STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

St. Johns Youth Academy

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

Review Date(s): January 7-10, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Gwen Nelson, Office of Program Accountability, Lead Reviewer ([Standard 1)
Renette Crosby, Office of Program Accountability, Regional Monitor (Standard 3)
Gail Goldberg, AMIKids Clay, Senior Case Manager (Standard 1 and Interviews)
Cindy Jones, DJJ Education, Government Analyst, (Standard 2)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 4)
Ben Marrufo, Office of Programming and Technical Assistance, Technical Specialist (SPEP)
Josh Maxwell, DJJ Probation, Circuit 5, Senior Probation Officer, (Standard 2)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)
Jake Turley, TrueCore Behavioral Solutions, Information System Project Manager (Standard 5)

Program Name: St. Johns Youth Academy
Provider Name: Sequel TSI of Florida, LLC
Location: St. Johns County / Circuit 7
Review Date(s): January 7-10, 2020

MQI Program Code: 1266
Contract Number: 10173
Number of Beds: 72
Lead Reviewer Code: 130

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.08 Youth Needs Assessment Summary (YNAS)	5.04 Ten Minute Checks *
5.06 Logbook Entries and Shift Report Review	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

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 contract with the Department. The program provides mental health overlay services (MHOS). The program provides treatment services to include individual, group, recreation, and family therapy. Treatment groups address the youth's mental health and substance abuse needs. Additionally, the program provides the following Standard Program Evaluation Protocol (SPEP) 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. Mental health staff at the program includes the clinical director, an assistant clinical director, and seven therapists. The program contracts with a psychiatrist, who provides psychiatric evaluations, prescribes, and monitors psychotropic medication. Medical services are provided 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. On-site medical services are provided by the director of nursing who is a registered nurse, a full-time registered nurse, and one part-time pro re nata (PRN) registered nurse. A contracted medical doctor (MD) serves as the designated health authority. The medical staff registered nurses (RN), a psychiatrist, and a psychiatric advanced practice registered nurse (APRN) have clear and active licenses to practice in the State of Florida. 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 facility administrator stated there were a total of six 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. There are two living units at opposite ends of the facility. Each living unit has three dorms and a master control area. The main master control room is in administration. The master control areas 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 one hundred two operating security cameras providing coverage with a retention period for recording sixty days. All security cameras were operational at the time of the annual compliance review.

Strengths and Innovative Approaches

- The program in collaboration with Workforce and National Center for Construction Evaluation and Research (NCCER) and the Clara White Mission in Jacksonville, Florida developed a seven-week, forty-two hour vocational program with the assistance of a NCCER Master Trainer. The program allows youth to obtain certifications in Occupational Safety and Health Administration (OSHA), (Hazardous Materials (HAZMAT), Hazardous Waste Operations and Emergency Response (HAZWOPER), forklift, construction site safety, environmental training, and blood borne pathogens. Youth completing the program receive $650 for completing the program.

- The program works with Tulsa Welding School in Jacksonville, Florida, Little Cesar's Pizza, Kentucky Fried Chicken, and McDonalds. Youth at the program work off-site and receive "managing your finances" counseling services from Regions Bank.

Standard 1: Management Accountability

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

The program has a written policy and procedures for completing initial background screening complying with the Department's Background Screening Unit (BSU) requirements. Since the last annual review, the program hired a total of twenty-four new employees. Each of the new employees were background screened prior to their hire dates. Ergometric tests to determine suitability for working with youth were completed and on file for the newly hired employees. A review of the criminal history, Staff Verification System module, and the Florida Department of Law Enforcement Automated Training Management System were reviewed. The Annual Affidavits of Compliance with Level 2 Screening Standards were completed by the program and education provider and submitted to the Department's BSU within the required time frame to meet the annual requirement. The annual affidavit for the program was submitted on December 4, 2019 and the annual affidavit for the education provider was submitted on December 6, 2019.

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 for five-year background rescreening's. The program had one staff member requiring a rescreening/re-submission. The program submitted the required information to the Department's Background Screening Unit/Clearinghouse prior to the staff's five-year anniversary.

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

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

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

The program has a policy and procedures to ensure the provision of an abuse- free environment. The annual compliance review team observed postings of the Florida Abuse Hotline, Department's Central Communications Center (CCC), and 9-1-1 contact information throughout the program during the tour of the facility. The program's policy states allegations of child abuse or suspected child abuse are to be immediately reported to the Florida Abuse Hotline and to the CCC within two hours of the incident or knowledge of the incident. Youth and staff have "unhindered access" to report alleged abuse. When a youth makes a request to contact the Florida Abuse Hotline, the staff immediately notifies the supervisor who arranges for the youth to contact the Florida Abuse Hotline or the CCC if the youth is eighteen years of age or older.

The program reported nine incidents to the CCC for suspected abuse since the last annual compliance review. Seven of the incidents were listed as closed with no justifications, the incident did not rise to the level of reasonable cause to suspect abuse, and the calls were not accepted for investigation. Two open incidents with the Department of Children and Families are pending investigation.

Seven youth were interviewed and reported they feel safe at the program and have not been stopped from reporting abuse. One interviewed youth reported case managers often use profanity and can be disrespectful to youth. Six youth reported staff are respectful and one youth reported staff are sometimes disrespectful. Seven staff were interviewed and three reported they have observed a co-worker use profanity. Seven staff reported they have never observed a co-worker tell a youth they cannot contact the Florida Abuse Hotline.

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

The program has a policy and procedures for responding to allegations of physical, psychological, or emotional abuse by staff and youth. The program substantiated one incident relating to violation of policy/rule, improper conduct, improper supervision, and unnecessary use of force by three staff members during an incident on the dorm. One staff member was terminated and two received written reprimands.

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

The program has a policy and procedures in place to report incidents to the Department's Central Communications Center (CCC). The program had a total of eighteen CCC reports in the past six months. Five reports were reviewed and 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's interview indicated CCC calls are made within two hours of the program becoming aware of reportable incidents and the internal investigation process starts 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 for Protective Action Response (PAR). The program reported eight incidents requiring the use of physical interventions in the last six months. Five PAR reports were reviewed and each PAR report was completed by the end of the shift and reviewed by administration within twenty-four hours. None of the incidents required the use of mechanical restraints. All five reports reviewed had documentation of a post-PAR interview within thirty minutes. All five reports had statements from all staff involved.

The facility administrator (FA) interview indicated the facility administrator and the assistant facility administrators (AFAs) reviews all videos of PAR incidents. The FA interview stated all PAR incidents are discussed during morning meetings and any violations of PAR policy and procedures result 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 0.49, which is below the statewide Residential PAR rate of 2.35.

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

The program has a policy and procedures for training of new employees. The program had a total of twenty-four new employees. 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, 2019. Trainings were entered in SkillPro.

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

The program has a policy and procedures for training of residential staff to complete twenty-four hours of in-service training. Training records and documentation in the Department's Learning Management System (SkillPro) were reviewed for seven staff for in-service training. Six of seven staff had over twenty-four hours of training in 2019 with staff completing between thirty-four to eighty hours of training. The one staff with less than the required twenty-four hours of annual training was on sick leave for more than six months and had a total of sixteen training hours. 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. Six staff completed training on professionalism and ethics. Two staff reviewed were shift supervisors and an additional supervisor was reviewed. The three supervisors completed fourteen to eighteen hours of supervisory training. The in-service annual training plan was approved by the Department's Office of Staff Development and Training on February 7, 2019.

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

The program has a policy and procedures for the grievance process, grievance training, and documentation. The policy allows for youth to grieve the actions of the program staff, peers, or conditions and/or circumstances of care and treatment. The policy includes an informal phase

(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 (FA) which is to occur within forty-eight hours. The grievance process is posted throughout the program and forms are available to youth. During the tour of the facility, grievance forms were located on the dorms and in the lunch room. Six of the seven interviewed youth reported grievance forms are available throughout the program.

During the annual compliance review period, the program had four grievances filed. Each grievance documented a review by the supervisor or designee and each grievance was resolved without needing to proceed to the appeal phase. Documentation indicated grievances were addressed within the time frame indicated by the program's policy. Fourteen staff training records were reviewed for grievance training. Each training record had documentation of staff receiving and completing grievance training.

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

The program has a policy and procedures to provide delinquency interventions for each youth. The program's delinquency interventions include Thinking for a Change (T4C), Impact of Crime (IOC), Skillstreaming the Adolescent, and Young Men's Work: Stopping Violence and Building Community. Staff providing delinquency interventions had the required experience and training to provide the interventions. A review of the program's activity schedule confirmed the program is providing structured programming sixty percent of the youth's awake hours. A review of sign-in sheets confirmed the groups were delivered, as required. The facility administrator (FA) interview confirmed delinquency interventions are being provided for the youth in the facility. The FA interview also stated staff must meet the experience, training, and education requirements before they can facilitate intervention groups.

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

The program has a written policy and procedures for life skills training for youth. The program schedule provides for life skill training and a review of sign-in sheets, worksheets, and youth interviews confirmed 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 and each reported they received life skills training in groups and were able to practice the life skills through role plays or skits in the groups. The clinical director interview indicated youth in the program participate in life skills training 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 restorative justice awareness for youth through Impact of Crime (IOC), a promising practice curriculum. 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. An IOC group started on December 11, 2019 and one finished on December 29, 2019. The program calendar indicated another group is scheduled for January 20, 2020. The IOC groups are conducted on Tuesdays and Thursdays for one hour. Four staff members are trained to conduct the IOC groups. A review of group sign-in sheets confirmed the curriculum is delivered, as designed. Five of seven reviewed records indicated youth are receiving restorative justice awareness. The remaining two youth were new admissions and will participate in the next IOC cohort. Five of the seven interviewed youth stated they were currently in or previously completed IOC groups. The facility administrator (FA)interview confirmed the program utilizes IOC and the IOC groups are conducted two days a week. The FA also indicated the program utilizes speakers to provide testimonies of being a victim. The program has a chicken pen and garden which was built and is maintained by youth at the program. The eggs from the chickens are donated to local food banks and a shelter. The program has "All Lives Matter" groups with youth speakers to influence youth not to make the same mistakes they have made.

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

The program 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 years of age 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 includes 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. Groups were once or twice a month until August 2019. Currently, the program has three staff members who facilitate Young Men's Work groups. A review of sign-in sheets indicated groups were conducted in August, September, October, November, and December 2019. The facility administrator and clinical director interview 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)	Satisfactory Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a policy and procedures for documenting all alerts. The policy states how, when, and who can enter information into the Department's Juvenile Justice Information System (JJIS) and program's internal alert system. Nursing staff maintains an alert list which is updated, as needed. The alerts on the internal alert list matched the alerts in JJIS.

The program has an alert board in the main master control listing youth with medical, mental health, and security alerts. Seven staff were interviewed to determine how staff is informed of youth's alerts. All seven staff members stated alerts were addressed during daily briefings. Five stated alerts are also posted in master control, the kitchen, and in the medical office.

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, a 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's identification number (DJJID), date of birth, date of arrival, county of residence, circuit of residence, and committing offense(s). The sections in the individual management record includes 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 maintained in a locked record rooms. Healthcare records are labeled "confidential" and 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 has both a formal process and an informal process for youth input. A review of the youth advisory board meetings from April through December 2019 indicated the board met monthly. The program has a binder with the sign-in sheets with date and time, attendees' signatures, agendas with topics, and minutes summarizing meeting discussions. Topics addressed at the meetings were dorm improvements, culture improvements, and the five Core

Norms. The youth's informal input is through "speak outs" and requesting to speak with the facility administrator (FA) or assistant facility administrator (AFA).

Seven youth were interviewed and five stated they can speak to the FA, AFA, and the regional director regarding issues and concerns in the program. Two youth responded by saying "no." The FA stated in an interview 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.

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

The program has a community advisory board. The board met on February 7, 2019, April 13, 2019, July 10, 2019, and October 9, 2019. The next scheduled community advisory board meeting is on February 7, 2020. The program maintains sign-in sheets and minutes from each meeting documenting the individuals who attended and what was discussed during 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 indicated 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 (FA)indicated the community advisory 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 FA stated the advisory board assists in enhancing programs offered at the facility, such as the program's chicken pen and garden programs.

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 and each reported monthly meetings and daily shift briefings. Seven staff felt information shared during the monthly meetings was helpful. One staff stated the meetings are too long. One staff rated communication among staff as very good, two staff members rated it as good, three staff members rated it as fair, and one rated it as poor. According to the facility administrator (FA), all-staff meetings are conducted monthly. Documentation reviewed found staff meetings were conducted monthly. The program also conducts daily morning meetings to discuss current issues and review standards.

The FA reported a total of six youth care worker positions vacant at the time of the annual compliance review. The FA reported offers have been made for four of the vacant positions. The FA reported the Comprehensive Accountability Report (CAR) is reviewed quarterly for trends. Youth and parent/guardian surveys have been completed on SurveyMonkey 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 indicates 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 (FA) interview confirmed staff receive an initial ninety-day performance evaluation and annual evaluations thereafter. In addition, the FA stated staff receive monthly coaching from their supervisor.

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

The program's daily schedule indicated a variety of recreation and leisure activities. The program has two recreational therapists. A review of the program's staffing roster as well as the therapist's credentials, schedule, and services provided to youth demonstrate all requirements are being met. The activity schedule documents a range of supervised and structured indoor and outdoor recreation and leisure activities for the youth. A review of the logbook demonstrated the activities are conducted according to the program's activity schedule.

The program has written policy and procedures stating activities will be provided based on the developmental levels and needs of the youth in the program. Activities includes a choice of leisure and recreation options. Youth are encouraged by staff and activity options to explore interest. Youth were observed to be engaged in constructive use of leisure time. Activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program takes precautionary measures to prevent over-exertion, heat stress, dehydration, frostbite, hypothermia, and exacerbation of existing conditions. A review of seven youth case management records demonstrated the therapeutic activities provided are a part of each youth's performance plan. Seven youth were interviewed and each agreed there are large muscle, physical, and leisure activities provided for at least one hour daily. The youth were able to describe some of the activities such as basketball, play station, cards, dominoes, maintenance, Home Builders, books, board games, and football. Each of the seven interviewed youth also affirmed they are provided with varying degree of mental and physical exertion throughout the day. Seven interviewed staff indicated youth participate both indoor/outdoor activities such as documented on the daily schedule such as board games, video games, ping pong, and weightlifting. The youth participate in outdoor recreational activities for at least one hour each day excluding extreme weather.

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 with a youth's parent/guardian and for court notification upon a youth's admission to the program. The policy requires contact by telephone to 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 to the parent/guardian within forty-eight hours of admission.

Seven youth 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 of admission. The program also contacted each youth's juvenile probation officer, post-residential services counselor, and the committing court within five working days 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 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 Department's 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 youth case management records were reviewed. Each record contained documentation to indicate the youth received an orientation on the day of admission to the program. Each record documented the orientation process, expectations, and responsibilities of each youth. Each youth signed a form to document their receipt of the orientation checklist and all covered topics. Daily schedules were posted in multiple locations. The program's behavior management system was posted. There were no admissions during the annual review to observe. Seven youth were interviewed and each reported having orientation on the date of admission to the program.

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 youth case management records were reviewed and one was applicable since the youth was eighteen years of age. The case file contained the written consent signed by the youth.

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

The program has a policy and procedures to address the classification process and reassessment for activities. The program's classification includes a review of the physical characteristics; age and maturity level, identified special needs including mental, developmental, intellectual, and 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 risks. 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 youth case management records were reviewed. Each record contained a completed classification form with all required elements. Living unit and room assignments were derived from the information gathered through the classification process. Each file contained a completed Victimization and Sexually Aggressive Behavior (VSAB) Form. Reassessments were completed during treatment team meetings. The facility administrator was interviewed and reported each youth's mental health, physical health, cognitive performance, age, and prior victimization were considered when assigning a youth to a living unit.

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 including notification of law enforcement. Seven youth case management records were reviewed and two were applicable for gang involvement. In the two records, the program notified local law enforcement regarding the youth's gang status. The program also provided notification to each youth's juvenile probation officer, local school district, and law enforcement in the home county. Gang alerts were entered in the Department's Juvenile Justice Information System (JJIS) for both applicable youth.

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. Seven youth case management records were reviewed. Two of the seven records were applicable for gang involvement. The two youth participated in monthly gang prevention and intervention strategies. Each youth's performance plan addressed gang interventions.

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

The program has a policy and procedures to address the completion of the Residential Assessment for Youth (RAY) and reassessments. The policy requires the completion of an initial RAY within thirty days of admission to the program and the completion of a reassessment prior to the program preparing a ninety-day summary.

Seven youth case management records were reviewed. Five records supported the RAY was completed within thirty days of admission. Two RAYs were late by twelve and nineteen days. Five of the seven youth were applicable for RAY reassessments. Four of the reassessments were completed within ninety days of the initial RAY and one was completed twelve days late. The remaining two youth were not applicable for RAY reassessments due to the youth not being in the program for ninety days. All RA assessments were completed in the Department's Juvenile Justice Information System (JJIS).

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

The program has a 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 youth case management records were reviewed and each contained a YNAS. Four of the seven were completed within thirty days of admission to the program and three were completed late. One was five days late, another was twelve days late, and the remaining was thirty days late. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has 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 youth case management records were reviewed. Performance plans were completed for each youth. Four performance plans were completed within thirty days of the youth's admission and three were completed late. One performance plan was late by five days, one was late by twelve days, and another was late by thirty days. All the performance plans were developed after the initial assessment. Each performance plan was developed by the treatment team and all relevant members participated during the development, including the youth parent/guardians. Each performance plan included goals for the youth to complete prior to release from the program. The goals were individualized and based on prioritized needs reflecting the risk and protective factors identified during the initial assessment. All goals on each performance plan contained target dates for completion, court-ordered sanctions which can be reasonably completed in the program, youth responsibilities to accomplish the goal, and the program's responsibilities to assist the youth to achieve the goals. Each performance plan included the top three criminogenic needs to be addressed. Each of the performance plans were signed by the youth, treatment team leader, and all parties who had significant responsibilities in goal completion. None of the performance plans were signed by the parent/guardians; although, the program did mail out the performance plans to all parent/guardians with a request to sign and

return the signature page. Each performance plan was sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of the plan being completed. Seven youth were interviewed and each reported they participated in the development of their performance plan, knowledgeable of their current performance plan goals, and had 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 a youth's performance plan when determined necessary by the intervention and treatment team. The policy requires revisions when new criminogenic needs are identified during the Residential Assessment for Youth (RAY) reassessments, when the youth demonstrates progress or lack of progress toward completing a goal or when new information is acquired or revealed.

Seven youth case management records were reviewed. Two records did not require a revision since the youth were in the program for a short amount of time and did not warrant a revision. The remaining five records had a performance plan revision. There had been at least one monthly review of each of the five youth due to RAY reassessments, newly acquired information, progress towards completing goals, and/or lack of progress toward goal completion.

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

The program has a 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 a 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 youth case management records were reviewed of which four were applicable for the completion of at least one performance summary and transmittal. Each of the four summaries were completed within ninety days of the performance plan. Each of the four summaries contained all the elements required within the summary including the youth's status on each goal, treatment progress, academic status, behavior, level of motivation/readiness to change, interaction with peers, interaction with staff, adjustment to the program, and positive/negative events. Each of the four summaries were signed by the applicable treatment team members

including each youth and the summaries were filed in the youth's case management record. Each of the four summaries were sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of completion. Each youth was provided a copy of the summary. Seven youth were interviewed and four were applicable for receiving a copy of their performance summary. Each of the four reported receiving a copy of their performance summary.

Three closed youth case management records were reviewed for release summaries. Each contained a copy of the original summary sent to the JPO along with the Pre-Release Notification (PRN) at least forty-five days prior to the youth's anticipated release date. Each summary contained the justification for release. The committing court did not object to any of the releases. The program provided written notification to each parent/guardian of the approval for release. The program completed a new RAY for the exit assessment in each record. The Sexually Violent Predator (SVPP) did not apply to any of the reviewed records. The Victim Notification Release letter was not applicable in any of the reviewed records. In each of the three records reviewed, the program provided the performance summary and transition plan to the JPO.

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 parent/guardians in the case management process. Seven youth case management records were reviewed. In each of the case management records, the case manager sent an admission letter to the parent/guardian and included the dates/times for treatment team meetings. Each record had documentation to indicate the parent/guardian was involved in the assessment process and participated in the development of the performance plan. A copy of the performance plan was mailed to each parent/guardian with a request to sign and return the signature page. There was documentation found the parent/guardian was called for each treatment team meeting. During the annual review, one treatment team meeting was observed. The case manager called the parent/guardian for participation but the parent/guardian did not answer the phone. The case manager left a voice mail stating the treatment team meeting was taking place and the case manager would call back to advise of the results. To reach out to parents/guardians, the program has family days. Case managers remain in contact with parent/guardians and promote involvement. Seven youth were interviewed and each reported their parent/guardians were involved in the case management process.

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

The program has a policy and procedures to address the members of the 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 youth case management records were reviewed. Each of the records documented the notification to the required participants of the treatment team and who attended. If the parent/guardian and/or JPO did not participate in the treatment team meeting, there was documentation to confirm attempts to contact the parent/guardian and JPO at the time of the treatment team meetings. All treatment team forms contained signatures from required team members.

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 procedures to address the incorporation of other plans into a youth's individualized performance plan. When a youth has a current behavior support plan or case plan through the Agency for Persons with Disabilities (APD), the program shall coordinate the youth's performance plan with the youth's APD plan for related issues. A youth's performance plan should incorporate their academic progress monitoring plan.

Seven youth case management records were reviewed. All seven records indicated the performance plan included the youth's academic performance and safety plans. All seven youth had separate mental health/substance abuse treatment plans, all of which were referenced in their performance plans. None of the seven case management records were applicable for a current case plan through the Department of Children and Families (DCF).

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

The program has a 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 Assessment for Youth (RAY) 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 monthly. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed.

Seven youth case management records were reviewed. Six documented formal treatment team reviews at least every thirty days. One record was not applicable for a formal treatment team review since the youth was new to the program and time had not passed to have a formal treatment team meeting. Treatment team documentation in the six applicable records included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, treatment progress, and RAY results. Each of the seven records had documentation of informal reviews which included the youth's name, date of

review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, and treatment progress. One record did not contain the RAY reassessment results in the informal treatment team review.

One treatment team meeting was observed during the review. All required treatment team members were present except the youth's parent/guardian. The case manager attempted telephone contact with the parent/guardian. The youth's progress on performance plan goals and treatment were discussed. The youth had one reported negative behavior which was addressed by the treatment team. There were no physical interventions during the review period. Each treatment team member spoke about the youth's progress in their respective departments.

Seven youth were interviewed and each reported to have the opportunity to demonstrate skills during treatment team meetings. Each of the seven youth reported staff review their performance to include progress on the performance plan goals, behaviors, and treatment progress.

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

The program has a policy and procedures to provide for career education. Three closed youth case management records were reviewed. The program provides a Type 3 vocational competency development program. Career education which includes the required vocational training, communication, and inter-personal and decision-making skills is provided by the educational component, as is an online course titled ServSafe Manager. The program also provides an option for some youth to participate in a program off-site to obtain vocational certifications such as Hazmat and Fork Lift operator, along with others. The facility administrator also indicated that the program provides workforce skills to the youth through CareerSource and Organization New Hope. The courses are all age appropriate and aligned with the youth's educational goals and abilities. The facility administrator and lead teacher interview also indicated the youth were obtaining vocational skills in floor maintenance, lawn restoration, Occupational Safety and Health Administration forklift safety, and SERV Safe.

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 provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of required minimum instruction distributed over 250 days. The district and site calendars were reviewed and incorporated the 250 days which included six fifty-two minute class periods a day, providing for the minimum of twenty-five hours of instruction a week. All youth are enrolled in an academic schedule and receive credit, as appropriate. An interview with the lead educator indicated the school schedule is adhered to with some deviation at times, which seems to be aligned with program staffing issues. In reviewing the logbook, there was inconsistent documentation as to when the youth were moved to and from the classrooms, there was no way to verify the youth were in school during the designated school hours. Seven interviewed youth indicated minimal interference of education instruction, with a few interruptions from "counselors".

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

The program has a policy and procedures to provide for an educational transition plan. Three closed youth case management records were reviewed and confirmed the program's instructional staff and youth completed an education transition plan upon entry which included services and interventions based on each student's assessed educational needs and post-release education plans. The following key personnel related to transition were included in the development of the plan such as the youth, parent/guardian, education representative, post-release staff, and school district personnel responsible for providing guidance services. All three youth records contained the documents essential to employment, such as a Florida identification card, a sample job application, résumé, and letters of reference provided by the program staff. All youth files included Electronic Educational Exit Plan and the Plan for Success form listing post-release appointments and contact information for appointments needing to be scheduled upon release.

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 youth case management records were reviewed. Each transition conference was conducted at least sixty days prior to the youth's release. The required participants were in attendance for each transition conference. All required participants were invited to participate by telephone or in person. If participation was not possible, the members were invited to provide written input prior to the meeting. The treatment team reviewed transition activities on all performance plans, identified transitional activities, target completion dates, and identified persons responsible for completion. In each of the three records, the treatment team leader obtained signatures of all applicable members. There was documentation in each record to reflect a community re-entry team (CRT) invite and to confirm a CRT meeting was conducted prior to the youth's release along with youth and case manager participation.

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 youth closed case management records were reviewed. The exit portfolio was discussed at transition in all three records. Each exit portfolio contained a Florida ID, transition plan, calendar with all dates/time/locations of the upcoming community appointments, educational/vocational certificates, educational records, transcripts, résumé, and sample employment application. Each of the exit portfolios were verified at the exit conference and given to the youth. The exit portfolio was forwarded to the juvenile probation officer (JPO) in each record.

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 exit conferences. Three closed youth case management records were reviewed. Each record documented an exit conference at least fourteen days prior to the release date. Each exit conference was conducted after the juvenile probation officer (JPO) was notified of the release. Each record had documentation of the exit conference date, signatures, and a summary of pending transition goals. Each record had documentation to confirm the treatment team leader, parent/guardian, education representative, therapist, JPO, youth, and other pertinent parties participated in the exit conference. Each record had documentation of the status of transition activities and finalized plans for the youth's release. The date of admission and date of release correlated with the Department's Juvenile Justice Information System (JJIS). Each exit conference was held separate from the transition conference and community re-entry team (CRT) meeting.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is licensed under Chapter 491, Florida Statutes. A review of the DMHCA's license was conducted which revealed the license is clear and active in the State of Florida and expires on March 31, 2021. The DMHCA is on-site five days a week for a total of forty hours each week and available for contact twenty-four hours a day, seven days a week. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services at the program. A copy of the DMHCA's licensure and position description were available for review while on-site.

An interview was conducted with the DMHCA, which confirmed their role at the program. The interview with the DMHCA reflected the DMHCA is aware of their responsibility to ensure all clinical services are being provided promptly and according to program policy and procedures.

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.	

In addition to the licensed designated mental health clinician authority (DMHCA) the program also employs two additional full-time licensed mental health counselor's (LMHC). Each of the LMHC's licenses are clear and active in the State of Florida and expire on March 31, 2021. The licensed mental health and substance abuse clinical staffing is in accordance with the current contract between the provider and the Department, along with Florida Administrative Code, 63N-1. A copy of each license was available for review while on-site. Each licensed professional provided services within the scope of their license, 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 written 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. As required in the program's contract, the program had five master's-level therapists during the annual compliance review period. At the time of the annual compliance review, one master's-level therapist position was vacant; however, the program had offered the position to a new master's-level therapist who was scheduled to start at the program on January 15, 2020. Non-licensed mental health and substance abuse clinical staff receive at least one hour each week of on-site face-to-face direct supervision by the licensed clinical supervisor. Twenty-six weeks were reviewed. The supervision was consistent and documentation of direct supervision was on a form similar to Department's form Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log and included all information. A review of each of the non-licensed clinical staff confirmed each holds the education and training specified in Rule 63N-1. The program is licensed under Chapter 397, to provide substance abuse treatment service, which expires on October 25, 2020. Three non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. One was hired on December 20, 2019 and is pending completion of this training. The non-licensed clinical staff's training was documented and included five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional.

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

The program has a written policy and procedures for the implementation of a standardized admission or intake mental health and substance abuse screening process. The procedures includes a standardized screening process which includes the review of commitment packet information, reports, and records; the administration of the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) on the Department's Juvenile Justice Information System (JJIS). Each screening was conducted by a "qualified professional", staff training in mental health and substance abuse issues and administration of the MAYSI-2, and a standardized process for referral of youth identified as in need of further mental health and/or substance abuse evaluation to an appropriate service provider or professional or, when immediate attention is needed, to a hospital or Baker Act or Marchman Act receiving facility.

Seven youth mental health and substance abuse records were reviewed. In all seven records, the youth were screened on the day of admission utilizing the MAYSI-2. The screenings were completed by trained case managers in JJIS and included the date and time in all seven records. Each record documented a review of all available information for each youth upon

admission to include the commitment packet, reports, and records for existing documentation of mental health or substance abuse problems. 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 according to the program's written facility operating procedures (FOPs) 3.04 – Mental Health and Substance Abuse Admission Screening. In all seven records, documentation on the ASR indicated consultation with the facility administrator (FA), the designated mental health clinician authority (DMHCA), and the staff making the referral upon admission.

An interview with the facility administrator indicated the program utilizes the Substance Abuse Subtle Screening Inventory (SASSI) and the Beck's Depression Inventory (BDI).

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

The program has a written policy and procedures related to mental health and substance abuse evaluations. Seven youth mental health records were reviewed and each youth was referred for a new mental health evaluation on the day of admission. All youth had a mental health evaluation completed by a non-licensed mental health clinical staff or licensed mental health counselor. In two of the seven charts, a non-licensed mental health clinical staff completed the evaluation which was signed within ten days by the licensed mental health counselor. All reviewed seven evaluations were completed within thirty calendar days of admission. The new evaluation included the demographic information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, and recommendations. Each evaluation also included a substance abuse assessment which included the patterns of alcohol and other drug abuse, impact of alcohol and other drug abuse on major life areas, and risk factors of continued alcohol, and other drug abuse. Each record contained a signed consent for substance abuse services.

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

The program has a written policy and procedures regarding mental health and substance abuse treatment. Seven youth mental health records were reviewed. All youth were assigned to a treatment team upon their arrival to the program. The multidisciplinary team is comprised of the youth, program administration, direct care staff, education, medical staff, and mental health staff. The same members are documented on the treatment team forms. One youth mental health records reviewed had not had a treatment team as the youth arrived on December 6, 2019 and had their treatment plan developed on January 5, 2020. In the remaining six records, documentation confirmed the treatment team is comprised of representatives from

administration, education, vocational training, medical staff, mental health staff, substance abuse staff, youth and, when possible, the youth's parent/guardian.

All seven youth mental health records reviewed had a properly executed Authority to Evaluate and Treatment (AET) form. Each record also contained a signed consent for substance abuse services. All seven youth had a documented diagnosis. Five youth were determined to need substance abuse treatment and received the services. Each youth received individual, group, and family counseling provided by a licensed qualified professional or a non-licensed substance abuse clinical staff working under the direct supervision of a qualified professional.

Mental health treatment notes or substance abuse treatment notes were documented on a provider form and included all information on Department's form Counseling/Therapy Progress Note. Group therapy is limited to ten or fewer youth for mental health treatment groups and limited to fifteen or fewer for substance abused treatment groups.

Individual psychotherapy documentation was available in each of the seven records reviewed. All seven youth mental health records contained documentation the youth were receiving psychosocial skills training designed to address specific skill deficits or maladaptive behaviors. All staff providing group are qualified to provide services.

Seven staff were interviewed and each confirmed direct care staff do not conduct mental health or substance abuse groups. All seven youth indicated they participate in group and receive therapy. An interview with the designated mental health clinician authority (DMHCA) indicated oversee the delivery of clinical services consisting of individual, family, and group therapy sessions.

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

The program has a written policy and procedures regarding treatment and discharge planning. Seven youth mental health records were reviewed and all had an initial mental health and substance abuse treatment plan completed on the date of admission. The initial mental health and substance abuse plan was documented on a provider form which includes all required elements. In two records, a non-licensed mental health clinical staff completed the initial plan and was signed within ten days by the licensed mental health counselor. The initial treatment plan was signed by other members of the treatment team in all seven cases. Each initial treatment plan had documentation indicating it was mailed to the parent/guardian. The initial treatment plan included the youth's psychiatric needs, including medication and frequency of monitoring by the psychiatrist for four applicable youth who were admitted with psychotropic medication.

An individualized treatment plan was developed for youth within thirty days of admission in all seven records reviewed on a provider form containing all elements on Department's form Individualized Mental Health/Substance Abuse Treatment Plan. The individualized treatment plans were signed by the non-licensed clinical staff completing the plan and signed by the licensed mental health counselor within ten days of completion. The plans were signed by all treatment team members who participated in development of the plan, along with the youth and parent/guardian, when available in all seven of the records reviewed. Each of the individualized treatment plans documented the ongoing prescribed services, individual, group, and/or family services, as needed. Six of the seven individualized treatment plans reviewed were applicable for the inclusion of psychiatric services to include psychotropic medication and frequency monitoring by the psychiatrist. Each of the six youth's individualized treatment plans reflected the required review and monitoring for psychiatric services.

Six records reviewed were applicable for treatment plan reviews. One youth was recently admitted and not due for a treatment plan review. Twenty-five treatment plan reviews were conducted in the six applicable records with the reviews being conducted monthly for each applicable youth. Each of the treatment plan reviews were documented on a provider form which included the information on Department's form Individualized Mental Health/Substance Abuse Treatment Plan Review.

Three closed youth records were reviewed for discharge plans. Each discharge plan was documented on Department's form Mental Health and Substance Abuse Treatment Discharge Summary. In the three records reviewed, none were applicable for a notification of suicide risk or precautions. The mental health and substance treatment discharge summaries considered the services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by youth during treatment. All three discharge plans contained documentation of the discharge plans having been discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference. A copy of the mental health and substance abuse treatment discharge summaries were provided to the youth, JPO, and parent/guardian in each of the three youth records reviewed.

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

The program provides mental health overlay services (MHOS). The program also provides substance abuse services for youth with co-occurring substance abuse disorders. The program provides individual, group, and/or family therapy seven days a week. Daily therapeutic activities include psychosocial skills training, cognitive behavior therapy, and skills streaming provided by mental health clinical staff. A review of seven youth treatment records confirmed treatment services were provided in accordance with Florida Statute (Administrative Rule 63N-1, F.A.C.) Interviews with the facility administrator and designated mental health clinician authority indicated the program provides MHOS treatment services.

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

Psychiatric services are primarily provided by a psychiatrist licensed under Chapter 458 or 459 through a cooperative working agreement with the program. Psychiatric services are also provided by a psychiatric advanced practice registered nurse (APRN) licensed under Chapter 464, meeting requirements in Rule 63N-1, F.A.C. to provide psychiatric services. The psychiatric APRN works under the protocol of the psychiatrist. A copy of the collaborative practice protocol between the psychiatrist and psychiatric APRN is maintained on-site. Both the psychiatrist and psychiatric APRN have valid and clear licenses. The psychiatrist is available for emergencies twenty-four hours a day, seven days a week. The APRN serves as the psychiatrist's backup for emergencies. A review of the sign-in and sign-out logs for the past six months confirmed visits by the psychiatrist or psychiatric APRN as required by the contract.

Seven youth treatment records were reviewed. All seven youth were referred for a psychiatric interview and received an initial diagnostic psychiatric interview within fourteen days of admission, which was completed using a provider form documented as a "Initial Diagnostic Psychiatric Interview." Each of the seven initial diagnostic psychiatric interviews included the youth's history, mental status examination, a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders, and treatment recommendations. The psychiatric interview included Page 3 of the Department's Clinical Psychotropic Progress Note (CPPN) to document prescribed psychotropic medications, explanation of the need for psychotropic medication, and frequency of medication monitoring, as applicable. Four youth were admitted with psychotropic medication which was documented in the psychiatric interview and on page 3 of the CPPN. Two youth were prescribed psychotropic medication after admission based on an evaluation by the psychiatrist. Both evaluations were documented using the Department's CPPN.

Psychotropic medication monitoring was completed at least every thirty days by the psychiatrist or psychiatric APRN for all youth on psychotropic medication, with each monitoring documented on a CPPN. The psychiatrist or psychiatric APRN brief a representative of the treatment team on the status of each youth receiving psychiatric services, their evaluation, and recommendations for the youth are incorporated into the youth's individualized mental health and substance abuse treatment plan.

An interview with the psychiatrist confirmed, the psychiatrist is aware of their responsibility to assess the youth, conduct psychiatric evaluations, and provide medication management. The psychiatrist is on-site biweekly and available by telephone.

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 which includes six hours annually to include mock drills for all staff including mental health staff, suicide precautions, levels of supervision (on-to-one, constant supervision, close supervision), referral, communication, notification, documentation, immediate staff response, and review process to include a mortality review process. The suicide prevention plan was reviewed and signed by the facility administrator (FA) and the designated mental health clinician authority (DMHCA) on December 1, 2019.

An interview with the FA indicated, the FA is aware of their responsibility to ensure mock drills and training occur on each shift quarterly. Additionally, the FA ensures drills simulate real life situations and staff members who are not present during a quarterly drill can review each drill scenario and procedures during staff meetings.

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

Pursuant to the program's written facility operating procedures (FOPs) 3.11 – Suicide Prevention Services, all youth are assessed with a Department's Suicide Risk Assessment upon admission. Seven reviewed records had a referral for Assessment of Suicide (ASR) the same date as admission to the program. The ASR was completed using the Department's form Assessment of Suicide Risk. Each ASR was completed on the day of admission. Six of the ASRs were completed by a licensed mental health counselor and the remaining ASR was completed by a trained non-licensed staff and reviewed by a licensed mental health counselor the same day. The Department's Juvenile Information System (JJIS) alerts were not applicable, as each youth was placed on standard supervision. Signatures of the facility administrator (FA) and the mental health professional including the date and time of conferral, were documented on all seven ASRs reviewed. The program did not have any youth on secure observation during the review period or since last review period.

The program has two suicide response kits with one located on each living unit sub-control. Each kit includes knife-for-life, wire cutters, and needle nose pliers. Seven staff interviews revealed each were aware of the location of the suicide kits.

The FA has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The review process includes circumstances surrounding the event, facility procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

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 written policy and procedures for documenting suicide precaution observations. The program reported three incidents of youth being on precautionary observation during the review period. Suicide precaution observation (PO) logs were maintained for each youth for the duration of their time on suicide precautions. The appropriate level of supervision and observations of the youth's behaviors were documented in real time and did not exceed thirty-minute intervals. The PO logs were reviewed and signed by each shift supervisor and mental health clinical staff. A review of completed PO logs indicated supervision, supervisory reviews, response to warnings signs, and safe housing requirements were met. Two of the three youth were still available to interview and both youth advised staff was with them at all times while on suicide precautions and they were never left alone.

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 written 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 seven staff pre-service and seven staff in-service training records found all staff completed the training.

Mock suicide drills were completed quarterly on each shift indicating at least thirty staff participated in a drill semi-annually. 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. The use of cardiopulmonary resuscitation (CPR) was utilized in all documented mock drills. The facility administrator advised staff members who are not present during a quarterly drill can review each drill scenario and procedures during all staff meetings. Seven staff interview results indicated staff participated in suicide prevention drills during the past twelve months.

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 notification and alert system, means of referral, including youth self-referral, communication, supervision (one-ton-one, constant, close, and standard supervision), documentation, and review.

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

The program has a written policy and procedures in place to ensure a crisis assessment is administered for youth demonstrating acute psychological distress. The crisis assessment is to be conducted by a licensed mental health professional (LMHP) or by a non-licensed mental health clinical staff working under direct supervision of a LMHP. The program utilizes a Crisis Assessment form which includes the elements of Department's form Crisis Assessment). According to the assistant clinical director, the program has not had any youth requiring a crisis assessment since the last annual compliance review.

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 immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397 (Marchman Act), documentation, training, and review.

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 written policy and procedures to complete Baker and Marchman Acts. The program had one Baker Act since the last annual compliance review. The youth was determined to need emergency care. The youth was observed by direct care staff member exhibiting signs and symptoms of imminent danger to self. The staff placed the youth on suicide precautions and notified mental health who contacted the designated mental health clinician authority (DMHCA) and facility administrator (FA). The youth was placed on one-to-one supervision at the time of discovery and mental health staff was involved. The youth was taken out of the facility transported by law enforcement. Upon return to the program, the youth was placed on constant supervision and a mental health referral was completed. An Assessment of Suicide Risk (ASR) which included a mental status exam was completed by a clinical staff and reviewed by a licensed mental health professional. The youth was maintained on constant supervision until properly transitioned to a lower level of supervision following an ASR, which documented mental health staff conferred with the LMHP and FA.

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 new designated health authority (DHA). The contract with the new DHA began January 1, 2020. The contract with the DHA and healthcare policy and procedures outline services to be provided by the DHA, which are in accordance with Department requirements. The new/current DHA is a medical doctor (MD) with a specialty in family medicine. The DHA has a clear and active license to practice in the State of Florida, which is effective through January 2022. The previous DHA, who is a MD with a specialty in internal medicine, also has a clear and active license effective through January 2022. Documentation showed a DHA was on-site at least once a week during the past six months. There was one instance of ten days between visits. There was one visit by another MD to ensure coverage when the DHA was on vacation. Each visit by the DHA was for at least two hours, in accordance with the contract. A review of seven medical records and interviews with nursing staff and program administration indicated there has been regular communication between the DHA and the program.

The DHA was interviewed. The DHA knew his responsibilities, and reported he performs comprehensive physical assessments (CPA), conducts periodic evaluations on the youth with chronic conditions, and develops policy and procedures. The DHA reported he is on-site once a week for two hours and as needed. The DHA stated he is available twenty-four hours a day, seven days a week and communicates with nursing and program staff by fax, phone, e-mail, and through weekly rounds. The DHA stated there is a physician who will cover for him when he is not available.

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

The designated health authority (DHA) reviewed, approved, and signed each healthcare policy and procedure on January 4, 2020. The DHA reviewed, approved, and signed all treatment protocols on January 6, 2020. The superintendent also signed the healthcare policies and procedures on January 4, 2020. All nursing staff signed a form acknowledging all healthcare policies and procedures and treatment protocols in 2019 and again in January 2020 when the new DHA reviewed and approved the policies, procedures, and protocols. There were two nurses hired since the last annual compliance review. Each newly hired nurse completed an orientation to healthcare services provided at the center upon hire. There was evidence of the psychiatrist's approval of policies and procedures related to psychiatric care and management of youth on psychotropic medication.

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

The program has a written policy and procedures to address obtaining an Authority for Evaluation and Treatment (AET) form or court order authorizing treatment. Seven youth individual healthcare records (IHCRs) were reviewed. Each IHCR contained an AET form signed by the parent/guardian. Each AET was a copy with the word "COPY" clearly stamped on each page. Each AET clearly reflected the signatures of the parent/guardian and Department staff completing the form. The AETs were included with commitment packets, and thus were in place prior to medical services being provided. The lead nurse was interviewed and was able to explain the process for obtaining an AET or court order to authorize medical treatment. In addition, the nurse was able to explain consent for youth who are eighteen years old or older.

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

The program has a written policy and procedures to address parental notification requirements. Seven youth individual healthcare records (IHCRs) were reviewed, which included over forty parental notifications. The parental notifications were completed for each youth's arrival, the initial visit and comprehensive physical assessment completed by the designated health authority, over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET) form, changes in existing medication, discontinuance of medication, emergency care, off-site care, prescription medications, initiation or changes of psychotropic medication, and monthly psychotropic medication monitoring. Nursing notes documented verbal parental notification in each record, as well as documented a witness to the verbal notification. Written parental notifications were completed in all but one case, which was a topical over-the-counter medication being applied in accordance with treatment protocols. The nurse interview showed the lead nurse was familiar with all parental notification requirements.

The vaccination status of each youth was reviewed by nursing staff on the day of admission in each of the seven records reviewed. Vaccinations were current for each youth. The nurse interview indicated the program has not had any youth requiring vaccinations and no instances of youth or parent/guardians/guardians refusing vaccinations. The nurse was able to explain the program's process for obtaining vaccinations for youth and how to address instances of youth or parent/guardians/guardians refusing vaccinations.

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

The program has a written policy and procedures to address healthcare admission screenings and rescreening's. Seven youth individual healthcare records (IHCRs) were reviewed. A Facility Entry Physical Health Screening (FEPHS) form was completed by a nurse on the date of admission in each record. In one record, two pages of the FEPHS form were not in the record. In another record, one page of the FEPHS form was missing. One youth within the original sample and two additional youth reviewed records required a rescreening due to a change in

custody. A new FEPHS form was immediately completed by a nurse upon the youth's return to the program. The lead nurse was interviewed and said all youth are seen by nursing staff immediately upon their arrival at the program, at which time the FEPHS form is completed.

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

The program has a policy and procedures in place to ensure all youth receive an orientation to healthcare services. A review of seven youth individual healthcare records (IHCRs) found each youth received an orientation to healthcare services and health education on their day of admission, which was documented on the Health Education Record, as well as a separate form to ensure all required health orientation topics were covered. The orientation and education covered all required topics, to include but not limited to, access to medical care, what constitutes an emergency, medication administration, the right to refuse care, the Prison Rape Elimination Act (PREA) and what to do case of a sexual assault or attempted sexual assault, the sick call process, and non-disciplinary role of the healthcare providers.

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

The program has a written policy and procedures to address the notification of the designated health authority (DHA) when a youth is admitted with a medical condition or requires emergency care. Seven youth individual healthcare records (IHCRs) were reviewed, which showed the program's practice is to notify the DHA and psychiatrist of all admissions, regardless of a youth's condition. The notification was completed by the nurse completing the admission process and was documented on a separate form and/or the admission note. The time of the notifications was documented in each record, showing the notifications were made within two hours of admission. None of the youth required emergency care upon admission to the program. The interview with the lead nurse confirmed this practice.

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

The program has a written policy and procedures in place addressing the completion of the Health-Related History (HRH) form upon a youth's admission. Seven youth individual healthcare records (IHCRs) were reviewed for completion of a HRH form. A new HRH form was completed by a nurse on the day of admission in all seven IHCRs. The designated health authority (DHA) documented a review of the HRH form in each record by signing each HRH form. When necessary, a nurse documented updates to the HRH forms to reflect changes or updates in a youth's medical condition, medication status, and/or alerts after admission. The nurse interview indicated a new HRH form is completed by a nurse for each youth upon admission

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

Seven youth individual healthcare records (IHCRs) were reviewed for Comprehensive Physical Assessments (CPA). The program's practice is to complete a new CPA for each youth, even if a current CPA is included in the commitment packet. A review of seven youth individual healthcare records (IHCRs) found a new CPA was completed by the designated health authority within seven days of admission in each case. Each CPA documented a tuberculosis skin test (TST) was completed within the last year. In one record, an updated tuberculosis screening was completed by nursing staff due to a TST being completed a year ago. All sections of the CPA were completed or noted sections of the examination were refused by youth. For the sections of the exam youth refused, the youth signed the CPA next to the sections refused. Updates to CPAs and the Department Problem Lists were documented when a youth's medical grade changed. The nurse interview reflected she was familiar with the process for the completion of CPAs, to include annual updates for CPAs and tuberculosis screenings

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

The program has a policy and procedures addressing screening and testing for sexually transmitted infections (STI). Policy and procedures also address human immunodeficiency virus (HIV) testing and services, which are provided at the program by a HIV certified nurse. The HIV certification for the nurse who provides HIV testing and services was current.

Seven youth individual healthcare records (IHCRs) were reviewed for STI and HIV screening. Five of the seven IHCRs documented a STI Screening Form was completed by a nurse upon admission. In the remaining two records, a STI Screening Form was not present in the record, but each youth was tested for STIs based on an order by the designated health authority (DHA). Each STI Screening Form completed was reviewed by the DHA and each youth was tested. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and in the lab section.

All seven IHCRs in the initial sample reviewed and an additional record reviewed found each youth was offered HIV testing during the medical intake process, with each youth indicating whether he consented to HIV testing. Three youth consented to testing. Testing was conducted for the three youth who consented. Pre-test and post-test counseling by an HIV certified nurse was documented for each youth receiving HIV testing. HIV test results were properly filed in sealed envelopes marked "confidential" within the three applicable youth IHCRs.

The nurse interview indicated all youth are screened for STIs and offered HIV testing and services upon admission. The nurse stated youth are rescreened if they out of Department custody and returned to the program. Seven youth were interviewed. All seven-youth reported they could ask for a HIV test.

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

Sick call is scheduled two times a day, seven days a week, in accordance with the program's contract. Sick call is conducted by registered nurses (RN). Sick Call Request Forms are available in the multi-purpose rooms on either side of the facility, which is where youth eat meals. Youth may also request a Sick Call Request Form at any time. Youth complete a Sick Call Request Form when they feel they need to be seen for a medical concern. Policy and procedures require sick call requests to be reviewed by supervisors if the requests are made more than four hours before a scheduled sick call. Supervisors will contact the on-call nurse if there are any concerns, which was documented.

Seven sick calls were reviewed. Each sick call was completed by a registered nurse (RN) and documented in accordance with Department requirements, with care documented on the Sick Call Request Form. Youth initialed or signed the forms to acknowledge they received sick call care. Youth were seen by nursing within twenty-four hours of their request. Completed Sick Call Request Forms were filed in the progress notes in reverse chronological order. All sick calls were documented on individual youth Sick Call Indexes and the Sick Call Log. No youth presented with a similar complaint three times in a two-week period, though youth were referred to the designated health authority (DHA) by nursing staff for follow-up, if needed. No youth complained of pain which staff were not familiar. Documentation showed youth in controlled observation were visited daily by nursing staff and offered sick call care.

Sick call is conducted in a room in the back of the clinic. The room has an exam table and there is a door to the room which can be closed to ensure privacy. A sick call for one youth was observed with the youth's consent. The sick call was conducted by a nurse and DHA. The youth received a full examination for his issue and privacy was ensured. The youth signed the sick call request form upon completion of the exam and care.

The lead nurse was interviewed and able to fully explain the sick call process, identifying when sick call is provided, who provides sick call, and when youth are referred to the DHA. Seven staff were interviewed. Six of the seven staff reported nursing staff review and conduct sick call. The remaining staff said he/she was not sure but thought that the supervisor conducted sick call. Seven youth were interviewed. All seven youth said nursing staff respond within one day of a sick call request. Six youth reported they could see a doctor, if needed, and five youth reported they could see a dentist if having tooth pain.

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

The program has a written policy and procedures for emergency care, which include all staff being able to call 9-1-1, staff training/certification, and emergency drills. Seven staff were interviewed. Six of seven staff reported they were personally allowed to call 9-1-1 if a youth has a medical emergency. The remaining staff said he/she was not sure if he/she could call 9-1-1,

but he/she would notify the nurse and supervisor. Fourteen staff training records were reviewed. All staff received pre-service training on their right and responsibility to contact 9-1-1 if a youth's condition appears compromised. All fourteen staff held current certifications for first aid, cardiopulmonary resuscitation (CPR), and use of an automated external defibrillators (AED). Nursing staff also held current first aid, CPR, and AED certifications. Training documentation also showed direct care staff, to include all supervisory level staff, received training on medication administration, which included use of an epinephrine auto injector. The list of direct care staff trained in medication administration is posted in the clinic.

The center has one AED, which is located in the clinic. The battery and pads for the AED were within expiration dates, with the expiration date for the battery being May 2020 and the expiration date for the pads being February 2020. The program had another set of pads with an expiration date of March 2021. A nurse tested each AED in front of a member of the annual compliance review team, demonstrating the AED was ready for use. Documentation indicated the AED was checked weekly by nursing staff.

The designated health Authority (DHA) has approved first aid kit contents. The center has first aid kits in each sub-control and kitchen. There are also first aid kits for each vehicle, which are kept in master control. Documentation indicated first aid kits were checked monthly by nursing staff to ensure all required contents were present and within expiration dates. The expiration dates for all items in the kits are documented, as applicable. The first aid kits are secured with breakaway ties, so it is known when first aid kits are opened, and supplies are used. A "Report of On-Site Health Care by Non-Health Care Staff" form is with each first aid kit for staff to document care when items from a first aid kit are used. Supplies are to be restocked whenever items are used or when they expire. Five first aid kits were observed, finding all were fully stocked with items approved by the DHA.

The program has a written policy and procedures addressing first aid and episodic care. Twenty-two instances of on-site episodic care were reviewed, which included three instances of episodic care provided by direct care staff. Each instance of care provided by direct care (non-licensed) staff was documented on the Department's Report of On-Site Health Care by Non-Health Care Staff form and included all required information. All instances of episodic care provided by nursing staff were appropriately documented in the SOAP (Subjective, Objective, Assessment, and Plan) format. Follow-up care or an assessment was completed the following day by nursing staff for all instances of episodic care. An episodic care log is maintained and reflected all instances of episodic care, to include follow-up care.

Documentation of emergency medical drills indicated drills were conducted on both shifts (the program has two twelve-hour shifts) at least quarterly. The first shift had drills requiring staff to demonstrate cardiopulmonary resuscitation (CPR) in three of the four quarters (required annually) since the last annual compliance review and the second shift has had a drill including CPR each quarter. All emergency medical drills were properly documented, indicating which staff participated. A review of the staff roster and drill documentation showed more than half the staff participated in mock emergency drills, with the only staff not having participated in the drills being recently hired staff. Emergency drills are reviewed with staff during all-staff meetings. Emergency phone numbers are posted in master control, each sub-control, and the clinic. The emergency numbers are not accessible to youth.

The lead nurse was able to explain all processes related to episodic and emergency care, to include the locations and monitoring for first aid kits and the AED, availability of emergency

numbers, completion of medical drills, off-site emergency care, documentation of care, and follow-up.

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

The program has a written policy and procedures to address off-site medical care. Six instances of off-site care were reviewed. An Off-Site Summary of Care form was utilized in each case. Discharge paperwork was returned with the youth or later obtained by nursing staff in each case. Verbal and written parental notifications were documented in each case. The Off-Site Summary of Care forms and discharge paperwork or instructions were reviewed and signed by designated health authority (DHA) in each case. Follow-up care was scheduled and provided, as needed. Nursing staff tracked off-site follow-up appointments.

The DHA was interviewed regarding off-site care. The DHA stated all paperwork needed for review is provided to him in a folder in the medical department. The DHA stated he reviews reports, care findings, and/or instructions for the off-site care provided. The interview with the lead nurse indicated documentation of off-site care is brought to nursing staff upon a youth's return from off-site care or later obtained by nursing staff if discharge paperwork or instructions are not returned with the youth. The nurse also indicated any follow-up care is scheduled, as needed, and nursing staff ensure off-site care documentation is provided to the DHA.

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

The program has written policies and procedures for the delivery of treatment to youth identified as having a chronic medical condition and/or taking medication(s) on an ongoing basis. The initial seven records reviewed included one youth with a chronic condition and six youth taking psychotropic medication on an ongoing basis. An additional two records were pulled for youth with chronic conditions. Each youth was classified with a Medical Grade two through five and the Department's Problem Lists were accurate, being updated as needed. The three youth with chronic conditions were documented on the chronic conditions list and each had a specialized treatment plan for their chronic condition(s). The designated health authority (DHA) conducted periodic evaluations within every three months for each youth with chronic conditions. The six youth on psychotropic medication were monitored by the psychiatrist. Two youth were prescribed psychotropic medication after admission and another had changes to his psychotropic medication after admission. Each youth was evaluated by the psychiatrist prior to starting or changing medication. The psychiatrist performed periodic evaluations of youth on psychotropic medication at least every thirty days. There were no indications of lapses in care or missed periodic evaluations.

The DHA was interviewed and reported he reviews youth with chronic conditions at least every three months and more frequently if the youth experiences problems with his chronic condition. The DHA stated nursing staff maintains a list of youth with chronic conditions and when they are due for periodic evaluations. The nurse reported youth with chronic conditions are monitored at

least every three months and that nursing staff utilize a medical tracker to ensure evaluations are completed.

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

The program has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. Seven youth individual healthcare records (IHCR) were reviewed. All seven youth were prescribed medication(s) at some point during their stay. A current, valid order by the designated health authority (DHA) or psychiatrist was present for each medication prescribed, to include over-the-counter (OTC) medications. There were no standing orders, emergency orders, or pro re nata (PRN) orders for psychotropic medications and program policy and procedures prohibits such orders.

Four youth were taking prescription medication prior to their admission. All four youth were transported to the program from a Department detention center and their medication was received from a Department staff. Nursing staff documented receipt and verification of the medication in the admission progress note. The DHA and psychiatrist were notified of each youth's admission and their medication. Orders to continue the medication(s) by the DHA or psychiatrist were documented in three records. In the remaining record, the psychiatrist ordered the medication be held until he could evaluate the youth. The psychiatrist evaluated the youth, discontinued the medication the youth had at admission, and ordered a new medication with parental consent.

The program uses the Department's Medication Administration Record (MAR). Each MAR included demographic information of youth, medication side effects, youth allergies, and medication start and stop dates. Nursing staff administer all prescription medication. Direct care supervisors have been trained to administer medication, but only administer medication if nursing staff are not on-site. Each administration of medication was documented by nursing staff initials or, if administered by trained direct care supervisory staff, the youth and direct care supervisor's initials. Refusals of medication were properly documented on the MAR and a Refusal of Care Form. In six records, there were no lapses or errors in medication administration. In the remaining record, the MARs indicated the youth received his medication, as prescribed, with one exception; there was one day for which there was no documentation of the youth receiving or refusing a medication. Documentation showed youth in restricted housing are visited by nursing staff or brought to the clinic to ensure they receive their medication as prescribed. Nursing staff documented weekly side effect monitoring for each medication.

A medication pass was observed during the annual compliance review, with the consent of each youth receiving medication. The nurse followed the six rights of medication administration (right youth, right medication, right dose, right route, right time, and right documentation). Youth approached the medication cart one at a time. Only the nurse had access to medications and youth were supervised by direct care staff. Youth would state their name and date of birth for identification, as well as state what medication they were taking, what the medication was for, and if they had experienced any side effects. For oral medication, the nurse verified youth consumed the medication by checking their mouths.

Seven youth were interviewed, of which six reported they take medication. All youth who said they took medication reported nursing staff administers medication and all were able to describe the medication process. Seven staff were interviewed. All seven staff stated nurses provide medication to youth. Two staff said supervisors also provide medication to youth.

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

The program has a written policy and procedures for storage and inventory of medications and sharps, and the disposal of medications. The program has a Modified Class II B Pharmacy Permit, which is effective through February 2021. Monthly consultant pharmacy visits and reviews were documented. The consultant pharmacist conducted a visit/review during the annual compliance review, observing medication storage, reviewing medication administration records, and interviewing nursing staff. The facility administrator reported to the clinic during the visit.

All medications and sharps are securely stored in the clinic and storage areas are not accessible to youth. Medications are stored in a secured medication cart, secured cabinets, or in a secured refrigerator in the medical clinic. Actively used medications and sharps are stored in the medication cart and stock medications and sharps are stored in the secured cabinets. Medication storage was organized, with medications stored separately by type (e.g., injectable, topical, drops, liquids) and by youth. There is a lockbox within the secured medication cart for controlled medications, resulting in controlled medication being stored behind two locks.

The program did not have any youth on controlled medications at the time of the annual compliance review. Nursing staff reported only one youth during the annual compliance review period was on controlled medication. This youth was released, and his records appropriately transferred, thus there were no controlled medication inventories to review. Monthly consultant pharmacist visits for when this youth was in the program documented the controlled medication was properly stored and inventoried.

Inventories for the past six months were reviewed, showing perpetual and weekly inventories were completed for all over-the-counter medications and sharps. A random inventory of three different sharps, two prescribed medications, and three over-the-counter (OTC) medications was conducted with nursing staff. The inventories for the medications and two of the sharps were accurate. The inventory for one sharp was off by one. Nursing staff followed procedures for inventory discrepancies, reviewed the inventory, and found an entry/calculation error on the most recent perpetual inventory completed earlier in the week. The error was corrected, and the inventory made accurate.

Medication disposal is completed by the consultant pharmacist with nursing staff present. Disposal of discontinued and expired medications was properly documented, with the consultant pharmacist and a nurse signing the form documenting disposal. In addition, observation of the consultant pharmacist's visit found he was aware of expiration dates for medications.

The lead nurse interview detailed the program's medication storage, medication inventories, and procedures for disposal. The nurse also detailed the program's collaboration with the consultant pharmacist.

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

The program has a written policy ensuring all staff and youth receive education on infection control. The program's Exposure Control Plan included all required elements outlined in the Department's standards, to include a comprehensive process for needle stick post-exposure evaluation and the requirement to maintain a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The Exposure Control Plan was reviewed and signed by the facility administrator and designated health authority (DHA). The program has not had any incidents of exposure requiring notification of the health department or Central Communications Center (CCC). Program staff are offered the Hepatitis B immunization upon hire, and sign a form acknowledging the availability of the immunization and whether the consent to the immunization.

A review of seven youth individual healthcare records (IHCR) found each youth received infection control education from nursing staff on their date of admission. The education included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. The education was documented on the Health Education Record and a separate form completed during the admission process. All infection control education was provided in accordance with the Center for Disease Control and Prevention guidelines. A review of fourteen staff training records confirmed staff received pre-service and in-service training on infection control.

The nurse reported youth receive infection control education upon admission and monthly thereafter. The nurse interview also indicated nursing staff provide infection control training to staff and that the exposure control plan is available to staff. The program director interview indicated the exposure control plan was available to staff in both sub controls, the clinic, and administration.

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures to provide for the active supervision of youth. A review of the logbook indicated the program follows the posted schedule. Staff were observed properly positioned and engaged in positive conversations with youth providing respectful feedback and redirection as needed. Staff were asked the number of youth for which they were responsible; each staff responded with the accurate number of youth. The staff were able to explain the procedures if they cannot reconcile the count. The day time staff-to-youth ratio requirements of one-to-eight and sleeping ratio of one-to-twelve were observed and maintained.

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

The program has a policy and procedures for a behavior management system. The system is explained to youth during the intake process. The behavior management system (BMS) is also documented in the resident handbook provided to each youth at admission. An overview of the BMS is included in the youth's orientation documentation. The BMS includes a variety of rewards/incentives to encourage youth. Written policy and procedures outline process to ensure a four-to-one ratio of rewards outnumber negative consequences. The BMS is posted in the dining room and on each mod.

Each of the seven interviewed staff indicated an understanding of the behavior management system. Fourteen of fourteen staff training records reflected staff received behavior management system training. The facility administrator interview indicated they use positive peer culture, positive reinforcement, and social modeling for the behavior management system, which is monitored through the executive team and treatment team. Four of the seven interviewed youth rating the BMS as fair to good, two rated the BMS as poor, and one youth rated the BMS as very good.

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

The program has a behavior management system policy and procedures, which includes monitoring implementation of the behavior management system. Informal interviews with staff indicated a clear understanding of the program's behavior management system. Room restriction is not utilized by the program. The program's behavior management system does not allow youth to be locked in rooms, youth to discipline other youth, or group punishment. Seven of seven staff interviews indicated they talk to youth about consequences and alternative acceptable behaviors. All seven interviewed staff indicated they receive feedback on their use of behavior management system from management. Each of the seven interviewed youth indicated the youth understand the behavior management system. The facility administrator interview indicated the management team, along with the treatment team and shift supervisors, provide support for the direct care staff and performance evaluations are used to monitor and provide feedback on their implementation of behavior management system.

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

The program has a policy and procedures for completing ten-minute checks. Ten-minute checks are documented on a head count sheet. Documentation includes time of each check and staff initials. Six of seven interviewed staff indicated room checks are conducted every ten-minutes and one staff indicated room checks are conducted every seven minutes.

Observations and video review of ten-minute checks on various days, times, and shifts confirmed staff typically checked youth rooms at least every ten minutes and checks were documented in real time, though there were exceptions. Ten-minute checks were not completed and documented in real time. The checks were either completed prior to or later than the ten-minute interval, or not completed at all. On January 7, 2020, during the facility tour on C-Dorm, staff documented a ten-minute check for 9:45 a.m., prior to check being completed. Video review for December 21, 2019 from 1:00 a.m. to 2:00 a.m. on F-Dorm indicated staff did not document checks after checking the rooms and length between two of the checks, from 1:11 a.m. to 1:28 a.m., was greater than ten minutes. On December 31, 2019 from 5:30 a.m. to 6:30 a.m. on A-Dorm, video confirmed the time between two checks being from 6:00 a.m. to 6:37 a.m. Video on December 21, 2019 on F-Dorm indicated staff did not check rooms two and three during the 1:11 a.m. check, and the head count sheet documentation for the night indicated

youth were assigned to rooms two and three. Video review for January 4, 2020 from 6:00 a.m. to 7:00 a.m. for C-Dorm indicated there were no checks conducted from 6:10 a.m. to 6:31 a.m. On January 7, 2020 from 9:00 a.m. to 10:17 a.m. on C-dorm, video confirmed checks were completed at 9:12 a.m., 9:44 a.m., and 10:14 a.m.

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

The program has a policy and procedures for youth census, counts, and tracking. A review of the facility logbook indicated headcounts are done at the beginning of each shift, after outside activities, and after disturbances. The facility logbook includes youth movements and daily census. The facility logbook also indicated new admissions, releases, transfers, and youth off-site. Youth census tracking is accomplished through the facility logbook and census sheet. Observations of youth counts show staff followed procedures in verifying an accurate count. Seven of seven interviewed staff indicated emergency counts are conducted when there is a discrepancy with the count.

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

Facility logbooks are bound with numbered pages. Entries are legible, include the date and time of the entry, names of staff and youth involved, and a brief description of the event. The name of the staff making the entry was not always included. Multiple mistakes were written over instead of being crossed through with a single line and initialed. A review of the logbook found all Central Communications Center (CCC) incidents were documented. Daily events were documented with few exceptions; two instances of controlled observation were not found in the logbook. In reviewing the logbooks to determine educational access, it was determined the logbooks did not include the youth movements in the narrative, as there is a separate section for movement but that information was not documented consistently. Shift reports are reviewed with the oncoming shift and staff sign and date the shift report and/or logbook to indicate review of the information from the previous shift. A review of shift reports from October to December 2019 found some reports were missing.

. 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 on key control. The policy addresses missing or lost keys and reporting and replacement of damaged keys. Distribution of program keys to staff was observed. Keys issued to staff were documented on key log. Interviews with master control and supervisory personnel indicated restricted keys are kept in a separate locked area and not issued to direct care staff. The program's keys are kept in locked box when not in use. A random review of issued key inventory matched the actual key rings in use. Master control staff were able to describe process for daily tracking and reconciliation of keys. Personal keys were not discovered during random check of staff. Seven of seven staff interviewed were able to explain key control process.

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

The program has a policy and procedures for the prevention of illegal contraband and prohibited items into the program. The program has a list of items identified as contraband and the consequences if youth are found with contraband. Contraband searches are conducted weekly and documented on contraband search forms. When contraband items are found, the program confiscates the items and dispose of them in accordance with program policy. The facility administrator's written interview indicated contraband can be either discarded, returned to the parent/guardian, or turned over law enforcement. A review of the facility logs indicated the frequency, type, and result of searches.

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

The program has a policy and procedures for body searches. Observations of searches of youth before and after movements indicated staff were thorough and provided instruction to youth politely. Searches were conducted by staff who were the same gender as the youth. An electronic hand-held metal detector is used to search visitors. Full body visual searches were not observed during this annual compliance review. Seven staff interviews indicated searches are completed by a staff the same gender as the youth through their clothing after any movement. Full body visual searches are done by two staff for new admissions or youth returning form off-site activity. Seven of seven youth interviews indicated searches are done regularly throughout the day, during admission or after returning from off-campus activity.

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

The program has a policy and procedures for the maintenance of vehicles used to transport youth. The program has two vehicles used for youth transport. Each vehicle had a seat belt cutter, window punch, fire extinguisher, and first aid kit. Both fire extinguishers were observed to be fully charged; however, the fire extinguisher in one van had not been checked since October 16, 2018, and the fire extinguisher in the second transport van did not have a fire inspection card. The maintenance records indicated vehicles were inspected regularly. Informal interviews with staff indicated all vehicle occupants wear seatbelts all the time. A random check of personal vehicles in the parking lot found all vehicles were locked. The annual safety inspection reports from an automotive shop for the two vans were reviewed and determined to be safe for transporting youth..

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

The program has a policy and procedures for transporting youth. Four of seven program staff interviews indicated personal cellular phones are used for communication during youth transports. Seven of seven staff interviews indicated personal vehicles are not used to transport youth. A review of the transportation logbook found at least two staff are used during transporting youth. All staff transporting youth had a current driver's license. An inspection of the program's vehicles found the rear doors could not be opened from the inside. An informal interview with staff confirmed youth are not permitted to drive, and staff do not leave youth unsupervised in a vehicle.

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

The program has a policy and procedures for weekly safety and security audits. The procedures outline the inspection process and identify who is responsible for completing weekly security audits and corrective action, when needed. Safety and security audits were completed and documented weekly. An interview with the facility administrator indicated daily checks are made by supervisors, program manager, and chief of security. All deficiencies are tracked, logged, and discussed at the morning meetings with the management team.

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

The program has a policy and procedures for tool inventory and management. The program uses shadow boards and inventory sheets to identify and keep track of tools. Tools are kept in locked spaces when not in use. A review of the tool inventory found all irregular used tools were listed with two exceptions, which were a hammer and electric screw driver. Regularly used tools are inventoried prior to each day's work and after being returned with the following exception of one broom was not listed on the inventory. Tools not used regularly are secured and inventoried monthly. Seven of seven staff interviews indicated youth can only use scrub brushes, mops, and brooms.

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 using tools. A review of the tool binder found all youth using tools had a youth risk assessment completed and were cleared for using tools. The tool binder also indicated 1:5 staff-to-youth ratios were maintained when youth were allowed to use tools. Seven of seven youth interviews indicated the youth use brooms and mops.

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 to address outside contractors on-site. All contractors are made aware of the program's policies regarding tools, contractor's conduct, confidentiality, youth interaction, restriction of personal cellular phones, and procedures concerning missing tools. A review of contractor visit documentation indicated tools were inventoried and contractors were informed of procedures. Reviewed work invoices coincided with dates contractors were on-site.

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

The program has a policy and procedures for conducting fire, safety, and evacuation drills. A review of drill documentation indicated the program conducts drills as outlined on the program's drill calendar. Observations during a tour of the facility found fire evacuation routes and egress plans posted throughout the facility. All fire extinguishers in the facility were inspected annually as required. An interview with the facility administrator indicated monthly escape, fire, and evacuation drills are conducted. The documentation for all drills contained the type of drill, date, time, participants, brief scenario and findings, and recommendations. Six of seven youth interviews indicated monthly fire drills. Seven of seven interviewed staff indicated participation in the following types of drills: weather, major disturbance, bomb threat, chemical spills, flooding, terrorism, and escape.

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

The program has a policy and procedures for disaster and continuity of operations planning. The program's Continuity of Operations Plan (COOP) was signed by the facility administrator on May 2, 2019 and by a Department representative on May 16, 2019. An interview with facility administrator indicated the COOP is located in master control and in administration, allowing staff access to the plan. The program maintains portable files with critical identifying youth information to be utilized by staff in an emergency.

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

The program has a policy and procedures for storing and inventorying of flammable, poisonous, and toxic items. The program's flammable, poisonous, and toxic materials are kept in a locked area where youth do not have access. Maintenance staff and supervisory staff have access to these secure areas. A review of the flammable, poisonous, and toxic items matched the documented inventory with one exception, which was the paint inventory had on five-gallon container of a certain paint and two five-gallon containers were observed. There were safety data sheets for all flammable, poisonous, and toxic items.

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

The program has a policy and procedures for control of flammable, poisonous, and toxic items and materials. Observations of routine cleaning activities revealed staff control access to cleaning supplies and do not allow youth handle flammable, poisonous, and toxic items. Six of seven youth interviews indicated youth are not permitted to handle hazardous cleaning items. A review of the program's preventative maintenance checklist included maintenance schedule and repairs were completed as outlined in the contract.

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

The program has a policy and procedures for the disposal of flammable, toxic, caustic, and poisonous items in accordance with Occupational Safety and Health Administration (OSHA) standards and safety data sheets. The maintenance staff was interviewed and stated flammable, toxic, caustic, and poisonous items and materials are disposed. The most common items disposed of are empty paint cans, which are left open to air dry then disposed of in the trash. The facility administrator interview indicated the program disposes of flammable, toxic, caustic, and poisonous items by following the safety data sheet. Kitchen grease is disposed of in the kitchen grease trap located at exterior of the facility, which is serviced quarterly.

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

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

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

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

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

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

The program has a policy and procedures indicating it does not participate in any water-related activities; therefore, this indicator rates as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures addressing visitation, mail, and correspondence. A review of visitation, telephone, and youth correspondence logs show youth can communicate with people on their approved list. Case management staff explained the process for inspection of youth mail and indicated youth are not present when incoming mail from family is opened. The visitation schedule is posted. If an approved visitor needs to arrange a different visitation time, the program staff coordinate a date and time outside of normal visitation. Seven of seven youth interviews indicated the youth have communicated with family through mail, telephone, and/or during visitation.

5.23 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 addressing youth and room searches prior to placing a youth in a controlled observation room. Eight instances of controlled observation were documented in the past six months. All eight controlled observation reports included documentation indicating the youth and room were searched prior to placing the youth in controlled observation. All eight records indicated staff of the same gender searched the youth before the youth was left alone in the controlled observation room. All reports indicated the date and time of placement, as well as the date and time of release.

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

The program has a policy and procedures addressing controlled observation placement authorization, reason for placement, health status checks, and placement exceeding two hours. Eight controlled observation reports were reviewed. All youth met the required criteria for placement in controlled observation. Authorization for placement in controlled observation was made by the facility administrator or designee in all eight cases. Documentation in all eight reports indicated youth were made aware of the reason for their placement in controlled observation. A health status checklist was completed by healthcare staff or a staff of the same sex of the youth in all eight cases. All eight reviewed reports indicated the youth were released from controlled observation in two hours or less. Five of seven interviewed youth reported they have never been sent to their room for punishment reasons. Two youth reported they were sent to their room for punishment reasons.

5.25 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.	

The program has a policy and procedures addressing monitoring of youth behavior, releasing youth from controlled observation, placing youth on alert after release if necessary, and controlled observation report review by the program director. The program had eight controlled observation reports during the annual compliance review period. All eight controlled observation reports included safety check forms, which documented youth behavior every fifteen minutes. Eight of eight controlled observation reports included authorization for release and determination whether the youth needed to be placed on alert status. All reports were reviewed by the facility administrator within fourteen days.

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

The program has a policy and procedures addressing youth behavior, warning signs, safety plan development, and staff responsibilities. The program updated safety plan content in November 2019 to include additional information along with warning signs, youth baseline behaviors, crisis recognition, coping and intervention strategies, youth preferences, and staff signatures.

Seven youth safety plans for the past six months were reviewed. Initial safety plans were developed for each youth within fourteen days of admission. Safety plans reviewed were updated monthly and available to staff on living units. Recent updates included positive and negative effects of stimuli, warning signs, baseline behaviors, crisis recognition, coping and intervention strategies, youth preferences, and staff signatures. Five of seven youth interviews indicated they were involved in the development of their safety plans when they arrived. Six of seven staff interviews indicated staff are aware of the process for reviewing youth safety plans.