management System (SkillPro).

A review of the program's mock suicide drills confirmed the program conducts monthly suicide drills in order to ensure all staff who come into contact with youth will participate at least one time semi-annually. A review of the program's staff roster indicated twenty-two staff were required to have participated in mock suicide drill at least semi-annually. Documented practice supported each staff participated as required. The reviewed drills allowed staff to practice contacting other program staff, medical personnel, and emergency medical services utilizing cardiopulmonary resuscitation (CPR) techniques, automated external defibrillator (AED), and other first aid procedures including the use of the both suicide response kits. The review of the completed drills provided staff members who were not present during the actual drill were able to review the mock drill scenario and procedures in order to receive the necessary training to respond to an incident of a suicide attempt or serious self-inflicted injury.

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 maintains a written crisis intervention plan which was reviewed, approved, signed, and dated by the facility administrator and the designated mental health clinician authority (DMHCA) on August 3, 2020 and the psychiatrist on August 23, 2020. Reviewed documentation confirmed the program's crisis intervention plan is reviewed annually. The plan includes notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation and review process, and contained an emergency staff notification list. The program practice is to submit a mental health and substance abuse referral summary to the mental health staff for any youth demonstrating acute emotional, psychological distress, or self-injurious behavioral issues to receive crisis assessment, intervention, and counseling.

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 maintains a written policy and procedures which was reviewed, approved, signed, and dated by the facility administrator and the designated mental health clinician authority (DMHCA) on August 3, 2020. The program's policy regarding crisis assessments ensures a crisis assessment is administered for youth demonstrating acute psychological distress, conducted by a licensed mental health professional or by a non-licensed mental health clinical staff working under the direct supervision of a licensed professional. A crisis assessment is conducted immediately or within two hours for emergencies or within twenty-four hours based on the needs of the youth. A mental health alert is entered into the Department's Juvenile Justice Information System (JJIS) for youth requiring a crisis assessment. A review of five youth mental health and substance abuse youth records indicated none of the five youth were applicable for a crisis assessment. Documentation reviewed and an interview with the DMHCA revealed only one youth in the last twelve months were applicable for requiring a crisis assessment during the annual compliance review period. The applicable youth was observed with moderate hostility and in psychological distress not associated with suicide risk factors or behaviors. The non-licensed mental health therapist under the direct supervision of the DMHCA, completed the crisis assessment which included all required elements. The DMHCA documented their review and signature the same day. The review of the assessment found it was completed within two hours of the crisis, the youth was not deemed in crisis and was placed on standard supervision. An Interview with the DMHCA indicated the program did not have any applicable Prison Rape Elimination Act (PREA) events during the annual compliance review period.

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 maintained a written emergency mental health and substance abuse services plan which was last revised, approved, signed, and dated by the program's facility administrator and the designated mental health clinician authority (DMHCA) on August 3, 2020 and the psychiatrist on August 23, 2020. The program's emergency care plan included procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Status, transport for emergency substance abuse assessment and treatment under Chapter 397, documentation, training including mock drills, and review. The plan contained all the elements required by Florida

administrative Code 63E-7 and 63N-1. All the program staff are required to be certified in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). All the program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. The program utilizes the Joe DiMaggio Children's Hospital located in Hollywood, Florida as the crisis stabilization unit.

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 a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. The program currently has an independent contract with a licensed medical doctor (MD) who has a specialty training in pediatrics to serve as the designated health authority (DHA) which was signed on November 3, 2016. The current contract renews automatically, annually. The DHA holds an unrestricted clear and active license in the State of Florida with an expiration date of January 31, 2022. The DHA is contracted to be on-site at a minimum of two hours weekly with no more than nine days passing between site visits. Reviewed physician logs for the past six months supported the DHA was on-site weekly, as required. The program also has a cooperative working agreement with a licensed MD to provide coverage in the event of scheduled absences, emergency services, and vacations. The program does not utilize an advance practice registered nurse (APRN) or physician's assistant (PA). The backup MD has an active license to practice in the State of Florida with an expiration date of January 31, 2022. The DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. Documentation related to healthcare services and the review of youth healthcare records confirmed the DHA provides oversite for all healthcare provided at the program. An interview with the DHA confirmed, the DHA sees all youth upon admission to complete a full Comprehensive Physical Assessment (CPA). The DHA also reported conducting sick calls, periodic evaluations, and reviewing/signing healthcare policies and procedures and nursing protocols.

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

The program maintains facility operating procedures (FOPs) for all health-related procedures and protocols utilized. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation found the DHA and facility administrator (FA) signed the healthcare policies and procedures and treatment protocols. Reviewed documentation validated the DHA and FA signed the healthcare policies and procedures on August 3, 2020 and August 10, 2020. The DHA signed the treatment protocols on July 29, 2020 and the FA signed the treatment protocols on August 3, 2020. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2022. All FOPs and protocols related to psychiatric services were reviewed and approved by the program's contracted psychiatrist on August 23, 2020. A review of the FOPs cover page documented signatures of all medical staff on July 1, 2019 through August 3, 2020. The program's director of nursing reported there were no new medical staff since the last annual compliance review; however, the program does maintain a training requirement which requires newly employed healthcare staff to complete a comprehensive clinical orientation to the Department's healthcare policies and procedures.

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

The program has a written policy and procedures regarding the authorization of treatment (AET) for all youth admitted into the program. The AET form is signed by the parent/guardian and serves as informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter (OTC) medications which can be treated by healthcare staff. The program also utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. A review of five youth healthcare records found one youth which turned eighteen years of age while in the program had a copy of an AET. Once the youth turned eighteen years of age, a signed Release of Information form was completed and filed in the youth's individual healthcare record (IHCR). Two youth were applicable for a signed AET. Each applicable IHCR had a parent/guardian signature along with a witness signature. Two of the five reviewed youth IHCRs contained a copy of the signed AET and the word, "copy" was clearly stamped on each. One youth's IHCR contained an original AET. Two youth were in the custody of the Department of Children and Families (DCF) and the records contained court orders to administer medical treatment. Each applicable IHCR included a copy of a completed parental notification behind the AET. During an interview, nursing staff reported all youth should have a valid AET upon admission to the program. If the youth does not have an AET, the healthcare staff will collaborate with both the juvenile probation officer (JPO) in obtaining a new and/or current AET. The nurse also reported a request for the parent/guardian to come on-site will be made to obtain a signature.

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

The program has a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of five youth healthcare records found two were applicable for parental notifications. One additional record was requested and reviewed. Each applicable IHCR confirmed the parent/guardians were notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic condition. All three IHCRs included parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET). Two youth were applicable for off-site emergency care and reviewed documentation supported the parent/guardians were notified. Reviewed documentation supported written notification was sent to the parent/guardian regardless of telephone notifications. Each applicable record contained documentation indicating the program obtained consent prior to administering psychotropic medications. Telephone consent conducted by the psychiatrist and witnessed by the nurse was documented, when applicable.

The parent/guardian received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note.

Copies of all correspondence were maintained in the applicable IHCRs. There were two reviewed youth records where there was shared custody with the Florida Department of Children and Families (DCF); however, there were no applicable medical events requiring the notification of the DCF case worker. Each youth's IHCRs reflected vaccinations were verified within thirty days of the youth's admission. Each record contained a copy of the youth's immunization record received from the Department, the Florida Shots website, and/or school records. There was no evidence of a youth's parent/guardian refusing to consent to a vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. An interview with the nursing staff confirmed this practice.

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

The program has a written policy and procedures in place ensuring each youth receives a screening for health concerns upon admission, or at a minimum each time the physical custody of the youth changes and returned or readmitted to the program. The program's practice is to complete a rescreening and complete the Department's Facility Entry Physical Health Screening (FEPHS) form when a youth is admitted into the program or return to the program following a physical custody change. A review of five youth individual healthcare records (IHCRs) validated each youth received an admission screening utilizing the Department's FEPHS form. All admission screenings were completed by a registered nurse (RN). None of the five reviewed healthcare records were applicable for a change in custody. An interview with the RN indicated the program did not have any applicable youth with a change in custody in the last twelve months.

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

The program has a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. The program's practice is to have the nurse or a medical staff knowledgeable with the health care delivery system provide healthcare orientation upon each youth's admission. Five youth individual healthcare records were reviewed and each reflected the youth received a general care orientation upon admission to the program. The topics reviewed included access to medical care, sick call, what constitutes an emergency, medication process to include side effect monitoring, the right to refuse care, sexual assault, and the non-disciplinary role of the healthcare providers. Youth and nursing staff signed the health education packet acknowledging the orientation was conducted and the youth reviewed and understood the information. A review of each applicable youth's health education form validated youth continue to receive health education throughout their stay.

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

The program has a written policy and procedures to notify the designated health authority (DHA) of all youth admitted into the program identified with chronic health conditions or youth in need

of emergency care. The program's practice is to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Five youth individual healthcare records (IHCRs) were reviewed. Each record documented the DHA was notified of the youth's admission even when the youth was not identified with a chronic condition. One youth was identified with a known or suspected chronic condition. Two additional youth records were requested and reviewed for youth with known or suspected chronic conditions. Each of the youth IHCRs reflected telephonic notification to the DHA of the youth's admission into the program. None of the youth presented a condition requiring an emergency response. Reviewed documentation confirmed nursing staff updated the Chronic Conditions Log after the notification was completed.

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

The program has a written policy and procedures to address the completion of the Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA) upon each youth's admission to the program. Five youth individual healthcare records were reviewed for completion of a Health-Related History (HRH) form. In each youth's record, the HRH was completed on the day of the youth's admission. The nursing staff provided their electronic signature on the HRH form. Each applicable record documented the designated health authority (DHA) reviewed the HRH by a check box on the CPA. An interview with the registered nurse confirmed this practice.

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

The program has a written policy and procedures ensuring each youth receives or has on file a current Comprehensive Physical Assessment (CPA) no later than seven calendar days of admission into the program. The program utilizes the Department's CPA form when assessing each youth. Five youth individual healthcare records (IHCRs) were reviewed for completion of the CPA form. All five CPAs were completed in full by the designated health authority (DHA) and each documented the current medical grade. All sections were marked with an "O", an "X", or a line indicating no need. All five reviewed IHCRs indicated no youth refused any portion of the medical examination. A review of each youth IHCR validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis (TB). In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening. All tier I TB screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's TST Purified Protein Derivative (PPD) form. There were no current youth with symptoms suggestive of active TB. The program's policy indicates youth will not be placed into the general population until their healthcare needs identified are deemed to not require immediate medical attention and/or a referral for further assessment by healthcare staff. Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. An interview with the registered nurse confirmed this practice.

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

The program has a written policy and procedures in place ensuring all youth entering the program are clinically screened, evaluated, and treated if necessary for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV). A review of five youth individual healthcare records (IHCRs) confirmed the STI screening form was signed by the youth and nurse at the time of the youth's admission. Each applicable healthcare record indicated each youth was identified as sexually active and was referred to the DHA. All test results were reviewed by the DHA and filed in the lab section of the youth's IHCR. In addition, the screening results were 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. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. One youth consented to the HIV testing and four did not consent testing. Two additional records were requested and reviewed. Each applicable youth's HIV results were filed confidentially in a sealed envelope marked "confidential." The program maintains a HIV testing tracking log for all youth who received testing. A review of the program's internal alert system validated none of the youth's HIV status were documented. Each youth's IHCR documented the pre-test counseling, post-test counseling, and education on the Department's Health Education Record form. The program has one registered nurse on-site who maintains a current 501 HIV/ acquired immunodeficiency syndrome (AIDS) certificate for HIV prevention counseling and testing with an expiration date of December 31, 2020. Five youth were interviewed and indicated they can request a HIV test while in the program.

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

The program has a 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. Sick call care is provided by licensed medical staff, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). Youth are informed of the sick call process at the time of their admission to the program during orientation. The program's practice is to have youth complete a sick call request utilizing the Sick Call Request form and submitting the form in the wall-mounted locked boxes located in designated areas in the program. The program's registered nurse (RN) checks the sick call box two times a day. Sick calls are scheduled Monday through Friday at 10:00 a.m. and 5:00 p.m., and Saturday and Sunday at 10:00 a.m. and 5:00 p.m. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the shift supervisor for review. The supervisor is required to review the sick call complaint promptly, but no longer than two hours after the request was submitted. The supervisor will then determine if the sick call requires immediate attention. The

DHA and/or designee are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. The program currently has all shift supervisors trained on the sick call process.

During a tour of the program, the annual compliance review team observed Sick Call Request forms mounted on the wall in designated areas. A review of five youth individual healthcare records validated three youth submitted at least one Sick Call Request form since their admission into the program. Reviewed documentation supported each youth received an orientation to healthcare services which included sick call request. None of the reviewed youth healthcare records documented similar sick call complaints three or more times within a two-week period. When applicable, youth in restricted housing individual healthcare record reflected the youth was seen by the nurse daily. All reviewed sick call incidents were documented on the Sick Call Index and Sick Call Referral Log. During the annual compliance review week, the director of nursing reported there were no sick calls to observe. However, an observation of the medical clinic validated youth are seen in a private area within the medical clinic. Five interviewed staff indicated nursing staff review and conduct sick call. Three interviewed youth indicated they can see the nurse within one day and two youth reported they have never submitted a sick call.

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

The program has a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Episodic care is provided by the nurse and documented in the progress chronological notes and tracked on the episodic log. Any episodic care provided by a non-licensed staff must have a follow-up evaluation by a licensed healthcare professional the next time the staff is on-site, or sooner if indicated. The healthcare staff documents the follow-up evaluation on a nursing chronological note. A review of five youth individual healthcare records (IHCRs) reflected two youth received on-site first aid or episodic care. One additional record was reviewed for episodic and emergency care. Two IHCRs reflected treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. One youth's IHCR reflected treatment was provided by a non-healthcare staff. The non-healthcare staff documented the nature of the complaint on the Report of On-Site Care by Non-Healthcare Staff form and the nurse documented the follow-up evaluation within the required time frame. Each episodic event was documented on the Department's Episodic Care Log.

The program maintains one automated external defibrillator (AED) located in the supervisor station. During the annual compliance review week, the nursing staff demonstrated the AED and found it to provide audio instructions. Nursing staff complete weekly checks and document the checks on the weekly log. Reviewed logs supported the AED battery expires on February 2029 and were last changed on October 21, 2019. The AED pads expire on December 2023 and were last changed on November 14, 2018. The program maintains nine designated health authority (DHA) approved first aid kits in various areas of the program. Three first aid kits were opened by nursing staff and each was fully stocked with the DHA approved contents as outlined on the lid of each kit. Reviewed documentation supported nursing staff conducts weekly checks on each first aid kit and documents the review on the weekly log. The program conducts mock medical drills monthly on each shift.

The program conducts announced and unannounced emergency medical drills monthly on each shift. Documentation reflected emergency drills were held monthly on each shift and included the use of AED and cardiopulmonary resuscitation (CPR). Five reviewed in-service and nine pre-service training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, CPR with AED, and administration of an epinephrine auto-injector. Reviewed documentation confirmed the programs registered nurses each maintained current certifications in CPR/AED and basic first aid. The program reported emergency telephone numbers were located at the supervisor's station and the medical clinic accessible to staff but inaccessible to youth. Five interviewed staff indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency. One staff also stated the supervisor can call 9-1-1. Five interviewed youth indicated they can see a doctor and/or dentist, if needed.

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

The program has a written policy and procedures ensuring timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth individual healthcare records (IHCRs) indicated two youth required off-site first aid and/or emergency care. One additional record was reviewed for first aid and/or emergency care. Parental notification was documented, when applicable. The Summary of Off-Site Care Form was completed for the youth and was filed in the IHCR. Reviewed documentation supported the DHA reviewed and completed the off-site care form and applicable discharge paperwork, as evidenced by the DHA signature and date. Each youth required follow-up care and was scheduled to receive services as prescribed. Reviewed documentation validated the DHA documents the review on the off-site care form and nursing staff track any follow-up appointments through the medical tracking calendar.

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

The program has a written policy and procedures ensuring youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the period evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. During the admission healthcare screening process, registered nursing staff complete the Facility Entry Physical Health Screening (FEPHS) form and the Health-Related History (HRH) form to identify youth allergies, disabilities of any kind, or chronic medical conditions. A review of five youth individual healthcare records (IHCRs) indicated one youth were identified upon admission and completion of the FEPHS form with a chronic condition. Two additional applicable youth IHCRs were reviewed. All three youth were classified with a medical grade two to five. One youth was undergoing treatment for a physical health condition which included a body mass index greater than thirty. There were no youth in the program prescribed anti-tuberculosis medication. The program maintains a youth roster of youth requiring periodic evaluations which documents the

youth's name, date of admission, whether the youth was admitted with prescribed medications, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations, as required. An interview with the registered nurse confirmed this practice. There was no indication of lapses in care or missed periodic evaluations in each of the reviewed records. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. All three IHCRs documented updating of the Department's Problem List as changes occurred. An interview with the program's designated health authority (DHA) confirmed this practice. In addition, medical staff meets with the facility administrator weekly to discuss any medical issues pertaining to the youth in the program.

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

The program has a written policy and procedures ensuring medical staff verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and indicated. Medications are administered only by the order of the consulting licensed physician, designated health authority (DHA) , and/or psychiatrist. A review of five youth individual healthcare records (IHCRs) found two youth were admitted into the program on prescribed medication. One additional record was requested during the annual compliance review. Reviewed documentation supported the nursing staff verified the medication during the admission healthcare screening and a new order to continue the medication was obtained by either the DHA or psychiatrist. The contact was documented on the DHA and Psychiatrist Notification of Admission form, as well as on the Admission Chronological Progress Note form. Any time current medications were continued, discontinued, changed, or a new prescription was ordered, the DHA and/or psychiatrist placed an order on the Physician's Order form which was signed and dated by the physician. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The registered nurse (RN) completed the Prescription Medication Verification Checklist and Medication Receipt, Transfer, and Disposition form when youth were admitted with current prescribed medications ensuring all medications have a current and valid order and were given pursuant to a current prescription. 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 initial MAR for each record matched the medication(s) listed. The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff and the youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two RNs. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. When applicable, each youth MAR outlined over-the-counter medications (OTC) approved through the Authority for Evaluation and Treatment (AET) form and was administered in accordance with the approved protocols and physician's order. When applicable, refusals of medications were documented. There were no indications of lapses and/or errors in the medication administration for the youth reviewed; however, on October 28, 2020 a Central Communications Center (CCC) was reported due to a youth being administered another youth's medication, which will impact the program's daily inventory count.

Nursing staff maintains locked cabinets in the medical clinic with OTC medications listed on the (AET form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on-site. The program's practice is to ensure the Six Rights of Medication Delivery and Administration is maintained for the youth.

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 Department requirements. The program's process for the disposal of medication is for all medications to be disposed utilizing the Drug Buster Destroyer or returned to First Choice Pharmacy. The program's procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. The medication cart was observed to be clean and well organized with youth-specific medications. Prescribed narcotic medications were stored in a locked box within the secured medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one medication refrigerator located the medical clinic. At the time of the annual compliance review, the program had one medication requiring refrigeration. Five staff were interviewed and reported the nurse provides youth with medication. One staff also reported the supervisors provide medication. Five youth were interviewed and three reported medication is administered by the nurse. One reported medication is administered by the doctor and two indicated not taking medication.

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

The program has a written policy and procedures ensuring medical equipment classified as medications/sharps are secured and inventoried by using a routine perpetual inventory. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Medications such as injectables, topicals, drops, and liquids are stored separately. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications. Reviewed documentation and nursing interviews confirmed all medications included over-the-counter (OTC) are inventoried weekly using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RNs). The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist's license expires on December 31, 2020. The program's practice is for the RN to send back all expired medication, unused medication, disposal of narcotics, and other controlled substances to the pharmacy at the end of the month for proper disposal. Non controlled substance can be destroyed by utilizing the Drug Buster Destroyer. Observations conducted during the annual compliance review week, supported three youth prescribed medication inventories were accurate. Three OTC medications, two controlled medications, and three sharps were reviewed and inventories were determined to be accurate. A review of the program's counts from the past six months validated no discrepancies were identified with inventory counts. The program utilizes a contracted vendor for all medical waste pickups. The contactor properly dispose of any medical waste at the program monthly.

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

The program has a written policy and procedures ensuring there is an approved plan for infection control and exposure control to ensure staff, youth, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan also includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. The plan was reviewed and approved by the facility administrator on August 19, 2020, the designated health authority (DHA) on August 26, 2020, and the nursing staff on July 1, 2019 through August 1, 2020.

The program maintains procedures for staff to adhere to universal precautions. The program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through a contracted vendor. The program reported applicable incidents to the Department's Central Communications Center (CCC) 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. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The program's plan has a comprehensive process for needle stick post-exposure evaluation. The plan includes risk assessment and methods of compliance. In the event of an incident, the facility administrator (FA) has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. The interim FA reported a copy of the program's exposure control and infection control plans are maintained in the medical clinic, human resource office, and supervisor station. The interim FA also reported the plan is reviewed with staff annually, or as needed.

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

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

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

The program has a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. Daily clinical care is performed by licensed medical staff such as a registered nurse (RN) in accordance to develop authorized protocols. All nurses have clear and active licensure and current cardiopulmonary resuscitation (CPR) certifications. At the time of the annual compliance review, the program had one director of nursing, one registered nurse, and one pro re nata (PRN) registered nurse. The program does not utilize a licensed practical nurse (LPN).

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. The program promotes safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system (BMS). Youth and staff observations were conducted each day throughout the annual compliance review week and reflected during group, lunch, day room activities, school and line movement, staff were positioned to ensure proper supervision, and to ensure there were no physical obstructions in their view of the youth. Observations made throughout the week of the annual compliance review included youth movement from classroom to the dayroom area as well as nighttime activities in the dorm when preparing for bed. Youth-to-staff ratios were observed in compliant with the program's contract of one staff for every eight youth during awake hours and one staff to ten youth during sleep hours. The staff were knowledgeable of the ratio during transportation with exception of one staff who was unaware of the youth-to-staff ratio during transport.. Informal interviews were conducted with supervising staff each day and reflected staff were aware of how many youth they were supervising and were knowledgeable of the program's procedures when there is a discrepancy in youth counts.

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

The program has a written behavior management system (BMS) approved by the facility administrator (FA) on August 12, 2019, which has not changed since the last annual compliance review. The BMS is clear, specific, and is included in the youth and parent/guardian handbook which offers a detailed explanation of the program's system, program rules, expectations, and teaches youth alternative prosocial methods of dealing with problems. A review of five youth case management records confirmed each youth received an orientation upon admission through the program's youth handbook, which includes a detailed outline of the BMS. Reviewed documentation reflected each youth signed the youth handbook to acknowledge their receipt of the handbook upon admission into the program. A review of nine pre-service training records and five in-service training records confirmed each staff was trained in the program's BMS. The program provided training and sign-in sheet documentation of staff members from the Broward County School District receiving training

on the program's BMS. Monitoring of the BMS reflected the program has postings of the BMS posted throughout the facility which is accessible to all youth and staff. A review of the program's facility operating procedures confirmed fidelity checks are used during daily and monthly staff and treatment team meetings to monitor rewards and consequences/punishments to ensure the rewards outnumber consequences at a minimum ratio of four-to-one positive to negative consequences. Five staff were interviewed and each were aware on how the BMS should be implemented, the point system used by the program, the usage of the level system and the individual behavior plans, and were able to explain the type of rewards given to youth. Five youth were interviewed and each reported rewards include Big Friday, having extra meals brought in, games, and movies.

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

The program has a specific and clearly written policy and procedures on the behavior management system (BMS). The BMS provides for positive and negative consequences in a ratio of four-to-one positive to negative consequences. The program does not utilize room restriction as a form of imposing sanctions for inappropriate behavior. The system makes provisions for staff to explain to the youth the reason for any sanctions imposed, youth to explain their behavior, and gives staff and youth the opportunity to discuss the behavior's impact on others. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and constantly imposed. All program infractions are reflected on the applicable youth's daily point cards. The BMS is not used to increase a youth's length of stay. A sample review of randomly selected staff position descriptions was reviewed and reflected they specified implementation of the BMS as a job requirement. Reviewed documentation confirmed staff receive an initial ninety-day performance evaluation followed by an annual evaluation which includes an evaluation of the staff's job duties overall; however, the evaluation does not specifically state BMS. Program management provides updates and feedback on the staff's use of rewards and consequences regarding the BMS when noticed, during staff meetings, and during shift briefings. Five staff were interviewed and each stated their supervisors provide feedback to staff regarding the implementation of the BMS during one on one supervision or during a coaching session. Five interviewed staff each confirmed rewards include verbal praise, Big Friday, weekly incentives, and off-site outings prior to the COVID-19 pandemic. Five youth were interviewed and four youth confirmed they are never allowed to punish another youth. One youth indicated they are allowed to punish; however, the youth would not elaborate upon further interview. When questioned how they would rate the program's BMS, all five youth rated the BMS system as good or very good.

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

The program has a written policy and procedures regarding ten-minute checks. All staff shall observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time, or at other times such as during an illness. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically. The program utilizes a Ten-Minute Check Log to document the checks while the youth are in their sleeping quarters. The interim facility administrator reported there is a total of thirty cameras in which twenty-six were operational. A work order with an outside vendor is in process to complete the repairs on the cameras. The video system stores video recordings for up to thirty-days. Reviewed documentation of the program's Ten-Minute Check Log reflected staff documented the actual time of the room check and initialed on the Ten-Minute Check Log Sheets verifying who completed the room check. A review of Ten-Minute Check Logs from six randomly selected days and times from two different shifts were reviewed and compared with corresponding video recordings. Reviewed documentation verified checks were conducted at least every ten minutes by staff with fidelity and were documented accordingly in real time. Five staff were interviewed and each confirmed room checks are conducted every ten minutes.

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

The program has a clear policy and procedures in place to ensure youth are accounted for through a system of physical counts at various times throughout the day. The program conducts and documents youth counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations. The program tracks daily census information including at a minimum the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. The program documents the counts in the facility logbook. According to the program's policy and an informal interview with the interim facility administrator, staff are to conduct counts of youth

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

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

The program has a clear and specific written policy and procedures for logbook entries. Staff maintain a daily bound logbook with numbered pages and all medical and mental health alerts are written in red ink. The logbook documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), Florida Abuse Hotline, and youth placed and removed from precautionary observation with instructions pertaining to the supervision of youth. A review of the logbooks for the last six months had minimal strike-through errors; however, when an error was made the staff did it correctly. The logbook did include late entries which was written correctly. All entries included the dates and times of the events the names of the staff and youth involved, a brief description of the events, and the names and signatures of the staff making the entries. There were two logbooks where the pages were stapled to consecutive pages due to the binding coming undone. Additionally, the program did not consistently document common area searches or youth body searches during movement.

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

The program maintains a written policy and procedures outlining the key control system. The system in place governs the control and use of keys which includes key assignment, restrictions on usage, inventory, tracking of keys, secure storage of keys, procedures addressing missing or lost keys, and the reporting and replacement of damage keys. The program maintains a key log which indicates the name of staff and the type of key assigned according to their position. Each key ring has a tag indicating the number of keys on the ring and a key reference number which can be cross-referenced to the master key inventory.

When staff arrive at work, they submit their personal keys to master control 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 program restricted keys which are stored 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. Reviewed documentation of permanent keys as assigned was reviewed and had all elements and required signatures. Reviewed documentation of the current key inventory was compared with the keys in use and the inventory matched the actual keys in use.

A random check of three staff indicated none had personal keys in their possession and a review of the key box for all keys were signed out and the personal keys were hanging in the designated area of the keys issued. There was one staff which had keys issued and no personal keys were found; however, it was identified the staff did not drive to work. Five staff were interviewed and were knowledgeable of the program's key control policy. An informal interview with the plant manager reported the program did not have any lost or missing keys within the last six months. The plant manager and interim FA reported if a key is missing or lost, the program will notify the shift supervisor or assistant FA immediately. The incident will be documented in the logbook and a replacement will be issued.

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

The program maintains written policy and procedures to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, incoming and outgoing mail, and youth. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The policy includes sharp objects, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non- facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, smart watches, unauthorized currency or coins, and non-facility issued keys. The program policy did include consequences if staff were found with contraband. Youth receive a youth handbook upon their admission to the program.

Observations were made of staff being searched upon arrival to the facility. Youth are notified of the unauthorized and illegal contraband and the consequences of possessing contraband. Any contraband found is documented on an incident reporting form and in the facility logbook which includes the method of disposal.

A review of the facility logbooks, daily search reports, and the safety perimeter check inspection reports for the past six months verified searches and facility checks are conducted daily on each shift. Any illegal contraband will be handed over to the local police department. An interview with the interim facility administrator (FA) determined discovery of unauthorized contraband is confiscated and is either discarded, returned to the original owner, mailed to the youth's home, or stored and returned to the youth upon their release. An interview with the interim FA indicated staff are to follow their facility operating procedures (FOPs) should illegal contraband be found, staff are to notify the Department's Central Communications Center (CCC) and illegal contraband is handled and disposed of in consultation with law enforcement. There were two calls made to the Department's CCC in the past six months; one for finding a tobacco product in possession of youth and one youth had medication in a sock. Both incidents were reported and addressed internally. While all Department required items were listed in the program's policy as to what contraband was listed in the policy, the youth and parent/guardian handbooks; the parent/guardian visitation letter varied which did not include all the same required items. Smart watches was not consistently listed.

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

The program maintains a written policy and procedures in place to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code. Youth searches were observed after groups, education, and moving from recreation to day room area. The program's practice for all searches are to be conducted by staff of the same gender as the youth. Observations confirmed searches were conducted by male staff. Staff prompted the youth to line up or stop line movement in order to be searched. Five interviewed staff were aware of the process for conducting searches and when to conduct a search on youth. Five interviewed youth were familiar when visual and full body searches are conducted. Observations of searches and full body visual searches determined searches were conducted in accordance with the Department's Protective Action Response (PAR) training policy.

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

The program maintains a written policy and procedures for vehicles and vehicle maintenance, ensuring vehicles are operated in a safe manner. The program utilizes two vehicles to transport youth at the program; however, one vehicle has not been used since June 2020. Reviewed documentation relating to both vans reflected both have up-to-date

maintenance, insurance, and registration documentation. Reviewed documentation for both vans confirmed an annual inspection was completed on October 20, 2020. Observations of both vans reflected the vehicles are equipped with safety screens separating the front seat compartment from the passenger's compartment. All safety equipment was in each van including a fire extinguisher, window punch, and a seatbelt cutter. An approved first aid kit remained in the administrative assistant office area and was issued at the time of transport. One transport was observed during the annual compliance review week and there were no issues identified. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles were locked when not in use. Both vehicles have paint missing from the exterior. The interior was neat, clean, and free from any graffiti.

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

The program maintains a written policy and procedures to ensure appropriate minimum staff-to- youth ratio for the safety and security of youth, staff, and the community when youth are transported outside of the facility. Reviewed documentation combined with an interview with the interim facility administrator confirmed the program has a minimum of two staff for each transport. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate staff vehicles. The program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted on all staff upon hire with monthly checks of staff on the approved driver list. The program also provided documentation of approved drivers who must complete a defensive driving course. Documentation for proof of training was provided. Observations of both vans reflected the vehicles are equipped with a safety screen separating the front seat compartment from the passenger's compartment. All safety equipment was in each van including a fire extinguisher, window punch, and a seatbelt cutter. An approved first aid kit is in the administrative assistant office which is to be taken at the time of transport. All seatbelts were operational in both vans. Observations of a random check of personal vehicles and facility vehicles confirmed the vehicles were locked when not in use. Five staff were interviewed and one was not aware of the staff to youth ratio during a transport. Five staff were interviewed and indicated a program cellular telephone is provided during transport. Personal vehicles are not used to transport youth. A review of perimeter checks reflected parking lots were checked during each shift and there were no instances found where vehicles were unlocked.

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

The program has a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's assistant faciality administrator (AFA) or designee is responsible for conducting safety and security audits every seven days. The program's policy meets all the requirements of Florida Administrative Code. The program ensures there is a clear process regarding the identification of tracking deficiencies which are addressed by the program. Reviewed documentation of invoices reflected the AFA utilized the Department's Facility Security Audit and Safety Inspections form to document the weekly completions of audits. There were exceptions to these being consistently completed every seven days by the program over the previous six months. There was one week missing and

three were completed outside of the every seven-day requirement as all three were one day late.

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

The program has a written policy and procedures to ensure youth do not use tools or equipment as weapons or security breaches. The procedures also address the issuance, inventory, control of equipment and tools, and staff shall report any discrepancy to the assistant facility administer (AFA) or designee for immediate follow-up action. The program prohibits tools such as machetes, bowie knives, or any long blade knives. The program's policy also addresses missing/lost tool procedures. According to the interim facility administrator the program identifies the maintenance manager as the designated tool control manager. The maintenance manager replaces and disposes of tools, as needed.

Observations of the maintenance storage area of tools found each was securely stored when not in use, marked for easy identification, and inventoried prior to being issued for work and when the work is completed. The program conducts the inventory of tools daily. A review of the daily inventory logs for the past six months verified this practice. A random review of the tools indicated the tools being stored is listed on the inventory sheet. Observations made of the tool storage area indicated it was organized. Reviewed training documentation indicated staff and youth are trained on the safety of tools. Five interviewed youth confirmed they use mops and brooms. One youth stated using a scrub brush. The program's maintenance area for tools met all requirements; however, the kitchen tools did not. The kitchen tool inventory had a daily check with the specified number of tools; however, the inventory did not match what was found in the kitchen storage area. The area was checked off by the kitchen manager as the daily inventory being accurate. There were additional or less counts of specific tools listed on the inventory. The kitchen tools did not have specific markings to easily identify the tools was not in place. The storage area was a shadow board with markings around each tool; however, there were several markings in which a tool did not have an assigned markings and was not signed out. It was explained by the kitchen manager the blank markings are tools which are no longer in the program's tool inventory.

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

The program has a composed strategy and methods to ensure youth use tools safely and are supervised appropriately to prevent injuries to themselves, other youth, and staff. The program maintains strict control of secure storage and the purchase of tools and sensitive items. All tools and sensitive items are under the control of the maintenance manager. The program's policy requires a minimum ratio of one staff for every five youth during activities involving tools, except in the case of disciplinary work projects involving tools which require a minimum ratio of one staff for every three youth. The program completes a risk assessment on each youth at the time of their admission and every thirty days thereafter. Youth are prohibited from using class A tools. Five youth records were reviewed and each contained risk assessments and updated risk assessments. Five staff were interviewed and each stated

youth are only permitted to use scrub brushes, mops, and brooms under staff supervision. Five youth were interviewed and each stated they may use mops, brooms, and scrub brushes only. One interviewed youth stated they was allowed to use a screwdriver; however, there was no record of this tool being signed out for the youth to use.

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

The program has a written policy and procedures to address outside contractors, which stipulates when an outside contractor or vendor enters the program to perform a work project requiring the use of tools, the tools are inventoried. Upon arrival, the contractor is provided a contractor agreement outlining the inventory of tools being used, sign-in, and example of items not allowed in the program. Personal cellular telephones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. A review of three randomly selected work invoices along with the corresponding visitors sign-in logs indicated each contractor signed in on the visitors log once on-site and completed the required contactor agreement from. The facility administrator (FA) or assistant facility administrator (AFA) are the only individuals responsible for providing approval/permissions if such items are required. The program form for outside contractors did not include smart watches; however, the form was updated during the annual compliance review week.

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

The program has a Continuity of Operations Plan (COOP) which states emergency drills will be conducted at random times and under varied conditions. The COOP was approved by the Department on May 16, 2019. Drills are documented and contain the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A random sample of the program's fire and safety drill forms for the past six months were reviewed. Drills were performed on varied shifts and included all staff on duty. Five staff were interviewed and each stated they participate in fire drills. Four staff responded they participated in escape drills, hostage situation drills, chemical drills, weather drills, bomb threats, and active shooter drills at least quarterly. Fire drills were conducted monthly on all shifts with the exception of two shifts in two different months. Five youth were interviewed and each stated they knew what to do in the case of a fire. The program was provided information on the program's profile stating the program conducted COOP drills monthly on each shift; however, the policy indicated COOP drills were conducted semi-annually, the requirement is quarterly. This issue was brought to the attention of the interim facility administrator and the regional director, they indicated the policy was updated.

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

The program has a written Continuity of Operations Plan (COOP) which includes a coordinated disaster plan. The plan provides for basic care and custody of youth in the event of an emergency or disaster while ensuring safety of staff, youth, and the public. The plan outlines a procedure which outlines critical identifying information and a current photograph of all youth are easily accessible to verify a youth's identity as needed, during their stay in the program and in the event of an emergency evacuation. The plan was approved by the Department on March 10, 2020. The COOP is located in master control, supervisor stations, and in the assistant facility administrator (AFA) office. The program has identified the various location within the program where staff, youth, and visitors can easily access the plan. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing should the program have to vacate due to an emergency or disaster. A review of the administrative hard-copy file included the youth name, a photograph, Department identification number, admission date, date of birth, gender and race, name, address, and parent/guardian contact information of name, address, telephone number of the person with whom the youth resides and their relationship to the youth, and person(s) to notify in case of an emergency.

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

The program maintains a written policy and procedures to ensure youth do not handle toxic, combustible or harmful chemicals and materials. The program's assistant facility administrator and maintenance manager maintains a monitor system to ensure compliance with flammable, poisonous, and toxic items. All flammable materials are stored in a metal fireproof safety secured locker in a shed/storage. Toxic materials are stored in a shed/storage room located outside the facility. The program maintains a list of all staff who are authorized to handle the materials. A safety data sheet (SDS) binder is located inside the storage area with a picture of each material corresponding to the SDS. The program maintains chemicals used daily in a locked storage area inside the facility. The program also has a chemical daily usage log to track all toxic materials when in use by authorized staff. Any chemicals used are signed out. Observation of the storage area indicated it is clearly marked hazardous chemicals, securely locked, and has a posted list of authorized staff. The kitchen had bleach and oven spray which was not secured or listed on the program's inventory sheet.

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

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

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

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

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures in place for youth to have visitation and communication while in the program. Youth are informed of visitation during admission. The program encourages visitation from the parent/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. Due to the COVID--19 pandemic, all in-personal visitations were eliminated for six months, beginning March 2020. During these six months, facetime visitation was offered as an alternative to in-person visitations. In September 2020, when in-person visitation was reinstated, the program initiated COVID-19 pre-screening and safety protocol in an effort to ensure the safety of staff and youth. A random review of the logbooks and visitation sign-in sheets verified the program allows

visitation for approved family members. The program provides stamps, envelopes, and writing material to youth who wish to correspond with approved family members by writing letters. The program has a practice of searching incoming and outgoing mail in the presence of the youth. During the program tour, the visitation schedules were posted in the main lobby, master control, and youth living area. Informal interviews with staff and youth confirmed the program also allows alternative visitation arrangements with the parent/guardian; however, it must be approved by the facility administrator or (FA) or assistant facility administrator (AFA). Five youth were interviewed and each stated they are given the opportunity to communicate with family members by mail, telephone, and during visitation.

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

The program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program does not use controlled observation; therefore, this indicator rates as non-applicable.