STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

St. Johns Youth Academy
Sequel TSI of Florida, LLC
(Contract Provider)
4500 Avenue D
St. Augustine, Florida 32085

Review Date(s): January 29 - February 1, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Mike Marino, Office of Program Accountability, Lead Reviewer (Standard 1)
Ashley Alban, TrueCore Behavioral Solutions, Regional Health Services Administrator (Standard 4)
Donna Connors, Office of Program Accountability, Regional Monitor (Standard 2)
Delmonica Harris, Duval Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)
Jillian Lewandowski, Office of Program Accountability, Regional Monitor (Interviews and Standard 1)
Ben Marrufo, Office of Programming and Technical Assistance, Technical Assistance Specialist (SPEP)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: St. Johns Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: St. Johns County / Circuit 7
Review Date(s): January 29 - February 1, 2019

MQI Program Code: 1266
Contract Number: 10173
Number of Beds: 72
Lead Reviewer Code: 37

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **2** # Case Managers
- **2** # Clinical Staff
- _____ # Food Service Personnel
- **2** # Healthcare Staff
- **1** # Maintenance Personnel
- **1** # Program Supervisors
- **7** # Staff
- **7** # Youth
- **2** # Other (listed by title): **2 Assistant Facility Administrators**

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Limited
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	Limited
1.14	*Internal Alerts System and Alerts (JJIS)	Limited
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	* Treatment and Discharge Planning	Satisfactory
3.08	* Specialized Treatment Services	Satisfactory
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Failed
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	Limited
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Limited
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Limited
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Limited
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Limited
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The St. Johns Youth Academy is a seventy-two-bed program, for fourteen to eighteen-year-old males, located in St. Augustine, Florida. The program is operated by Sequel TSI of Florida, LLC, through a contract with the Department. The program provides mental health overlay services (MHOS). Additional treatment services provided include individual, group, recreation, and family therapy. Treatment groups address both mental health and substance abuse. In addition, the program provides the following curriculums: Thinking for a Change (T4C), Impact of Crime (IOC), Skill-Streaming the Adolescent, and Young Men's Work: Stopping Violence and Building Community.

Program administration is comprised of a facility administrator (FA), an assistant facility administrator (AFA) for administration, an AFA for operations, a training manager, a program manager, a clinical director, a director of case management, a director of nursing, a kitchen manager, and business office manager. Case management services are provided by the director of case management, five case managers, and two transitional case managers. The director of case management and one case manager had been out for an extended period due to illness at the time of the annual compliance review. Mental health staff at the program includes the clinical director, an assistant clinical director, and seven therapists. There is also a contracted psychiatrist, who provides psychiatric evaluations and prescribes and monitors psychotropic medication. Medical services are offered Monday through Friday from 7:00 a.m. to 7:00 p.m., and on Saturdays and Sundays from 8:00 a.m. to 6:00 p.m. and are provided by the director of nursing, who is a registered nurse, another full-time registered nurse, and one part-time, pro-re-nada (PRN) registered nurse. A contracted medical doctor (MD) serves as the designated health authority. Educational services are provided by TrueCore Behavioral Solutions through a contract with the St. Johns County School District. At the time of the annual compliance review, the program had three youth care worker positions vacant.

The facility is hardware-secure with perimeter fencing lined with no climb mesh and topped with razor wire. Outside recreation areas adjacent to each dorm and a large recreation field are enclosed by fencing lined with no climb mesh and topped with razor wire as well. The security fencing on the roof by the C dorm recreation area was damaged by Hurricane Irma in 2017 and youth have not been taken to this recreation area since. There are two living units at opposite ends of the facility. Each living unit has three dorms and a master control area. There is a main master control room in administration. The master control area on the living units also serve as supervisor offices. Five dorms are used to house youth and the remaining dorm has exercise equipment and is used as a reward for youth. The program has sixty-seven operating security cameras providing coverage.

Standard 1: Management Accountability

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

The program has a written policy and procedures requiring compliance with the Department's Background Screening Unit (BSU) requirements. The program's procedures were not consistent with the Department's requirement in relation to breaks in service, stating staff could be re-hired without a new screening if the break in service was less than 180 days rather than less than ninety days. This policy was updated during the annual compliance review. Records for thirty-one newly hired staff were reviewed for background screening. Background screenings were completed prior to hire for thirty of the thirty-one staff. The remaining staff had a break in service from March 16 to June 26, 2018 (102 days) and should have been background screened prior to his rehire. The BSU was contacted and reported this staff's finger prints had been retained and he/she was still considered eligible. There was another rehired staff who was appropriately background screened prior to their new start date. Ergometrics tests to determine suitability for working with youth were completed and on file for all but two direct care staff, both of whom were rehires. Annual Affidavits of Compliance with Level 2 Screening Standards were completed by the program and education provider and submitted to the BSU well within the required time frame to meet the annual requirement, with the affidavit for the program being submitted on December 27, 2018, and the affidavit for the education provider being submitted on December 4, 2018.

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

The program has a policy and procedures in place regarding five-year background rescreenings. The program took over the contract in 2015; therefore, there were no staff requiring a five-year background rescreening at the time of the annual compliance review.

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

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

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

A tour of the facility found the phone numbers for the Florida Abuse Hotline and Central Communications Center (CCC) are posted throughout the facility. The program has a policy and procedures addressing provisions of an abuse free environment and management response to allegations. The program's policy indicates allegations of child abuse or suspected child abuse are to be immediately reported to the Florida Abuse Hotline first and then reported to the CCC within two hours of the incident or knowledge of the incident. When a youth makes a request to the contact the Florida Abuse Hotline, the staff is to immediately notify the supervisor, who is to arrange for the youth to contact the Florida Abuse Hotline or the CCC, if they are eighteen years or older. Staff sign an acknowledgement of receipt of the employee handbook, which also outlines requirements for an abuse-free environment.

The program had nine incidents reported to the CCC regarding suspected abuse since the last annual compliance review. Three of the incidents were substantiated for Improper Use of Force and one for Improper Conduct. In addition, the CCC reports reflected four pending investigations referenced allegations of a youth being denied a call to the Florida Abuse Hotline. At the time of posting, two of the pending incidents have been closed as inconclusive. Five random incidents involving suspected abuse were reviewed. Each incident was reported to the CCC and three documented a call was made to the Florida Abuse Hotline.

Seven youth were interviewed. All youth reported they feel safe at the program and they have not been stopped from reporting abuse. Although, one youth reported he asked for an abuse call, but he was not given the call. When asked during the interview if he wanted a call, the youth stated he did not want to contact the Florida Abuse Hotline. Of the seven youth interviewed, two youth reported staff use profanity often and two youth reported staff use profanity occasionally. The remaining three youth stated they have not observed staff use profanity, threats, intimidation, or use humiliation when interacting with youth. Six youth reported staff are respectful, and one youth reported staff are sometimes respectful. Seven staff were interviewed, and five staff reported they have observed a co-worker use profanity when speaking with or in front of youth. Two of these five staff reported observing staff use profanity on daily basis and towards youth. Two staff reported hearing staff use profanity in conversation on occasion and one staff stating they hear staff use profanity in conversation daily. When

asked about the process for reporting suspected abuse, six staff reported they notify a supervisor. Seven staff reported they have never observed a co-worker tell a youth they cannot contact the abuse hotline.

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

The facility administrator (FA) reported all staff receive training in appropriate behavior and the proper procedures to take when they have knowledge of abuse. According to the FA, staff are informed of their professional responsibility as mandatory reporters upon hire, and youth are provided the telephone number to the Florida Abuse Hotline and Central Communications Center (CCC) during the intake process and the numbers are posted in each youth living area. The facility administrator stated all reportable incidents are reported to the FA, assistant FA, or the supervisor within two hours of the incident and an internal investigation is initiated immediately. A review of internal investigation forms, incident report forms, and personnel action requests reflected management takes immediate action to address incidents of physical, psychological, and emotional abuse. An interview with the facility administrator (FA) reflected if physical abuse is alleged, the staff in question is removed from having any contact with youth to avoid any further issues or any appearance of intimidation. According to the FA, the staff is placed on administrative leave and an internal investigation is initiated. If allegations are found to be valid, the staff is terminated from employment. The FA stated the program has zero-tolerance for physical abuse, profanity, or threats towards staff or youth.

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

The program has a policy and procedures in place regarding incident reporting to the Central Communications Center (CCC). Five CCC reports occurring during the past six months were reviewed. All five incidents were reported to the CCC within two hours. A review of the program's logbooks and internal incident reports found there were no other incidents identified as reportable. The facility administrator reported the CCC is contacted within two hours of the program becoming aware of reportable incidents and an internal investigation begins immediately.

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

The program has a policy and procedures in place regarding Protective Action Response (PAR). Five PAR reports were reviewed. Each PAR report was completed by the end of the shift

and reviewed by administration within twenty-four hours. Mechanical restraint logs were completed, as required, in two applicable reports, showing the use of mechanical restraints were authorized by administration and youth were supervised, as required. Two youth made allegations of abuse. One of the allegations was made immediately and the other was made after the youth spoke to his parent/guardian. The Florida Abuse Hotline and Central Communications Center (CCC) were contacted in both incidents. Three of the five reports documented a post-PAR interview within thirty minutes. The two remaining reports showed the post-PAR interview was completed by an administrator, but not within thirty minutes, as each was dated the day after the PAR incident. Four of the five reports had statements from all staff involved. In the remaining report, statements from three of the four staff involved in the restraint were included in the report.

An interview with the facility administrator (FA) reflected he and the assistant facility administrators (AFA) review video whenever a PAR incident occurs. Further, the FA stated all PAR incidents are discussed during morning meetings and any violations of PAR policy and procedures results in corrective action. The program submits monthly PAR reports to the Department. The PAR training plan was approved by the Residential Regional Director in January 2019. The program's PAR rate during the annual compliance review period was 1.17, which is below the statewide Residential PAR rate of 1.47.

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

Training records and documentation in the Department's Learning Management System (SkillPro) were reviewed for seven staff for pre-service training. All staff completed over 120 hours of training within 180 days of hire. Each staff completed the required certifications prior to having contact with youth, which included cardiopulmonary resuscitation (CPR), first aid, use of an automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also received training in suicide prevention, child abuse reporting, emergency procedures, trauma-informed care, the Prison Rape Elimination Act (PREA), and ethics. The pre-service annual training plan was approved by the Department's Office of Staff Development and Training on January 30, 2018. Trainings were entered into SkillPro with few exceptions.

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

Training records and documentation in the Department's Learning Management System (SkillPro) were reviewed for seven staff for in-service training. All staff had over twenty-four hours of training in 2018, with staff completing between thirty-four and fifty-seven hours of training. All staff held a current certification in cardiopulmonary resuscitation (CPR), first aid, and use of an automated external defibrillator (AED). Each staff had a Protective Action Response (PAR) update and training on suicide prevention. Five of seven staff completed training on professionalism and ethics. Five staff were considered for supervisory training, which included a

youth care worker who previously served as a supervisor. All five of these staff had an eight-hour course in management. The in-service annual training plan was approved by the Department's Office of Staff Development and Training on January 30, 2018.

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

The program has a policy and procedures addressing the grievance process, grievance training, and documentation. The policy allows for youth to grieve the actions of the program staff, their peers, or conditions and/or circumstances of care and treatment. The policy includes an informal phase in the form of a "speak out" form, a formal phase where the supervisor reviews the grievance within four days of receipt, and an appeal phase where the assistant facility administrator (AFA) reviews the grievance within twenty-four hours of the request for appeal. If the youth is not satisfied with the decision of the AFA, the youth may request a review by the facility administrator, which is to occur within forty-eight hours. According to program's policy, the grievance process is to be posted throughout the program and forms are to be readily available to youth at any time. A tour of the program found grievance forms were not readily available in two of the dorms. Six of the seven youth interviewed reported grievance forms are available.

An interview with the facility administrator confirmed the informal process through the use of "speak out" forms, which allows youth an opportunity to informally resolve their issues with staff. The facility administrator stated youth have uninhibited access to grievance forms and they are allowed to file a grievance on yellow grievance forms, which are located on the dorms and multi-purpose rooms. The staff are not to interfere in any manner of a youth submitting a grievance. Grievances are to be responded to immediately by supervisors and the youth may appeal to the facility administrator or designee. Seven youth were interviewed regarding the program's grievance process. Six youth reported grievance forms are located throughout the program. One interviewed youth reported there are no grievance forms in the dorm area and they are only refilled every two to three weeks in the other areas of the program. Each youth reported they can ask for assistance in completing a grievance form. Seven staff were interviewed, and each staff reported grievance forms are placed throughout the program. Four staff reported youth can request assistance in completing the form.

During the annual compliance review period, the program had three grievances filed, which were reviewed. Each grievance documented a review by the supervisor or designee and each grievance was resolved without needing to proceed to the appeal phase. Documentation showed two of three grievances were addressed within the time frame indicated by the program's policy. The remaining grievance was not clear as to when it was filed by the youth in order to determine if it was addressed within the required time frame. Two of three grievances documented the youth agreed with the investigation and recommendation. The remaining grievance was signed by the youth but did not indicate if the youth agreed with the investigation and recommendation. Fourteen staff training records were reviewed, which reflected each staff received grievance training.

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

Delinquency interventions provided by the program include Thinking for a Change (T4C), Impact of Crime (IOC), Skill Streaming the Adolescent, and Young Men's Work: Stopping Violence and Building Community. Staff providing delinquency interventions had the requisite experience and training to provide the interventions. A review of the program's activity schedule confirmed the program was providing structured programming sixty percent of the youths' awake hours. A review of sign-in sheets confirmed the groups were delivered, as required. The interview with the facility administrator (FA) confirmed the interventions provided by the program. The FA reported staff experience, training, and expertise when selecting staff to provide a service and when assigning staff to work with youth.

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

The program has a written policy and procedures to address life skills training. The program schedule provides for life skill training and documentation showed all youth receive life skills training through groups. Performance plans include goals related to life skills and treatment teams assessed youth progress towards the life skills goals. Seven youth were interviewed. Each youth reported they received life skills training in groups and they were able to practice the life skills through role plays or skits in the groups.

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 provides Impact of Crime (IOC), which is a promising practice curriculum, to youth in the program. The instruction assists youth in accepting responsibility for harm they have caused and teach youth about the impact of their crime on the victim(s), their families, and their communities. A cohort began on August 30, 2018 and is conducted on Tuesdays and Thursdays for one hour. The previous cohort was conducted from May 1, 2018 until August 14, 2018. Four staff members are trained to conduct the IOC groups. A review of group sign-in sheets reflected the curriculum was delivered, as designed. Four of seven reviewed records reflected youth are receiving restorative justice awareness. The remaining three youth were participating in another group at the program and will participate in the next IOC cohort. Four of the seven youth interviewed said they were currently in or previously completed IOC groups. An interview with the facility administrator confirmed the program utilizes IOC, which is conducted two days a week. The facility administrator reported the program utilizes speakers to provide testimonies of being a victim. The program has a chicken coop and garden, which was built and is maintained by youth at the program. The eggs from the chicken coop are donated to local food banks and a shelter. The program had a victim speaker come in and discuss restorative

justice, as well as, an “All Lives Matter” group made up of youth speakers in an effort to prevent the youth from making the same mistakes they have made.

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

The program utilizes Young Men’s Work: Stopping Violence and Building Community for gender-specific treatment programming. The curriculum is designed for young men ages fourteen to nineteen to address male violence. The curriculum includes twenty-six sessions to assist youth in working together to solve problems without resorting to violence. The sessions include objectives, an agenda, and exercises for youth to complete. The Young Men’s Work group is scheduled on Saturdays from 11:00 a.m. to 12:00 p.m. An interview with the clinical director reflected there was a gap in services due to staff turnover. A review of sign-in sheets reflected four groups were conducted in September; however, only one group was conducted in each October, November, and December 2018. It was reported there were no additional sign-in sheets to review. The clinical director reported additional staff will be trained to provide the service and the program is working to re-start the group. An interview with the facility administrator confirmed the program utilizes Young Men’s Work to address the needs of the targeted gender group.

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

The program has two policies and procedures regarding alerts. One policy addresses alerts being entered into and updated, as needed, in the Department’s Juvenile Justice Information System (JJIS) and the other describes an internal alert system. Nursing staff maintain an alert list, which is updated, as needed. The alerts on the internal alert list completed by nursing staff and alerts in JJIS matched.

The procedures for the internal alert system, which also includes mental health and security alerts, references alerts being identified in binders on each master control, which was not found to be the case. There is an alert board in the main master control listing youth with medical, mental health, and security alerts, though the board did not reflect all youth with alerts. In addition, the alert list in the main master control was dated January 21, 2019. The alert list in the kitchen when first observed was from December. In addition, six youth were identified by medical as requiring a lower calorie diet. A cook interviewed did not report any youth being on a lower calorie diet. The six youth were interviewed and reported their trays were not distinguished from others. Seven staff were interviewed, which resulted in varying explanations regarding the alert system, with two staff reporting they don’t get alerts and five reporting they

could ask master control, nursing, or mental health, or other staff for alerts. None of the staff reported having access to the alert list.

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 an individual healthcare record, and mental health treatment record, and a separate individual management record on each youth. The individual management record contains a tab identifying the youth's name, Department identification (DJJID) number, date of birth, date of arrival, county of residence, circuit of residence, and committing offense(s). The sections in the individual management record include legal information, demographic and chronological information, correspondence, case management and treatment team activities, miscellaneous, and transition. Individual management and mental health treatment records are labeled "confidential" and are kept in locked record rooms. Healthcare records are maintained in the clinic. File cabinets, which also have locks, are utilized to store official youth case records and are marked "confidential."

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

The program conducted a youth advisory board meeting at least once a month from June 2018 to December 2018. Each meeting was conducted with a youth representative from each dorm and supervisory staff. Reviewed documentation included sign-in sheets for each meeting, which listed the date, time, topic, focus of the meeting, youth names, youth signatures, and staff signatures. In addition, minutes from each meeting identified what was discussed during the youth advisory board meeting. The topics from the meetings addressed dorm improvements, dorm concerns, staff concerns, and shower protocol.

Seven youth were interviewed, and each youth reported the program has a process allowing youth to provide input about what happens at the program. Three youth reported the program conducts dorm meetings for youth to provide input. An interview with the facility administrator reflected the program holds monthly youth advisory board meetings for the youth to provide feedback, input, and provide suggestions to administration after they have spoken with their peers. The facility administrator stated the program holds assemblies with the youth and the youth are allowed to meet with the administration team monthly to provide their input.

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

The program has an established community advisory board, which held meetings on a quarterly basis in March, June, September, and December 2018. The next scheduled community advisory board meeting is on February 7, 2019. The program maintains sign-in sheets and minutes from each meeting documenting the individuals who attended and what was discussed in the meeting. The program has written documentation of invitations soliciting active

involvement from a law enforcement representative, judiciary staff, community partners, the business community, education, and the faith community. Sign-in sheets reflect the community advisory board participants also included a victim advocate, a parent/guardian whose child was previously in the program, and a former youth. An interview with the facility administrator indicated the community board is made up of community members to include law enforcement, youth, parent/guardians, pastors, and other community stakeholders. The meetings are held on a quarterly basis and last for one hour. The facility administrator stated the advisory board assists in enhancing programs offered at the facility, to include a chicken coup and garden program, which have been implemented.

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

Seven staff were interviewed. All staff reported monthly meetings and daily shift briefings. Six of the seven staff felt information discussed and shared during the meetings was valuable. When asked to rate communication among staff, two staff rated communication was good, one said fair, two said poor, and two said very poor. The facility administrator stated all-staff meetings are conducted monthly. Documentation showed monthly staff meetings were conducted monthly with the exception of September and October 2018. There are also daily morning meetings to discuss current issues and review standards.

The facility administrator has developed a group of staff to address staff retention. Staff vacancies are lower than have been in the past, with only three youth care worker positions vacant at the time of the annual compliance review. There is also a follow-up team to track youth after they are released from the program. The FA reported the Comprehensive Accountability Report (CAR) is reviewed quarterly for trends. Youth and parent/guardian surveys have been completed on Survey monkey and results are reviewed.

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

The program has a policy and procedures addressing staff performance and evaluations. The procedures state staff will receive an initial performance evaluation ninety days after hire and annually thereafter. Seven staff records were reviewed for performance evaluations and all seven had an evaluation completed in accordance with policy. The facility administrator interview confirmed staff receive an initial ninety-day performance evaluation and annual evaluations thereafter. In addition, the facility administrator stated staff receive monthly coaching from their supervisor.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures to address initial contact a youth's parent/guardian and for court notification upon a youth's admission to the program. The policy requires telephonic contact the parent/guardian within twenty-four hours of admission. The policy further requires the program's assigned case manager to send written notification and specific program information within forty-eight hours of admission. Seven case management records were reviewed. Each record contained documentation of telephone contact with the youth's parent/guardian on the day of the youth's admission to the program. Each record also included a letter to the youth's parent/guardian within forty-eight hours. The program consistently contacted the youth's juvenile probation officer and the committing court, in writing, within forty-eight hours of the youth's admission to the program.

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 policy and procedures to address the youth orientation process. The program provides an orientation to each youth on the day of admission, which is completed by a case manager. Youth receive an overview of the program's services and a student handbook, which includes a more detailed description of program services and a review of the rules governing conduct and positive and negative consequences for behavior. The case manager and youth sign an orientation checklist to document a review of each topic. The program's orientation process includes the following topics: services available; expectations and responsibilities of youth; the behavioral management system; availability of and access to medical and mental health services; access to the Florida Abuse Hotline, or if the youth is eighteen years or older, the Central Communications Center (CCC); items considered contraband, including illegal contraband and prohibited items, possession of which may result in the youth being prosecuted; performance planning process; dress code and hygiene practices; procedures on visitation, mail, and use of the telephone; anticipated length of stay in the program and expectations for release from the program, including the youth's successful completion of individual performance plan goals, the program's recommendation to the court for release based on the youth's performance in the program, and the court's decision to release; community access; grievance procedures; emergency procedures, including procedures for fire drills and building evacuation; and the physical design of the facility, including those areas not accessible to youth. The program will assign the youth to a living unit and room, treatment team and, if applicable, a staff advisor or youth group.

Seven case management records were reviewed. Each record contained documentation to show the youth received an orientation on the day of admission to the program. Each record documented the orientation process contained an explanation of all services provided to the youth while in the program and included all required topics. Each youth signed a form to

document their receipt of the student handbook. The orientation process includes a written test, which requires the youth to select the correct answer to eighteen questions. The written test was completed by all seven youth. There was a daily schedule posted in various locations, to allow easy access for youth. The program's behavior management system was posted. During the annual compliance review, an admission orientation for one youth was observed. The youth provided verbal consent for this observation. While the youth was eating the meal provided, the case manager reviewed the services provided at the program. The youth was comfortable with the process and was permitted to ask questions for further clarification. The youth and case manager signed the orientation checklist, as well as the forms describing the specific services, such as the grievance process. The program documented each youth's admission in the logbook. Seven youth were interviewed and all seven reported having orientation on the date of admission to the program. Each youth was able to provide an explanation of the orientation.

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 policy and procedures to address consents for youth who are eighteen years of age or older, which requires the program to obtain written consent of any eighteen-year-old youth prior to providing or discussing any information with the youth's parent/guardian. Seven case management records were reviewed, of which four were applicable. In the four applicable records, the program obtained a written consent from the youth before providing or discussing information with the youth's parent/guardian. Three youth turned eighteen subsequent to their admission to the program and each signed the consent on their birthday. One youth was eighteen at admission and signed the consent upon his admission to the program.

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

The program has a policy and procedures to address the classification process and reassessment for activities. The program's classification includes a review of the following factors: physical characteristics, age and maturity level, identified special needs, including mental, developmental, intellectual, physical disabilities, history of violence, applicable gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified or suspected medical, suicide, escape, or security risk. On the day of the youth's admission, the program conducts an admission classification meeting to discuss classification factors, which is attended by the youth, case manager, and program administration. Seven case management records were reviewed. Each record contained a completed classification form. Six of the seven

forms included all required elements. In one record, the classification form did not have the youth's maturity level documented on one form, though all other required information was documented. The information gathered from the classification process was used to assign each youth to a living unit and room. The program completed an escape assessment on each youth on the day of admission to the program, which documented any previous escapes or absconding by the youth. The youth's initial classification sheet documented the youth's initial alert classification, including suicide, escape, security, medical, and gang alerts. The program completed a risk assessment questionnaire for each youth. There were scores attached to each question and the total from all questions determined the youth's risk rating. Regardless of the risk rating, no youth may use any tools during the initial phase of the program. Each reviewed record contained documentation to support a reassessment was conducted during the youth's treatment team meetings. In all seven records, the reassessments allowed for an increase of privileges, and in two records, the results of the reassessment permitted the youth to participate in work projects. There was documentation to support four youth, who were not in the sample, had assisted in various work projects utilizing tools and electrical items, such as buffers. The program provided the reassessments for each youth, which documented each youth was determined not to be a safety risk and was permitted to use tools. The facility administrator was interviewed and reported the youth's mental health, physical health, cognitive performance, age, and prior victimization were considered during the assessment to assist with housing.

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 policy and procedures to address gang identification, which includes notification of law enforcement. Seven case management records were reviewed, two of which were applicable for gang involvement. The program provided an additional applicable record for review. In all three records, the program notified local law enforcement by mail regarding the youth's gang activity. The program also provided notification to each youth's juvenile probation officer. The program's practice is to provide notification to law enforcement in the youth's hometown upon the youth's release from the program.

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

The program has a policy and procedures to address a youth's participation in gang prevention and/or intervention activities. The program facilitates groups for youth identified with gang participation. The topics of the monthly meetings included, 'Understanding Roles in Community,' 'Acceptance and Identification,' 'High Risk Situations,' 'The Five Myths and Realities,' and 'Walking Away.' Case management records for three youth with identified with gang involvement were reviewed. All three applicable youth participated in gang intervention groups. Each youth's performance plan included a goal related to gang intervention strategies.

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

The program has a policy and procedures to address the completion of Residential Positive Achievement Change Tool (R-PACT) assessments and reassessments. The policy requires the completion of an initial R-PACT within thirty days of admission to the program and the completion of a reassessment prior to the program preparing a ninety-day summary. Seven case management records were reviewed. Six records contained documentation to support the R-PACT was completed within thirty days of admission to the program. One R-PACT was completed three days late. Each initial assessment was in the youth's record and had been completed on the Department's Juvenile Justice Information System (JJIS). There were five records applicable for the completion of an R-PACT Reassessment. Four reassessments were prepared within ninety days of the youth's initial R-PACT. In the remaining record, the R-PACT Reassessment was completed forty-six days late. All R-PACT Reassessments were completed in JJIS. All of the reassessments were maintained in case management records.

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

The program has a policy and procedures to address the completion of a Youth Needs Assessment Summary (YNAS), requiring the completion of the YNAS within thirty days of admission. Seven case management records were reviewed and all seven contained a YNAS. Five assessments were completed within thirty days of admission to the program. One YNAS was completed three days late and one was completed one day late. Each YNAS was completed in the Department's Juvenile Justice Information System (JJIS) and 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 policy and procedures to address the intervention and multidisciplinary treatment team. The treatment teams are required to develop an individualized performance plan within thirty days of admission to the program. Seven case management records were reviewed. Six youth had been placed in a residential program prior to being placed in this program. For each of these youth, the performance plan from the previous residential program had not been closed, thus the performance plan was a revision of the plan from the previous program. The performance plans were revised based on the youth's date of placement into this program. Four performance plans were revised/developed within thirty days of the youth's admission. The remaining three performance plans were completed one, three, and five days late. Each reviewed performance plan was based on findings of the youth's initial assessment. Each youth's performance plan was developed by the treatment team and included goals for the youth to complete prior to release from the program. All goals were individualized, measurable, and based on the prioritized needs identified in the Youth Needs Assessment Summary (YNAS) to address the youth's risk and protective factors. All goals on each performance plan contained target dates for completion, the youth's responsibility to accomplish the goal, and the program's responsibilities to help the youth achieve the goal. All seven performance plans included goals targeting the youth's top three criminogenic risk factors identified by the YNAS and the Residential Positive Achievement Change Tool (R-PACT). Four youth were over the age of eighteen, thus parental input was not required. In two applicable records, the performance plan was mailed to the parent/guardian with a request to sign and return the signature page. One youth was co-served by the Department and the Department of Children and Families (DCF), and this youth's performance plan was sent to the youth's DCF case worker. A copy of each youth's performance plan was mailed to the committing court, the youth's parent/guardian, and juvenile probation officer within ten days of completion. Seven youth were interviewed. Each youth was able to describe the treatment team process, including who was on the treatment team and what was discussed during the meetings. Five youth were able to list a goal on their performance plan on which they were currently working. All seven youth reported having a copy of their performance plan.

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

The program has a policy and procedures to address revisions to youth's individualized performance plan, when determined necessary, by the intervention and treatment team. The

policy requires revisions when new criminogenic needs are identified during the Residential Positive Achievement Change Tool (R-PACT) Reassessment, when the youth demonstrates progress or lack of progress toward completing a goal, or when new information is acquired or revealed. Seven case management records were reviewed. There had been at least one monthly review of each youth's performance plan. Six performance plans required an update due to the youth's progress or lack of progress, completion of goals, or new information, such as the youth being arrested. None of the performance plans required updates based on the youth's R-PACT Reassessment results. Each youth's performance plan was updated in the Department's Juvenile Justice Information System (JJIS) when goals were completed, added, or continued. A copy was printed and placed in the applicable youth's case management record.

2.11 Performance Summaries and Transmittals	Limited 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 policy and procedures to address the requirements for completion of performance summaries every ninety days. The summaries are due within ninety days of the signing of the youth's performance plan, or at shorter intervals, if requested by the committing court. The policy further requires the treatment team to prepare a performance summary prior to the youth's release, discharge, or transfer from the program. The performance summary provides information to the youth, parent/guardian, juvenile probation officer (JPO), and other parties related to the status of each performance goal and describes the youth's overall adjustment to and performance in the program. Seven open case management records were reviewed, of which five were applicable for the completion of at least one performance summary and transmittal. The summaries for three youth were completed within ninety days of the performance plan and two summaries were completed late. The performance plan for one youth was completed twenty-one days late. While the second youth's plan was completed thirty-eight days late. The reviewed summaries included the youth's readiness to change or level of motivation, significant positive/negative events which occurred over the review period, the youth's performance in each educational class subject, to include grades, and a brief statement in each category/section, with one exception. The summary for one youth, which was completed on December 8, 2018, was partially completed, with several items, such as general program behavior, education/vocational behavior, and response to treatment services left blank. The summaries for four youth were sent to the committing court, and the youth's parent/guardian and JPO. For one youth, there was no documentation to support a summary had been sent to the committing court, the youth's parent/guardian, or juvenile probation officer. The program reported the exceptions were due to the illness of a case manager, who has been out of work for quite some time. Each reviewed performance summary contained required signatures. The summaries were filed in each of the reviewed records.

Three closed case management records were reviewed for release summaries. All three records contained a copy of the original summary sent to the JPO. All three Pre-Release Notifications (PRN) and summaries were sent to the JPO at least forty-five days prior to the

youth's anticipated release date. The court initially objected to one youth's release, but it was later approved. All three summaries clearly documented the justification for release. The program provided written notification to the youth's parent/guardian of the court's approval of the youth's release from the program. There was documentation in all reviewed records to support the youth received a copy of their performance summary. Seven youth were interviewed. Six youth reported receiving a copy of their performance summary.

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

The program has a policy and procedures to address the inclusion of parents/guardians in the case management process. On the day of a youth's admission to the program, the case manager sends an admission letter to the youth's parent/guardian. The letter includes a list of the dates and times for the youth's treatment team meetings. Seven case management records were reviewed. Four youth were over the age of eighteen; however, each youth signed consent forms to allow parental involvement. In all applicable records, documentation revealed information was obtained from the parent/guardian prior to the development of the youth's performance plan. Upon the completion of each performance plan, a copy was mailed to the youth's parent/guardian with a request to sign and return the signature page. The treatment team meeting forms for each youth were reviewed, which included documentation to support the youth's parent/guardian was called during the meetings. The records contained a survey sent to the youth's parent/guardian, which asked how soon the program contacted them following their son's admission to the program, whether an intake packet was received from the program, had there been any contact regarding family sessions, and were there any medical issues with their son. There was documentation to support the youth's parent/guardian was involved in the transition process for the three applicable youth. During the annual compliance review, there were no treatment team meetings conducted, thus no observations were made. The program's facility administrator was interviewed and reported the program conducts quarterly family days and provides summaries to the youth's parent/guardian. The facility administrator further reported the program conducts Parent Nights, during which the parent/guardian can discuss needs and services for their son. Seven youth were interviewed. All seven youth reported their parents/guardians were involved in the case management process. All youth reported their parents/guardians attended treatment team meetings and family sessions.

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

The program has a policy and procedures to address the members of multidisciplinary treatment team. The policy identifies the case manager to be the treatment team leader. The program's treatment team members consist of the case manager/treatment team leader, youth, representatives from program administration, education, the youth's living unit, mental health treatment, education, medical, juvenile probation officer (JPO), and, when applicable, the transition case manager. When applicable, the team also includes the youth's parent/guardian or the Department of Children and Families (DCF) case worker. Seven case management records were reviewed. There was a total of thirty-six formal treatment team review meetings for the seven youth. All review forms documented the participation of required treatment team

members. There were documented attempts to contact the parent/guardian and JPO for all treatment team meetings. All forms contained signatures from required team members. One youth was co-served by the Department and DCF. The youth's DCF case worker was notified of the youth's treatment team meetings and there was documentation of the case worker's attendance at the meetings.

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 policy and procedure to address the incorporation of other plans into a youth's performance plan. Seven case management records were reviewed. Each record contained an individual performance plan. Each youth's academic plan was addressed in their performance plan, as was the treatment plan and wellness plan for each youth. One youth was co-served by the Department and the Department of Children and Families (DCF), which was addressed in this youth's performance plan. No youth records were applicable for involvement with the Agency for Persons with Disabilities (APD).

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

The program has a policy and procedures to address the provision of intervention and multidisciplinary treatment teams. The treatment teams are required to meet every thirty days to formally review each youth's performance, to include Residential Positive Achievement Change Tool (R-PACT) Reassessment results, progress on individualized performance plan goals, and positive and negative behavior, including behavior which resulted in physical interventions. The policy requires the case manager to conduct informal reviews of each youth's performance on a monthly basis. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed. Seven case management records were reviewed. There was a total of thirty-six formal treatment team review meetings for the seven youth. For each treatment team meeting, the documentation included the youth's name, date of review, reports from treatment team members, and R-PACT Reassessment results. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were encouraged to participate, and were notified in advance. When the youth's JPO, parent/guardian, or other pertinent parties were unable to participate in person, they were invited to participate by telephone or provide written input. For all thirty-six formal treatment team reviews, the meeting attendees consisted of the youth, case manager, therapist, education, the transition case manager, and representatives from program administration and the youth's living unit. The program has two recreation therapists, and a recreation therapist was in attendance or provided written input for each treatment team review. There was written input from the medical department for each treatment team review. One youth was co-served by the Department and

the Department of Children and Families (DCF) and there was notification made to the youth's DCF case worker. There was information on each goal, documenting whether a goal was closed or revised. There was documentation to support informal treatment team meetings were conducted monthly for each youth, with one exception. For one youth, there was no documentation of an informal treatment team meeting in December 2018. The informal treatment team meetings, which included the youth and the case manager, documented a brief synopsis of the youth's progress, any needed revisions to the performance plans, progress on goals, the youth's behavior, and the youth's progress in mental health treatment. The youth were permitted an opportunity to demonstrate skills learned, and for applicable youth, R-PACT Reassessment results were discussed. Seven youth were interviewed. Six youth reported being given the opportunity to demonstrate learned skills during treatment team meetings and described the process for the treatment team meetings.

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

The program has a policy and procedures to address the provision of career education for the youth. The program is required to provide Type 3 career education programming. Three closed case management records were reviewed. Each record contained a completed employment application and appropriate documents essential to obtaining employment. Each record contained documentation to support the youth's parent/guardian and juvenile probation officer were aware of the vocational plan for the youth. The youth had previously been able to gain vocational certification in manager-level food service (ServSafe). The certified instructor resigned in October 2018, and a new certified instructor was not hired until the week of the review (the end of January 2019). During the time of the vacancy, youth were not provided the required vocational training, certification, or career education programming, which includes communication, interpersonal, and decision-making skills. An interview was completed with the facility administrator and he reported the program provides CareerSource and Organization New Hope to provide the youth with workforce skills. He further reported the youth receive ServSafe certification, as well as certificates in lawn restoration and floor maintenance.

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 has a policy and procedures to address the provision of education access for youth. Teachers incorporate the academic calendar into their daily activity schedule to meet the required 250 days of instruction time. The instruction days are distributed over twelve months, with a minimum of twenty-five hours of instruction weekly. There are six classes daily, each lasting fifty minutes. The school day is from 7:30 a.m. to 1:45 p.m., which was documented in logbooks reviewed. Youth receive credits for academics and training received while at the program. The lead teacher was interviewed and reported the program has a drum group which interrupts the educational instruction on a weekly basis. Eight youth are pulled at random beginning the fifth period class to participate in the drum group each week. Seven youth were interviewed. None of the youth reported interruptions during educational instruction.

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

The program has a policy and procedures to address the provision of education transition. The program's educational staff and youth complete an education transition plan including provisions for continuation of education and/or employment. Seven youth case management records were reviewed for the completion of an educational transition plan. Each record contained an individual education transition plan. Each plan was developed upon the youth's admission to the program and was based on the youth's post-release goals. Key personnel related to transition activities, including the youth, parent/guardian, education representative, post-release staff, school counselor, and designee of the program's district with access to the management information system, were included. Each individual education transition plan included services based on the youth's assessed educational needs and post-release education plans, the recommended education placement, specific monitoring by persons responsible for the reintegration, and coordination of the provision of services.

Three closed records were reviewed for youth who had employability as a transition goal. Each youth's transition plan included provisions for the continuation of the youth's education and/or employment. The appropriate documents essential to obtaining employment were in each record, as well documentation to support the youth's juvenile probation officer (JPO) and parent/guardian were aware of the plan. The records contained a sample employment application, a résumé, and a valid Florida identification card. The reviewed records contained documentation which reflected the youth, case manager/treatment team leader, transition case manager, program administration, medical staff and mental health therapist, the youth's JPO, parent/guardian, and education staff participated in each transition conference.

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 policy and procedures to ensure the treatment team plans for the youth's successful transition to the community upon release from the program. Three closed case management records were reviewed. A transition conference was conducted at least sixty days prior to the youth's release in each case. The youth, treatment team leader, education representative, program administration, and the youth's juvenile probation officer (JPO) were in attendance for each conference. Other participants were invited by mail to participate by

telephone or in person. If participation could not be arranged, the parties were invited to provide verbal or written input prior to the meeting. The treatment team leader obtained all signatures of parties attending and documented the participants attending by telephone. Each transition plan included appropriate goals, with end dates for the youth's release back into the community. Each plan also identified persons responsible for the completion of each goal. A copy of the transition plan was sent to all parties not in attendance, with a request for returned signature on the document. A return e-mail acknowledging the JPO's receipt and review of the transition plan was printed and filed in each reviewed record. There was documentation in each closed record to support the program received an invitation, by e-mail, to participate in each youth's Community Re-Entry Team (CRT) meeting. There was documentation in the chronological notes in each youth's record to support the program's participation in the youth's CRT meeting. The CRT meeting was separate from the transition and exit meetings. All meetings were conducted prior to the youth's release.

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 policy and procedures to address the transition and exit process. Three closed case management records were reviewed. Each record contained an exit portfolio, which was discussed and initiated at the youth's transition conference. For two youth, there was a state-issued identification card or driver's license. For the third youth, there was an issue regarding his birth certificate, which prevented him from obtaining an identification card. There was a calendar of events for each youth. The portfolio for two youth included their birth certificates. There were copies of certificates earned, a résumé, a completed sample job application, and education records in each portfolio. One youth received his General Equivalency Diploma (GED) while in the program and would not be attending school upon his release. There was documentation to support information was forwarded to the school board in the youth's home district for the two applicable youth. There was documentation to support each youth received their exit portfolio upon their release from the program.

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 policy and procedures to address the transition and exit process. Three closed case management records were reviewed. Each record documented an exit conference was conducted at least fourteen days prior to the day of release. The documentation revealed each exit conference was attended by the intervention and treatment team leader, facility administrator/designee, parent/guardian, transition case manager, mental health therapist, educational representative, juvenile probation officer (JPO), youth, and other pertinent parties, in person or by telephone. The exit conference was completed after the program notified the youth's juvenile probation officer (JPO) of the youth's release. The status of each youth's transition activities was reviewed. A review of the Department's Juvenile Justice Information System confirmed the date of admission and termination correlated with the dates in each record. One of the three youth was over the age of eighteen and parent involvement was not applicable. All exit conferences were separate from the transition and Community Re-Entry Team meetings.

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 designated mental health clinician authority (DMHCA) is licensed under Chapter 491, F.S. The DMHCA is on-site forty hours a week and is on-call weekends and for all emergencies. The DMHCA is responsible for the oversight of the mental health and substance abuse services at the program. A copy of the DMHCA's license and position description were reviewed, which indicated the DMHCA meets all the requirements of the position. The DMHCA's license expiration date is March 31, 2019. An interview with the DMHCA verified he understood his role. The DMHCA had knowledge of mental health and substance abuse overlay services provided by the program.

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

The facility administrator acknowledged responsibility for ensuring mental health and substance abuse services are provided by qualified individuals. The program had three licensed clinical staff at the time of the annual compliance review. Copies of the clinical staff licenses were reviewed, which showed they each had clear and active credentials as licensed mental health counselors (LMHC). Reviewed documentation and treatment records found licensed clinical staff provided services within the scope of their licensure, training, and education.

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

The program has a policy and procedures requiring all non-licensed mental health and substance abuse clinical staff to work under the supervision of a licensed mental health clinician. The licensed clinician must ensure non-licensed staff working under their supervision are qualified to provide services based on education, training, and experience. The program has six non-licensed clinicians, who all have master's degree in a human services-related field. A

review of the clinical supervision logs/reports for May-December 2018 indicated the non-licensed clinical staff received one hour a week of on-site, face-to-face direct supervision from the designated mental health clinician authority (DMHCA) or the assistant DMHCA, both of whom are licensed mental health counselors (LMHC). All non-licensed staff completed all required trainings.

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 policy and procedures in place for identifying youth in need of mental health and substance abuse services. The program reviews all available information for each youth upon admission, to include the commitment packet and reports of previous treatment services, for existing documentation of mental health or substance abuse problems. Seven mental health and substance abuse records were reviewed. None of the youth were in the program over twelve months. Seven records documented each youth was screened using the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) on the day of admission. The screenings were completed by trained staff and documented in the Department's Juvenile Justice Information System (JJIS). All seven records indicated youth were referred for mental health services and substance abuse services. All records had an Assessment of Suicide Risk (ASR) completed as a part of the initial intake process. None of the youth were determined to be at risk for suicide on the ASR and all were placed on standard supervision. The facility administrator's interview indicated he understands the screening process.

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

The program has a policy and procedures in place to identify youth in need of services through screenings, staff observation, and the behavior of the youth after admission. The procedures also address the completion of a comprehensive mental health and substance abuse assessment. Seven records were reviewed. All records had documentation of a referral for a mental health and substance abuse assessment. The program completed a combined mental health and substance abuse assessment for each youth. The assessments included all of the required elements. Five of seven assessments were completed by a licensed therapist and two were completed by a non-licensed therapist and reviewed by a licensed therapist within ten days. All assessments were completed within thirty days of admission. All seven records had signed consent forms.

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

The program has a policy and procedures in place to provide mental health and substance abuse treatment. The program is certified under Chapter 397, Florida Statute, to provide substance abuse treatment. A review of seven youth mental health records indicated youth are assigned to a multidisciplinary treatment team at intake. The treatment team is responsible for assisting in the development, review, and updating of the youth's initial and individualized mental health and substance abuse treatment plans. Treatment team members consists of the youth, program administration, living unit representative (youth care worker), medical, education, and clinical staff. Youth in need of mental health or substance abuse treatment received individual, group, or family counseling by licensed or non-licensed mental health professionals working under the supervision of a licensed professional. Seven youth's records indicated treatment services were provided based on the youth's treatment plan. Each youth had an executed Authority for Evaluation and Treatment (AET) form. Each youth had a signed Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records form (MHSA 012 and MHSA 013). A review of the seven records indicated mental health/substance abuse services were documented on the program's forms, which contained all of the information in the Department's Counseling/Therapy Progress Note form (MHSA 018). A review of youth sign-in sheets for mental health and substance abuse overlay services treatment groups indicated the mental health groups did not exceed ten participants and the substance abuse groups did not exceed fifteen participants. Seven staff interviews indicated direct care staff do not facilitate any mental health or substance abuse groups.

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

The program has a policy and procedures for the development of treatment and discharge plans. Seven reviewed youth mental health records contained documentation of an initial treatment plan. Each initial treatment plan was developed within seven days of treatment and documented the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). The initial treatment plans for four youth who entered the program on prescribed psychotropic medications address the youth's psychiatric needs. All plans were signed by the

youth's assigned mental health therapist and were reviewed and signed by a licensed mental health counselor (LMHC) within ten days of completion. All initial treatment plans were also signed by the youth and the treatment team members.

Each reviewed record contained an individualized treatment plan developed within thirty days of admission. The individualized treatment plans were signed by the mental health clinical staff completing the plan and were reviewed and signed by a LMHC within ten days. The individualized treatment plans also were signed by the treatment team members and the youth. An interview with the designated mental health clinician authority (DMHCA) and a review of each youth's record confirmed copies of the treatment plans were mailed to the parent/guardian for review and signature.

All seven reviewed records contained documentation of individualized treatment plan reviews conducted every thirty days. Each individualized treatment plan review was completed on a site-specific form, which contained all of the required information contained within the Department's Individualized Mental Health Treatment Plan Review form (MHSA 017).

Three closed youth records were reviewed to evaluate the program's discharge practices. Each of the three closed records contained a discharge plan for mental health and substance abuse treatment services, which was documented on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA 011). None of the three youth required any type of notification for suicide risk or precautions. All three summaries contained directions for services to be considered for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. An interview with the assistant DMHCA verified the discharge plans were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. Documentation showed case management sent out a copy of the discharge summary to the youth, JPO, and parent/guardian.

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

The program provides mental health overlay services (MHOS) in accordance with Florida Statute, Administrative Rule, Rule 63N-1, F.A.C.. The program also provides substance abuse services for youth with co-occurring substance abuse disorders. The program provides individual, group, or family therapy seven days a week. Daily therapeutic activities include psychosocial skills training, psycho-education, and supportive counseling provided by mental health clinical staff. The program has three licensed mental health professionals on-site at least five days a week. A licensed psychiatrist is contracted to be on-site and provide services bi-weekly. Mental health therapist caseloads do not exceed sixteen youth. The interview with the facility administrator showed he was familiar with the treatment services provided by the program.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program contracts with a psychiatrist licensed under Chapter 458 or 459 and a psychiatric advanced registered nurse practitioner (ARNP) licensed under Chapter 464, meeting requirements in Rule 63N-1, F.A.C. to provide psychiatric services. The ARNP works under the protocol of the psychiatrist. Both licenses are clear and active. Four of the seven youth records reviewed were applicable for psychiatric services. The four youth entered the program with an active prescription for psychotropic medication(s). The four youth received an initial diagnostic psychiatric interview, which was completed using the Department's Clinical Psychotropic Progress Note (CPPN) form and were documented as a "Initial Diagnostic Psychiatric Interview." Each of the four initial diagnostic psychiatric interviews included the youth's history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. Each of the initial diagnostic psychiatric interviews was completed within fourteen days of admission. An interview with the assistant designated mental health clinician authority and a review of the sign-in logs confirmed the psychiatrist was on-site bi-weekly. The psychiatrist is available for emergencies twenty-four hours a day, seven days a week. The ARNP serves as the psychiatrist's backup for emergencies.

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

The program has a written plan detailing suicide prevention procedures. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The suicide prevention plan updated, reviewed, and signed on December 1, 2018 by the facility administrator and the designated mental health clinician authority (DMHCA).

3.11 Suicide Prevention Services (Critical)	Failed 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.*	

According to the designated mental health clinician authority (DMHCA) and the assistant DMHCA, the program did not have any suicide-related issues requiring youth to be placed on precautionary observations since the last annual compliance review. However, the DMCHA and the assistant DMHCA reported there have been youth who have made threats or spoke of suicide, perhaps trying to get attention or a need met. In these circumstances, mental health staff responded and spoke with and counseled the youth, but did not complete an Assessment of Suicide Risk (ASR). This practice is not consistent with the program's suicide precaution protocol, which states any youth exhibiting any form of suicide risk will be placed on suicide precautions and an ASR will be completed. In addition, one youth placed in controlled observation was documented as making attempts to harm himself and there was not a referral to mental health documented or an ASR completed.

The program did have two youth Baker Acted during the annual compliance review period. A review of the two youth records indicated the youth were placed on precautionary observation for suicide prevention services. Each youth was observed by staff to be at risk of suicide and initially placed on constant supervision. All applicable alerts were entered and removed from the Department's Juvenile Justice Information System. Each youth had an ASR completed by a licensed mental health counselor (LMHC). Each youth had observation logs, which were completed correctly. The two youth were transported to the Baker Act facility by the St. Johns County Sheriff's Office. Upon return to the program, the youth were placed on constant supervision until a new ASR was completed by the LMHC.

Seven staff were interviewed. All staff stated they notify their supervisor if a youth expresses suicidal thoughts and the youth is placed on constant sight and sound supervision. All staff knew the location of the suicide response kit.

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 has a policy and procedures for documenting suicide precaution observations. The program reported two incidents, both involving Baker Acts, requiring precaution observation since the last annual compliance review. The clinical staff followed the program's protocol in completing the Baker Acts, both prior to the youth being Baker Acted and upon each youth's return to the program. Log books were completed, as required. Entries were entered in real

time, in intervals not exceeding thirty minutes, documented warning signs and safe housing, and were reviewed and signed by mental health staff daily.

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

The program's policy and procedures require all staff who work with youth to receive a minimum of six hours of annual training on suicide prevention and implementation of suicide precautions. A review of fourteen training records found all staff completed six hours of suicide prevention training in 2018. Mock suicide drills were completed quarterly on each shift. Documentation of the mock suicide drills included the date and time of the drill, name and title of staff member in charge at the time of the drill, name of the mental health staff conducting the drill, nature of the incident, list of all persons involved, type of medical care given and by whom, type of mental health/crisis intervention provided, outcome of incident, and staff signatures.

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

The program has a written crisis intervention plan. The plan includes the following elements: notification to staff, family, and juvenile probation officer (JPO); documenting the crisis as an alert in the Department's Juvenile Justice Information System (JJIS); referral process; line of communication; supervision level; documentation/report; and the review process. The mental health crisis intervention plan was reviewed, updated, and signed on December 1, 2018 by the facility administrator and the designated mental health clinician authority (DMHCA).

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.	

Crisis assessments were completed on two youth during the annual compliance review period. A review of the two crisis assessments indicated each assessment was completed within two hours of identification of the crisis. The assessments documented the date, time, and reason for the assessment. The documentation also included the youth's mental status, danger to

self/others, initial clinical impressions, supervision and treatment recommendations, follow-up evaluation, and notification to parents/guardians. The mental health clinical staff completing the crisis assessments provided the description of the crisis and action taken to intervene, and the youth's symptoms or behavior, relevant medical or mental health history, and current behavioral observation. The program director notifies the supervisor on duty who is responsible for documenting the crisis on the shift pass-on report. All applicable alerts were entered into the Department's Juvenile Justice Information System, as required.

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

The program has a written emergency mental health and substance abuse plan. The plan includes notification to staff, family, and juvenile probation officer (JPO), documentation of an alert in the Department's Juvenile Justice Information System (JJIS), referral process, line of communication, supervision level, documentation and reporting, authorization to transport, and the review process. The emergency mental health and substance abuse plan was reviewed and signed on December 1, 2018 by the facility administrator and the designated mental health clinician authority (DMHCA).

3.17 Baker and Marchman Acts (Critical)	Satisfactory Compliance
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 has a policy and procedures to complete Baker and Marchman Acts. The program had two Baker Acts since the last annual compliance review. Both youth were determined to need emergency care. The youth were observed by direct care staff member exhibiting signs and symptoms of imminent danger to themselves and staff. The staff contacted the shift supervisor, who in turn contacted the mental health clinical staff and the facility administrator. Each youth's record indicated authorization to transport was completed by mental health clinical staff. The two youth were transported to the mental health crisis stabilization unit by the St. Johns Sheriff's Office. The case manager contacted the youth's parent/guardian and juvenile probation officer (JPO). Upon return to the program, both youth were placed on constant supervision until appropriate assessments were completed.

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 procedure identifying a designated health authority (DHA) as being clinically responsible for the medical care at the program. The program has a contract with a licensed physician who specializes in family medicine and holds an unrestricted license. The DHA meets all requirements for independent and unsupervised practice in the State of Florida. There is a coverage plan in place with another doctor for scheduled absences or vacations. The covering physician also holds an unrestricted license to practice in the State of Florida. There is evidence of the DHA was on-site once weekly for the past six months, as documented on the DHA logs. The DHA interview reflected he is available twenty-four hours a day, seven days a week to address youth needs for acute medical concerns, emergency care, and/or coordination of off-site medical care. Current licensure for all five registered nurses employed by the program during the annual compliance review period was validated through the Florida Department of Health.

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

The program has written facility operating procedures (FOP) in place for all health-related procedures and protocols utilized at the program. There was documentation to support the facility operating procedures were approved and signed by the executive director and the designated health authority (DHA) on January 15, 2019. The DHA later signed and dated a cover page for the written nursing treatment protocols on January 29, 2019, during the annual compliance review. A review of the 2018 nursing protocols found a nurse with the program for much of 2018 had not signed the acknowledgement of the protocols. Three healthcare staff reviewed, signed, and dated a cover page for 2019 nursing protocols. A part-time registered nurse hired in November 2018 had not signed the nursing protocols. In addition, there was no evidence of an orientation to healthcare services being provided to the newly hired part-time registered nurse. One FOP for psychiatric services was not signed by the program's psychiatrist. The FOP for restricted housing (which includes room restriction and controlled observation) stated the program did not use restricted housing; however, the program does, as they utilize controlled observation, which was reflected in a policy and procedures in the security section. A FOP for restricted housing was created during the annual compliance review to outline the medical staff's role in the use of room restriction, but it was pending the signature of the DHA.

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 policy and procedures in place for reviewing the Authority for Evaluation and Treatment (AET) form. A review of seven youth records confirmed three of seven youth had a valid copy of the AET signed by the parent/guardian. Four youth were eighteen years of age

and all records contained an AET for youth eighteen years old or older signed by each youth in accordance the program's policy (Note: this is no longer required by the Department). The AETs were stamped "copy." A release of information for eighteen-year-olds was maintained in a designated folder. Copies and originals of completed parental notifications maintained behind the AET in the individual healthcare record.

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

The program has a policy and procedures in place to inform the parent/guardian of significant changes in a youth's condition and obtain consent when new medication and/or treatment is initiated. A review of seven records found seven were applicable for parental notifications, with some records containing multiple notifications. Verbal notifications were documented in each case and a witness was documented for each verbal notification with one exception. One record was missing a witness signature. Each verbal notification was followed by written parental notifications utilizing the Parental Notification of Health-Related Care: Medication Management (Form HS 021) or the Parental Notification of Health-Related Care: Vaccination/Immunization (Form HS 022). Notifications for the youth who were eighteen-years-old were signed by the youth.

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

The program has a written policy and procedures to inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Four of the seven youth records reviewed were applicable for psychotropic medication. Each record indicated the program informed the parent/guardian and obtained witnessed verbal consent when new psychotropic medication was initially prescribed, discontinued, or a significant dosage adjustment was made. Each record contained documentation to show the Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN), page 3, was mailed to the parent/guardian. Completed parent/guardian notifications were filed in each youth's Individual Healthcare Record (IHCR) behind the Authority for Evaluation and Treatment (AET). The CPPN page 3 indicated the youth and parent/guardian were notified of treatment plan and the parent agreed to treatment.

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

The program has a written policy and procedures to ensure a youth's immunization status is verified to meet state and Department requirements. A review of seven youth records indicated each youth's immunization history and status were reviewed and verified within thirty days of admission to the program. Immunization records are obtained from either school records or the Florida Shots website. None of the reviewed youth records required any immunizations upon

admission. There was no documentation to indicate a religious exemption was requested by a parent/guardian.

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

The program has a written policy and procedures to ensure all youth are screened upon admission in order to determine healthcare concerns which may warrant a referral for further assessment by healthcare staff. A review of seven youth records confirmed each youth received an initial medical screening utilizing the Facility Entry Physical Health Screening Form (FEPHS) on the day of admission. All seven reviewed records indicated the screening was completed by a registered nurse.

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

The program maintains an internal alert system, which identifies medical issues which may affect safety and security of youth at the program. An internal alert list is printed by the nurse and displayed in master control, medical, and the kitchen. All youth with allergies, chronic medical conditions, visual impairments, and medication side effects were confirmed on the alert log. Seven youth records were reviewed, and each alert matched information contained in the Individual Healthcare Record (IHCR) and the Department's Juvenile Justice Information System (JJIS). Confidentiality is maintained for all alerts. (Note: There were inconsistencies in the communication of alerts to staff and posting of the current alert list, which are reflected and rated under Indicator 1.14)

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

The program has a policy and procedures in place to ensure all youth receive an orientation to healthcare services. The procedures outline orientation topics, which include access to medical care, access to sick call, what constitutes an emergency, medication process and side effect monitoring, the right to refuse care, what to do if sexually assaulted, and the non-disciplinary role of healthcare providers. A review of seven Individual Healthcare Records indicated all youth received an orientation to the program's healthcare services on the same day of their admission to the program, which was acknowledge by signatures by both the youth and the registered nurse. Observations of the intake process confirmed information delivery and required topics were reviewed verbally. The nurse interview identified youth are provided an orientation and informed of the program's designated health authority (DHA) and psychiatrist during the admission process.

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

The program has a written policy and procedures to address designated health authority (DHA) notification when a youth is admitted to the program with a medical condition or requires emergency care. A review of seven youth records indicated the DHA was notified of all admissions, regardless of whether or not the youth was identified with a chronic health condition. The DHA notification form identified notifications were made by the registered nurse on the same day of admission, with time of notification documented. The documentation did not reveal any youth required emergency care upon admission to the program.

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

The program has a written policy and procedures to ensure a healthcare admission rescreening is completed each time the physical custody of a youth changes. One of seven reviewed youth records indicated a need for rescreening due a change in physical custody. There were two additional applicable records provided for review. Documentation indicated a new Facility Entry Physical Health Screenings (FEPHS) was completed by a registered nurse upon each youth's returns to the program.

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

The program has a policy and procedures in place addressing the completion of the Health-Related History (HRH) form upon a youth's admission. A review of seven youth records indicated a HRH form was completed for each youth using the Department's HRH form. Each of the HRH forms was completed by the registered nurse at the time of admission, which was prior to completion of the Comprehensive Physical Assessment (CPA). All seven reviewed Individual Healthcare Records documented a review of the HRH form by the designated health authority (DHA) during completion of the CPA. This was accomplished by checking a box on the CPA and signing the bottom of each HRH form. Two youth had special diet requirements not identified on the HRH form.

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

The program has a written policy and procedures to address the completion of Comprehensive Physical Assessments (CPA) for youth admitted to the program. A review of seven youth records indicated the program utilizes the Department's Comprehensive Physical Assessment (CPA) form for each youth admitted to the program. All seven reviewed Individual Healthcare Records contained a new CPA completed by the designated health authority (DHA) within seven days of the youth's admission. Five of the seven CPAs had all fields of the physical

examination completed, as required. Documentation confirms a portion of the exam was refused by all seven youth, as documented with the youth's signature. The Department's Problem List was subsequently updated upon completion of the CPA with one exception.

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

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

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

The program has a written policy and procedures in place to ensure all youth receive a Tier I Tuberculosis screening within seventy-two hours of admission to the program. A review of seven youth records found documentation of at least one Tuberculosis Skin Test (TST). The TST results are documented on the Comprehensive Physical Assessment (CPA), the Infectious and Communicable Disease (ICD) form, and the outside jacket of each youth's record. Two of the seven records had TST results more than a year old. In each of these two records, a nurse completed a tuberculosis screening questionnaire and assessment, as required. Within the past year, the program had no youth admitted to the program with signs or symptoms of tuberculosis.

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

The program has a written policy and procedures in place to ensure all youth are screened and evaluated for sexually transmitted infections (STIs). Documentation of each screening is reflected on the Department's STI screening form. A review of seven youth records indicated each of the youth were found to be sexually active and were screened and referred to the physician upon admission. All youth had STI testing ordered by the designated health authority (DHA) and completed. There was documentation of each screening result on the Infectious and Communicable Disease form. All laboratory results are reviewed, signed, and dated by the DHA and filed in the lab section of the Individual Healthcare Record.

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

The program routinely offers counseling, testing, and referrals for treatment to all youth at risk for the human immunodeficiency virus (HIV). There was evidence in each Individual Healthcare Record reviewed to support all seven youth were offered HIV counseling and testing. Two of the seven IHCRs indicated the youth requested and received HIV testing following written consent documented in the IHCR. One additional record was reviewed. All three reviewed applicable youth records provided documentation on the Department's Health Education Record indicating pre-test and post-test counseling was completed, as required. All HIV results were sealed in an envelope, marked "confidential," and filed in the lab section of each IHCR. There was no

evidence of a youth's HIV status on the internal alert system. A nurse previously with the program who left in 2018 was a HIV certified counselor. There was no evidence of the current nurse conducting testing and counseling was certified. The last 500/501 training the current nurse completed was in 2016 and there were no annual updates for certification documented. Seven youth were interviewed and reported they could request HIV testing.

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

The program has a written policy and procedures in places to address youth sick call requests and ensures youth are seen in a timely manner. Youth receive information regarding the sick call process during orientation on the same day of admission. A review of seven youth records found six sick call encounters. None of the records showed a youth presented with the same complaint three or more times within a two-week period. Each record contained documentation of the youth being assessed by a registered nurse within twenty-four hours. One youth required a referral to the designated health authority (DHA) as a result of the sick call request. Completed sick call forms are filed with the chronological progress notes in each Individual Healthcare Record. Sick call hours are visibly posted throughout the program. Youth have access to sick call forms, which are maintained next to the sick call boxes on the living units. Youth place completed sick call forms in the sick call box. The sick call boxes frequently checked by the registered nurse when on-site. An interview with staff confirmed the shift supervisor reviews the sick call requests at regular intervals, no longer than four hours after sick call requests are submitted, when there is no licensed nurse on-site. If it is determined a higher level of service is needed than they can provide, the supervisor will contact the DHA and document the referral on the "Report of On-Site Healthcare by Non-Healthcare Staff" form. In addition, notifications are made to the clinical nurse manager and director of operations. All seven youth interviewed said they are seen by a nurse within twenty-four hours of requesting a sick call.

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

There is a written policy and procedures in place to ensure youth receive timely medical care through the sick call process. The program's policy requires youth privacy is ensured during all sick call encounters. There were six sick call encounters in the seven records reviewed. Each sick call was conducted by a registered nurse. All sick call encounters were documented on the sick call index and all but one was documented on the program's sick call referral log. Documentation was in SOAP (subjective, objective, assessment, plan) format and in accordance with the health services rule. Sick calls reflected vital signs, treatment, education, and follow up care, if needed. There was no opportunity to observe sick call during the review. All youth signed, indicating they were seen.

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

The program's medical policy and procedures indicated the program does not use restricted housing or confinement, as did the nurse interview. Although, the program does use room restriction/controlled observation, placing youth in controlled observation rooms in intake. A review of controlled observation reports confirmed a registered nurse completed the health status checklist prior to the youth being placed in confinement and the youth received medical care while in controlled observation.

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

The program has a written policy and procedures to address episodic and first aid care. Three of seven reviewed youth records showed episodic care was rendered. All three youth records contained documentation in the SOAP (subjective, objective, assessment, plan) format, including referrals. Documentation of episodic care was filed in the chronological section of each Individual Healthcare Record. Each episodic encounter was documented on the episodic care log. There were no instances of episodic care rendered by non-healthcare staff. There was one instance of episodic care rendered by a registered nurse on December 6, 2018, which stated the youth needed to follow-up, but no follow-up care was evident.

The program has first aid kits located in north and south master control units, as well as in the medical clinic. The first aid kits were fully stocked and sealed with a breakaway tag. Each kit contained contents approved by the designated health authority and none of the contents were expired. The program has procedures in place for periodic monitoring of first aid kits and emergency equipment. The first aid kits and automated external defibrillator (AED) are checked weekly by the registered nurse and contents are replenished, as needed.

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

The program has a written policy and procedures to ensure all youth receive appropriate emergency care, monitoring, and follow-up. Seven staff were interviewed. Five staff interviewed reported being able to call 9-1-1 when a youth is identified with a medical emergency, one stated they were unsure, and another stated they would radio for help due to not being able to have a phone on the floor. There was evidence in the staff training records to support all staff had current certifications in cardiopulmonary resuscitation (CPR), first aid, and use of an automated external defibrillator (AED). All healthcare staff also have current certifications in CPR, first aid, and use of an AED. The program maintains one AED, located in the medical office. It was noted the medical office is only accessible during nursing hours or by the shift supervisor after obtaining a key in a combo box. The AED procedures are attached to the AED unit. The AED pads were installed on February 1, 2018 and expire February 29, 2020. The AED battery was installed on January 15, 2019 and expires May 30, 2020. Monthly emergency equipment checks are completed by a registered nurse. There is a list of emergency phone numbers, including Poison Control, located in the medical office and master control. A review of

medical drills indicated drills were conducted on each shift on a quarterly basis using various scenarios simulating the use of first aid and/or administration of CPR. Each drill was conducted by the registered nurse and signed by each program staff, indicating their participation. Documentation of each drill was reflected on the emergency medical drill form. There is evidence of epinephrine auto injector training for staff, which was conducted by the training coordinator while the registered nurse conducted training for medication.

4.23 Off-Site Care/Referrals	Limited 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 in place to provide for coordination of off-site medical services. Five of the seven reviewed records indicated off-site care was provided for dental assessments. The off-site consultation form was completed for all five off-site instances and all were reviewed and signed by the designated health authority (DHA), as required. Parental notification of each off-site encounter was mailed to the parent/guardian for youth who were under eighteen years of age. There was evidence of referrals being tracked, but lack of follow-up. The five dental visits, which occurred from August to December, identified the need for follow-up dental treatments and/or oral surgeon referrals; however, none of the youth have had a follow-up appointment as of the time of the annual compliance review.

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

There is a written policy and procedures in place to ensure youth who have chronic illnesses receive regularly scheduled evaluations and follow-up care, as necessary. The program has a system in place for monitoring youth who have chronic illnesses. Youth are tracked by utilizing a medical tracking form. Four of the seven reviewed youth records were applicable for review of chronic illness. Reviewed documentation indicated youth were evaluated by the physician prior to the renewal of prescription medication. Periodic evaluations were conducted every ninety days and as necessary. Each record contained a specialized treatment plan. The Department's Problem List was also updated, as necessary.

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

The program has a written policy and procedures in place to ensure a youth's medication is verified upon admission. Four of the seven reviewed youth records were applicable and reviewed. A review of Facility Entry Physical Health Screenings (FEPHS) forms confirmed each youth's medication regimen was verified upon admission to the program. Each record contained documentation in the chronological progress notes indicating the designated health authority (DHA) and/or the psychiatrist were notified of each youth's admission and the medication the youth was taking. The DHA is notified of all admissions regardless of medical condition.

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

The program has a written policy and procedures in place to ensure all medications are current and patient specific. Four of the seven reviewed youth records were applicable and contained a current, valid order for prescription medication. Each prescription was given pursuant to a current practitioner's order. Each Individual Healthcare Record (IHCR) contained orders on a physician order form indicating the medication was continued upon admission to the program. Medication Administration Records confirmed each youth received prescribed medications, as required.

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

The program has a written policy and procedures in place to ensure all medications are stored in a locked and secure area. Observations indicated medications were stored in a locked medication cart located in the medical clinic. All non-controlled medications were stored separately and inaccessible to youth. Oral medications were not stored with injectable or topical medications. All syringes and sharps were secured in the medical clinic in a locked cabinet behind an additional locked door. The medication cart was clean and organized, with stock items maintained separately from youth specific medications. The program maintains bulk supplies of over-the-counter medications in a locked closet located in the clinic. The program has a pharmacy consultant who assists with disposal and destruction of controlled and non-controlled medications when they have expired or been discontinued. The program has only one refrigerator at the time of the review, which contained a lab specimen when observed. No medications required refrigeration at the time of the review.

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

There is a written policy and procedures regarding medication and sharps inventories. The program conducted weekly inventory counts for over-the-counter medications and sharps for the past six months. There were no discrepancies noted. Counts for three sharps and three over-the-counter medications were conducted and matched the program's inventory. Three youth prescriptions were counted and was found to be consistent with the number of pills on hand. There is a perpetual inventory with running balances of all prescribed medication administered to the youth. The program has written procedures in place for inventory discrepancies.

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

The program has a policy and procedures in place for all controlled medications to be inventoried, stored, and documented, as per the Board of Pharmacy. Two controlled medications were counted and were consistent with the controlled substance inventory record.

There is documentation to support all controlled medications were counted two times daily by the licensed nurse during shift-to-shift counts over the past six months. During observation, all controlled medications were stored in a locked box inside the locked medication cart.

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

There is a written policy and procedures to ensure a Medication Administration Record (MAR) is maintained for each youth. The program utilizes Medication Administration Records (MARs) completed on-site by the nurse. A review of five youth MARs reflected a current, valid medication order along with all other required elements. The youth's photo was also attached to the MAR. A review of the MARs indicated each youth received medication as ordered. Start and stop dates for medications were documented on the MARs. Nursing staff documented side effect monitoring at least once weekly on the MAR. Over-the-counter medication administration was documented on the back of each youth MAR, as necessary. Three episodes of refusals were documented using the treatment refusal form and were indicated on the MAR.

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

There is a written policy and procedures regarding medication administration by licensed healthcare staff. Medication administration is conducted by a registered nurse, as scheduled, in the doorway of each living unit. Observation of afternoon medication pass was conducted. Youth approached the medication cart individually to receive their prescribed medication. Direct care staff were positioned at the door providing supervision while also monitoring the medication process. The Five Rights of Medication Administration were followed during medication administration. The nurse initialed youth Medication Administration Records (MAR) to document the medication was given. Each youth was asked to show his mouth and cough to ensure medication was taken. Direct care staff performed an additional mouth check. The working space was clean and organized. Seven youth were interviewed. Six youth stated nursing staff administers medication and one youth stated he did not take medication. The seven staff interviewed said nursing staff administer medication.

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

The program has a written policy and procedures for trained non-licensed staff to administer medication. Non-licensed staff only administer medication when nursing is not on-site, and all scheduled medication passes are done by nursing staff. Shift supervisors and staff who sometimes have supervisory responsibilities are the only non-licensed staff who are selected receive training to administer medication. The non-licensed staff may only access and administer medication after completing the program's training curriculum on medication

administration, which is conducted by a registered nurse. The program maintains a list of non-licensed staff who have completed the training curriculum. There were three instances of youth receiving over-the-counter medication administered by non-licensed staff. There was documentation of treatment rendered (the over-the-counter medication administered) by non-licensed staff on The Report of On-Site Healthcare by Non-Healthcare staff (HS049) and the youth's MAR. The treatment rendered/medication administered was in accordance with protocols developed by the designated health authority (DHA). Both youth and staff initialed, indicated the youth was seen.

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

The program has a written policy and procedures in place for periodic monitoring of psychotropic medications. Four of the seven reviewed youth records were applicable and reviewed for receiving prescribed psychotropic medication upon admission to the program. The designated health authority (DHA) and psychiatrist were notified of each youth's admission. The medications were continued until the completion of the initial diagnostic psychiatric evaluation. The psychiatric evaluations were completed within fourteen days admission. All four records reviewed confirmed each youth received medication management every thirty days. There were no standing or pro re nata (PRN) treatment orders for psychotropic medications. Each youth's record had Clinical Psychotropic Progress Note (CPPN) page 3 had all boxes marked "yes" for explaining treatment plans to the youth, parent/guardian, and for the parent/guardian agreeing to the plan.

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

The program has written infection control procedures including prevention, containment, treatment, and reporting requirements per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. Infection control procedures address all required types and categories of diseases, to include common infectious diseases, contagious illnesses, bacterial infectious diseases, tuberculosis, hepatitis, pediculosis, scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorist agents, and chemical exposures in the workplace. Documentation supports universal precautions are included in the program's education and prevention program for staff and youth. A review of fourteen staff training records indicated the required training was completed. There were no instances requiring notification to the local health department, CDC, or Central Communications Center (CCC). The infection control procedures and Sequel personnel policy states staff are offered the Hepatitis B vaccine during new hire orientation. However, documentation in personnel records reviewed and staff interviews indicated staff hired during the annual compliance review period were not offered the Hepatitis B vaccine.

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

The program has a written comprehensive infection control education plan, which outlines pre-service and in-service training for all staff and infection control education for youth. A review of seven youth records indicated each youth received infection control education upon admission during the orientation process, which included prevention of communicable diseases and prevention of bloodborne pathogens. Each record documented the education on the individual Health Education Record form. A review of seven staff training records for new hires indicated all staff received pre-service training in infection control practices. A review of seven training records for in-service training found four of the seven staff received the annual training on infection control.

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

The program has an exposure control plan, which is written in accordance with OSHA standards. All staff have access to review the exposure control plan. The plan is reviewed annually by the facility administrator and designated health authority (DHA), and the last review was conducted in January 2019. There were no instances requiring notification to the local health department, Centers for Disease Control and Prevention (CDC), or Central Communications Center (CCC). A biomedical waste exemption certificate was issued to the program. The last inspection was rated satisfactory in September 2018 according to Duval County website. The facility administrator interview indicated the exposure control plan is available to staff in each master control, the clinic, and administration.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures addressing youth supervision. The staff-to-youth ratios required by contract for the program are 1:8 during awake hours, 1:12 during sleep hours, and 1:5 for off-campus activities. Staff were observed supervising youth while in their dorms, in school, during meals, and during recreation time. Observations also included youth movements to and from school, recreation, counseling groups, and meals. Youth were properly supervised by staff and the required staff-to-youth ratio was maintained. Documentation showed staffing for the sleep period met the ratio requirement. Staff were observed interacting with youth in an appropriate manner, utilizing the behavior management system, and the program schedule was followed. Staff were aware of the number of youth under their supervision. Youth head counts were observed, resulting in an accurate count each time. If a count does not clear, a “code black” is announced, all movement is stopped, and youth are secured and visually counted by staff. This status remains until the count is reconciled with an explanation as to what led to the error.

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

A point and level system is used for the program’s behavior management system (BMS). The program supports positive behavior and confronts negative behavior. Points are earned by youth through leadership merits (bed made up, room organized and neat, completing school work, and behaving while in school). Dorm of the week is used as an extra incentive. Youth lose or “give up” points for failing to follow the program rules. Points can be used to purchase items from the point store, which consists of food and hygiene items. Consequences are monitored through treatment team meetings, which provides the opportunity for youth to learn from any negative behavior. Youth receive an orientation on the BMS during the admission process, during which the different levels and how to advance through the different levels are explained. Twelve of fourteen staff training records reviewed found staff received training on the BMS in 2018. An interview with the facility administrator showed he was able to fully explain the BMS. Seven youth were interviewed. Each youth knew what level they were on for the behavior management system and was able to describe how to advance through the level system. When asked to rate the behavior management system, one youth rated it as very good, three rated it as good, two rated it as fair, and one rated it as poor.

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 written description of the behavior management system (BMS) and program policy and procedures outline consequences and rewards to be used though the BMS. Consequences for infractions include write-ups, losing points for point store, early bed times, emergency treatment team meetings, new or revised goals on performance plans, or room restriction. Rewards for positive behavior include point, Dorm of the Week, FaceTime phone calls, extra phone call time, use of the multi-purpose room, and a later bed time. Point store is conducted twice a month alternating between snacks and hygiene items. Dorm of the Week receives a party with music, food, and additional snacks. A review of incident reports for infractions found the date and time were noted along with who recommended/approved the consequences. Treatment team documentation showed consequences for infractions were reviewed. The facility administrator interview indicated youth consequences are monitored by treatment teams, which include an administrator. The facility administrator also stated youth consequences are discussed during morning meetings.

Seven youth were interviewed. Each youth was able to identify consequences for rule violations or inappropriate behavior. When asked if youth were allowed to punish other youth, all seven youth said no. All seven youth were able to identify rewards given through the behavior management system. Six of seven youth stated staff are consistent in applying consequences. Seven staff were interviewed. All staff were able to identify consequences and rewards used as part of the BMS. All staff reported youth are allowed to explain their behavior when receiving consequences. Five of the seven staff stated they receive feedback from their supervisor regarding their use of consequences, with the staff saying this is done at shift briefing or through coaching notes.

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 policy and procedures to address ten-minute checks of youth while they are in their sleeping rooms. Staff conduct ten-minute checks by visually looking into the rooms when a youth is secured behind their room door and then document the check on form designated for recording the checks. During the sleep period, an all-call is announced by master control over the radio instructing staff to complete their "less than ten-minute check." Staff interviews and documentation showed the checks are typically completed every nine minutes. A review of security video confirmed the process of master control calling for the checks, as staff in all

dorms conducted the checks at the same time. The security video confirmed checks of youth in their rooms were completed within ten-minute intervals.

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

The program has a written policy and procedures to address census, counts, and tracking of youth. A review of the master control logbook noted head counts are conducted at the beginning and end of each shift, whenever there is youth movement, and whenever there are any adjustments to the census due to an admission or release from the program. Emergency counts are conducted when the count cannot be reconciled, after an incident, and after a drill is completed. A board is maintained in master control the facility count. The board identifies counts on the north side and south side of the facility, as well as individual dorm counts. A handwritten list of the youth, along with their module assignment, is maintained in master control. A copy of this list is given to staff at the start of their shift during briefing. The shift supervisor also maintains a copy of this list.

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

The program maintains a logbook to record program activities. The logbook is kept in master control and maintained by the master control operator. Logbooks for the past six months were reviewed. The logbook is bound with pages numbered. Staff used ink for all entries and there were no entries removed through erasure, whiteout, or other methods. Entries were legible and included the date, time, brief description of the event, including names of staff or youth, as appropriate, and the name and signature of the staff making the entry. The beginning and end of each shift was noted in the logbook. Entries reflected youth movements for school and meal times, med pass start and end times, incidents, departure and return of youth to the program, staff entering and exiting the program, and census counts (including counts at the start and end of each shift). Shift briefings and reviews of previous shifts were noted in the logbooks. The logbooks appeared to reflect all program activities. There was one Central Communications Center (CCC) report not documented in the logbook.

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

The program has a policy and procedures for key control. A review of the key inventory found it was accurate. Facility staff keys are maintained in master control. Supervisors, medical staff, case managers, teachers, and therapists receive their keys from master control upon reporting for duty. A chit is provided to staff for their personal keys and an entry is written on the key control log. This log contains the staff's name, time of arrival/departure, what chit was assigned, their work area, and their agency. Youth care workers (YCW) are not assigned facility keys while working in the module areas with youth. Both key control boxes are secured and monitored by the master control supervisor and staff. Facility keys are reconciled at the beginning and end of every shift by the master control supervisor and staff. If a key is missing or lost, the shift supervisor is immediately notified, and all youth movement is stopped. All youth are secured, and a thorough search of the facility is conducted unit the missing key is found. Youth do not have access to the facility keys. A master control operator was interviewed and clearly explained the system for issuing and tracking keys. Seven staff were interviewed and able to explain the program's key control process.

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

The program has a policy and procedures addressing contraband, which identifies items considered to be contraband and contraband search processes. Contraband inspections of youth living areas are completed once to twice a week. A written log is completed by the staff conducting the room searches for contraband. Unauthorized items are removed from the youth's room and noted on the log. Any illegal contraband is turned over to the shift supervisor and given to the facility administrator. Disposition of the contraband depends on the type of

contraband item found. The facility administrator was interviewed and reported there is a system in place to prevent the entry of contraband into the facility. Staff and visitors must pass through a metal detector as well as be scanned with a hand-held metal detector wand before entering the secure area of the facility.

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.	

Observations found youth are searched after meals, after recreation, and whenever returning to their dorm. The searches were conducted in an orderly fashion and conducted in a respectful manner. All searches were conducted by male staff. Observations during the searches showed the youth were familiar with the search process. Seven staff were interviewed. The staff stated youth are searched after each movement, after visitation, and when it is suspected a youth may have contraband. The staff reported only male staff conduct searches. Seven youth were interviewed. Each youth reported searches are conducted after activities and movement.

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

The program has a policy and procedures to ensure all vehicles transporting youth receive the appropriate maintenance and contain safety and emergency equipment. The program has two vehicles in use for transportation of youth. Vehicles logs were maintained for each vehicle with invoices for annual inspections, service provided, and repairs. Logs for daily inspection of the vehicles were documented by maintenance staff. Each vehicle had all required safety and emergency equipment inside (fire extinguisher, first aid kit, seat belt cutter, window punch) and the required number of seatbelts needed for the youth.

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

The program has a policy and procedures related to transportation of youth. Staff must have a current, valid driver license and the program maintains a list of staff eligible to transport youth. The vehicles are equipped with safety equipment and a screen separating youth from the vehicles driver. At least one male staff must be on each transport with youth (this is an all-male program). Staff are issued a cell phone for transports to be able to communicate with the program, which was confirmed in interviews conducted with seven staff. A transport was not observed during the annual compliance review.

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

The program has a policy and procedures for the completion of weekly safety and security audits. The facility administrator or an assistant facility administrator complete the weekly safety and security audit. A log is maintained on the completed audits, which showed the audits have been completed weekly. The audits identify deficiencies and corrective action needed. Any current or outstanding deficiencies are reviewed during daily morning meetings and corrective action measures or plans are tracked and monitored until fully completed. Maintenance personnel complete preventative maintenance on the generator monthly. The interview with the facility administrator confirmed safety and security audits and issues are brought up during morning meetings and addressed, as needed.

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

The program has a policy and procedures to address tool inventory and management, which includes issuance, inventory, and control of equipment and tools. Tools are kept in the maintenance office, which is kept locked and restricted from youth access. An inventory is maintained for all tool items, which is reviewed daily and the formally monthly. Tools are signed out when used. All tools were marked for identification. Documentation showed tools are inventoried by maintenance staff upon their arrival for duty. No discrepancies were found. Staff are trained on the safe use of tools.

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 policy and procedures for youth handling of tools and supervision of youth handling tools. Risk assessments are completed on youth to determine if they can use tools and the type of tools they can use. If assessed to be able to use tools, youth are trained on how to use the tools and supervised by staff when using tools with a ratio of at least one staff for three youth. Seven staff and seven youth were interviewed. The interviews revealed youth are allowed to use mops and brooms for cleaning.

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 policy and procedures in place to address outside contracts bringing tools and equipment on site when completing work at the facility. When outside contractors arrive at the facility, the outside contractor must sign in and an inventory of their tools and equipment is conducted. The contractors were escorted by maintenance staff to areas they needed to access. Upon completion of their work, another inventory was conducted to ensure all tools and equipment were accounted for.

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.	

Reviewed documentation showed fire drills were conducted twice a month for both shifts. Escape drills, Continuity of Operations Plan (COOP) drills, and medical drills are conducted according to a schedule issued by program administration. Shift supervisors complete drills with their staff, review the policy regarding the drill, review the scenario used for the drill, and turn in the required paperwork to program administration for final review. Drills are noted in the master control logbook as well. A review of the staff interviews revealed staff conduct/participate in the facility drills. An interview with the facility administrator confirmed the frequency of fire, safety, and evacuation drills. Seven youth were interviewed. Four youth reported they had been instructed on what to do in case of a fire and all seven said they had participated in a fire drill.

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

The program's Continuity of Operations Plan (COOP) was approved by the Department's residential regional director on May 11, 2018. The COOP is kept in an assistant facility administrator's office and each master control. Drills for emergency situations addressed in the COOP, to include evacuation, were conducted by program administration. The COOP identifies primary and alternate locations in the event the program must evacuate youth and staff, which includes medical and case managers. The facility administrator reported the COOP is available to staff in each master control and administration. A review of fourteen training record showed staff have been trained on emergency procedures.

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

The program has a policy and procedures on the storage and inventory of flammable, poisonous, and toxic items. All flammable, poisonous, and toxic Items and materials were stored and secured in an area with limited access to staff. Shift supervisors are responsible to hand out the supplies needed to their staff and collect them at the end the shift. All items were inventoried and the inventory was found to be accurate. Safety Data Sheets (SDS) are properly maintained by maintenance staff.

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

Program policy and procedures outline strict control of flammable, poisonous, and toxic items and materials. Youth can assist with general clean up (mopping, sweeping, and wiping down furniture or windows) but are supervised by staff when cleaning and they do not have access to the cleaning materials. Seven youth were interviewed. Four youth reported using paint, as the program has painted multiple areas of the facility. Five of seven reported staff spray cleaning solutions on items and youth wipe up afterward. Each youth stated youth are supervised by staff whenever painting or cleaning.

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

According to maintenance staff, liquid waste resulting from work details is disposed of in the plumbing area of each dorm with a drain. Kitchen liquid waste is disposed of in the kitchen drain and grease is placed in a separate container for disposal. Any hazardous materials shall be disposed of according to the manufacturers' recommendation or instructions on Safety Data Sheets (SDS). The facility administrator interview showed he was familiar with the program's process and practices for the disposal of flammable, toxic, caustic, and poisonous items.

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

The program has two recreational therapists, both of whom had the proper credentials. The recreational therapists plan various recreation activities for youth and are involved with performance planning for recreation related goals. The program schedule reflects leisure and outside recreation activities. The program partners with St. Augustine Compassionate to provide services to the youth, which include tapping, art, music, and a chess club. Seven staff and seven youth were interviewed. All youth and staff reported youth receive at least one hour of physical activity daily. A review of seven youth records found recreational goals were included on each of the performance plans.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures addressing visitation and communication. The program provides an opportunity for the youth to communicate with family members by mail and telephone.

The program schedule reflects visitation on Saturdays for three hours, from 9:00 a.m. to 12:00 p.m. The policy states the case manager and the juvenile probation officer review and verify approved visitors. The program maintains a visitation sign-in log, which identifies the date, the youth's name, the visitor's name, the visitor's driver's license/identification number, and the time the visitation began and ended. A review of visitation logs for five youth reflected only approved individuals visited youth. The program allows the youth to mail two letters each week and the mail is reviewed by the youth's therapist. The program maintains a log of incoming and outgoing mail, which identifies the youth's name, the date, the individual being corresponded with, and

who approved the letter to be mailed. The program also maintains a log of “not approved” incoming and outgoing mail, which notates the individuals were not on the approved correspondence list. A review of seven youth records reflected four youth have documented correspondence as either incoming or outgoing mail. Each youth’s log reflected the youth were corresponding with approved individuals.

The program provides the youth with weekly ten-minute phone calls to family members. The youth are provided an additional phone call each week when they are promoted to a higher level. The program maintains a telephone log for each dorm, which identifies the youth’s name, names of individuals the youth may communicate with and their relation to the youth, and each approved individual’s phone number. The log also documented the date of the call, the start time and end time of the call, the length of time of the call, and the individual(s) who were contacted. Each call logged included the youth’s initials, and the initials of the staff monitoring the call. A review of seven telephone logs reflected youth were allowed to communicate with approved family members and on a weekly basis with one exception, which was one youth missing one weekly phone call.

Seven youth were interviewed. All youth reported they are given the opportunity to communicate with family members by mail, telephone, and visitation.

5.24 Search and Inspection of Controlled Observation Room	**Satisfactory Compliance**
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program has a policy and procedures for the use of controlled observation, which outlines youth search and room inspection requirements. The program used confinement rooms in intake for controlled observation. The room meets the size and other requirements for controlled observation. A review of ten controlled observation reports documented an inspection of the room to be used for controlled observation was inspected and youth were searched prior to youth being placed in controlled observation.

5.25 Controlled Observation	**Limited Compliance**
Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.	

Ten controlled observation reports were reviewed. Each youth displayed behaviors or had major program rule violations to meet criteria for placement in controlled observation and each placement was authorized by a supervisor or program administrator. However, two youth were placed in controlled observation despite displaying suicidal behavior or acts of self-harm. One of these two youth was later Baker Acted and the other had visible self-inflected marks on his arm. A Health Status Checklist was completed in each case. Extensions beyond two hours were approved by the facility administrator or designee. No youth remained in controlled observation over twenty-four hours.

5.26 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
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.	

Ten controlled observation packets were reviewed. Each packet contained observation check sheets, which documented staff checked on youth in controlled observation every fifteen minutes. The staff recorded their initials and a code to describe the youth's behavior for every check. The facility administrator or designee approves youth to be removed from controlled observation. Prior to removal, a youth is counseled about his expected behavior, which is noted on the report, and then the youth is returned to population.

Program Name: St. Johns Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: St. Johns County / Circuit 7
Review Date(s): January 29 - February 1, 2019

MQI Program Code: 1266
Contract Number: 10173
Number of Beds: 72
Lead Reviewer Code: 37

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.03 Provision of an Abuse-Free Environment*	3.11 Suicide Prevention Services*
1.13 Gender-Specific Programming	
1.14 Internal Alerts System and Alerts (JJIS)*	
2.11 Performance Summaries and Transmittals	
2.16 Career Education	
4.02 Facility Operating Procedures	
4.17 HIV Testing	
4.20 Room Restriction/Controlled Observation	
4.23 Off-Site Care/Referrals	
4.34 Infection Control - Surveillance, Screening, and Management	
5.25 Controlled Observation	