STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Tampa Residential Facility

TrueCore Behavioral Solutions, LLC.
(Contract Provider)
9508 East Columbus Drive
Tampa, Florida 33619

Review Date(s): September 8-11, 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:

Paul Sheffer, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Kara Brown, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Johnnie Downing, Sequel Youth Services, Executive Director (Standard 5)
Melissa Johnson, Office of Accountability and Program Support, Regional Monitoring Supervisor, Central Region (Standard 4)
Ken Myers, Office of Education, North West Region Education Coordinator (Standard 2)
Greg Mahoum-Nassar, Office of Accountability and Program Support, Regional Monitor (Standard 1)
Amanda Nelson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Stephanie Shay, Office of Accountability and Program Support, Deputy Supervisor, Central Region (Standard 3)
Jonathan Thompson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Ron Warrick, Office of Education, South West Region Education Coordinator (Standard 2)

Program Name: Tampa Residential Facility
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): September 8-11, 2020

MQI Program Code: 1281
Contract Number: 10098
Number of Beds: 60
Lead Reviewer Code: 118

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
2.04 Classification Factors, Procedures, and Reassessment for Activities	3.09 Psychiatric Services *
2.18 Education Transitions Plan	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	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 *	Failed
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	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

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Program Overview

Tampa Residential Facility is a sixty-bed program, for fourteen to eighteen year old males, located in Tampa, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides the following services: comprehensive mental health services and Substance Abuse Overlay Services (SAOS). In addition, the program fosters each youth by providing The Boys Council, Young Men's Work, Anger Management for Substance Abuse and Mental Health Clients, Living in Balance, Pathways to Self-Discovery and Change, Adolescents Coping with Depression, Coping with Stress, Teen Relationships, Strategies for Anger Management, The Passport Program, Thinking for a Change, and Impact of Crime. Additional treatment services provided include group, individual and family counseling, and recreational therapy. Program administration is comprised of a facility administrator, two assistant facility administrators, an administrative assistant, and human resources. Case management services are provided by a director of case management, four case managers, and a transitional services manager. Mental health staff at the program includes the director of clinical services, two assistant directors of clinical services, four licensed therapists, four non-licensed therapists, a recreation therapist, a certified behavior analyst, and a file clerk. Medical services are offered twenty-four hours a day and are provided by the health services administrator and four and one half nursing positions. Educational services are provided by the Hillsborough County School Board. The layout of the program includes: an administrative building, a kitchen with an attached cafeteria with classrooms located across a breezeway, education portables, and three youth living unit/dormitory buildings. The program has an outdoor basketball court covered by a large pavilion. The program has 120 operating security cameras providing coverage, all of which were functioning during the annual compliance review. At the time of the annual compliance review, the program had twenty-two vacant positions; twenty youth care worker I positions, one certified behavior analyst, and one licensed therapist.

Standard 1: Management Accountability

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

The program maintains a policy and procedures ensuring initial background screenings are conducted on all newly hired staff and volunteers. The program had fourteen newly hired staff since the last annual compliance review. There were nine volunteers and/or mentors applicable for an initial background screening. Reviewed documentation supported the fourteen newly hired staff, and nine volunteers and/or mentors received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to each individual's date of hire and/or contact with youth or access to confidential information. None of the newly hired staff required an exemption. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification System (SVS) module, and the Department's Central Communications Center (CCC) Person Involvement Report was reviewed. Each newly hired staff, and volunteer was added to the Clearinghouse roster, and none were applicable for breaks in service. Each direct care staff is required to complete a pre-employment assessment and receive a passing score. The program had seven direct care staff who required a pre-employment assessment since the last annual compliance review. Reviewed documentation found a pre-employment assessment was completed by the seven newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on December 3, 2019. The school board's annual screening, was submitted to the Department's BSU on December 4, 2019, meeting the annual requirement.

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

The program maintains a policy and procedures outlining the background rescreening process for staff every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resource manager to determine

when a five-year rescreening is required. Five-year rescreening's shall not be completed more than twelve months prior to the staff's anniversary date and at least ten business days prior to the anniversary date. A review of the program's staff roster indicated four staff and one volunteer were applicable for a five-year background screening. Reviewed documentation found the rescreenings for the four staff and volunteer were completed and submitted to the Department's BSU prior to their anniversary date. Each of their rescreenings determined they still met eligibility requirements.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.* • *The program shall complete or schedule a TRACE self-assessment.*	

The program maintains a policy and procedures for abuse reporting and for providing an abuse-free environment. The policy stipulates youth and staff are to have unhindered access to report alleged abuse to the Florida Abuse Hotline without intimidation or reprisal. Observations during the facility tour revealed postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers throughout the program. The program's policy outlines the reporting procedures for all staff to follow when a youth would like to report abuse. The procedures for program staff indicate youth will be provided with timely access to report allegations of abuse without intimidation or reprisal. If the youth requests telephone access during a structured activity, they are to provide access as soon as the activity concludes. Staff are never to prevent a youth from self-reporting or making a call to the Florida Abuse Hotline. Staff are to notify the shift manager or master control to let them know a youth is going to access the Florida Abuse Hotline or the CCC, as appropriate. The youth is allowed to freely communicate with the Florida Abuse Hotline or CCC operator. Once the call has been completed, staff are to notify the shift manager or master control to indicate the youth has completed their call. Any youth's refusal to make the abuse call themselves does not relieve the staff from their mandate to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred. The program completed a Trauma Responsive and Caring Environment (TRACE) Self-Assessment in February 2020. The results of this, coupled with survey

information, were reviewed with all staff at a monthly staff meeting. Upon hire, all staff acknowledge their receipt and understanding of the code of conduct in the provider's electronic personnel system. A resident handbook is provided to each youth upon admission. The handbook includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC telephone numbers. A review of documentation for the annual review period was conducted for allegations of suspected abuse to the Florida Abuse Hotline or CCC; six reports alleging abuse were found. Documentation review found one had substantiated findings, with the substantiation being made by the provider for improper conduct. The employee was terminated for their actions. Staff were terminated and/or suspended in the other five which are pending investigations. Two were assigned to the inspector general, two were assigned for a management review, and one was assigned as a program review.

An interview was conducted with the facility administrator (FA) to determine the program's code of conduct. The policy was shared, and it includes specific standards of conduct which staff must follow. Abuse of youth will not be tolerated. The FA indicated failure to follow the standards of conduct may result in disciplinary action from an oral warning to termination of employment. The severity of the penalty depends on the frequency and nature of a particular offense. These actions will be taken when physical abuse, threats, or profanity are used towards youth. He shared the program's trauma responsive environment policy. This policy, and reviewed documentation, reflected the program begins looking into each youth's individual traumas during the intake process. Assessments are conducted and the findings are used during the classification process. The program uses the gathered information to assist each youth in developing their individual safety plan. These are used by the treatment team to ensure therapeutic value, practicality, and accessibility. The plans are reviewed, at a minimum, during each formal treatment team meeting. Additionally, they were able to share the completion of the TRACE Self-Assessments. This tool is completed annually to determine where improvements can be made and to assist with future action planning. He confirmed the program's incident reporting process matches the program policy and procedures.

Interviews were conducted with seven staff to determine their knowledge of the abuse reporting process. All staff indicated they will allow youth to make a call to the abuse hotline if they ask, four respondents indicated they will notify the supervisor, and three indicated they will notify the facility administrator. Four of the staff reported a supervisor will make the call, while five of the total respondents indicated staff are allowed to call. Additional responses indicated they will notify the supervisor of call and the call will be documented in the logbook, to include the call time, date, and report number, if received. None of the staff indicated ever seeing a coworker tell a youth they could not call the Florida Abuse Hotline. All seven respondents reported never having heard a coworker used profanity and/or threats, intimidation or humiliation when interacting with a youth.

Interviews with eight youth revealed all feel safe in the program. Individual responses indicated staff maintain good order and discipline, and programs are made to be safe. None of the youth reported ever having been stopped from calling the Florida Abuse Hotline, with two indicating they have never needed to call. All eight youth reported staff are respectful when speaking with them, with one youth adding unless you disrespect the staff. Five of the youth indicated never having heard staff use profanity, while one youth said they had heard staff curse once and two others said they have heard it occasionally. All three of the youth who indicated they have heard staff curse reported this was never used in a derogatory way towards youth. They said it is used conversationally at times and to get attention, when needed. When asked if they had ever exchanged emails, telephone numbers, or social media information with staff all eight youth reported they have not done so.

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

The program maintains a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff member from youth contact, when necessary. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. An interview with the facility administrator (FA) confirmed this practice. A review of documentation for the annual review period was conducted for allegations of physical, psychological, or emotional abuse to the Florida Abuse Hotline or CCC; six reports alleging abuse were found. A review of documentation for five of the incidents found management took appropriate and immediate action by initiating an internal investigation regarding staff on each allegation of abuse. Documentation confirmed staff were removed from youth contact as appropriate. One of the reviewed incidents was substantiated by the provider for improper conduct and the staff was terminated. Investigations are still pending for the other four incidents; however, staff involved in three of the other incidents have already been terminated for their role.

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 maintains a policy and procedures ensuring the program reports incidents to the Department's Central Communications Center (CCC) within the required time frame. The program shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The program had fifty reportable incidents within the last six months, of which five were reviewed. Documentation revealed eighteen of the fifty incidents were COVID-19 related. Documentation confirmed all five reviewed incidents were reported to the CCC within the mandatory two-hour time frame. The program maintains master control logbooks, in which they record reports to the CCC. All five incidents reviewed were documented in the master control logbooks. A review of internal incidents for the past six months showed there were no incidents which should have been reported to the CCC.

An informal interview was conducted with the program's facility administrator (FA). The program's FA stated if a youth believes they have been abused or neglected, they are given unrestricted access to the Florida Abuse Hotline and/or the CCC for youth eighteen years old and over. If the youth refuses to make an abuse call, the staff is responsible for making the call as they are mandatory reporters. The program has experienced an increase in the number of reportable incidents to the CCC in comparison to the last annual compliance review. During an interview with the facility administrator, they indicated the increase in reportable incidents was most likely due to the youth being in medical isolation as a result of testing positive for COVID-19 and construction being completed at the facility. Due to construction being completed on the living modules and the fencing additions around the outside recreation yard, youth had restricted access to areas of the facility and outside recreation.

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

The program maintains a policy and procedures, as well as a written plan, ensuring the utilization of Protective Action Response (PAR) techniques. All direct care staff shall be trained in PAR, and a PAR report shall be completed any time a PAR incident occurs. Each PAR report shall include statements by everyone involved, a review by a PAR certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by a facility administrator (FA) or designee within seventy-two hours of the incident. An interview with the program's FA confirmed the program's practice. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020.

The program had eight PAR incidents within the last six months, and five reports were selected for review. Reviewed documentation confirmed each report included statements from all staff involved which reflected completion by the end of the staff's workday. Each report contained a documented review by a PAR certified instructor and was processed by all required parties. Reviewed documentation showed all five records documented a post-PAR interview conducted within thirty minutes of the incident. A review of the PAR incident reports and written comments by the FA and/or designee within seventy-two hours of the incident, was found in each PAR report. The reviews indicated the PAR moves used were approved by the Department.

One youth required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR medical review. Documentation confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. None of the reports reviewed mandated a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which are submitted to the Department monthly. The program's PAR rate has increased from .30 to .59 since the last annual compliance review. During an interview with the FA they indicated this was most likely due to the youth being in medical isolation as a result of testing positive for COVID-19 and construction projects which restricted outside recreation due to construction on the living modules and the fencing additions. The program's PAR rate during the annual compliance review period was .59 which is below the statewide Residential PAR rate of 2.23. The program's compliance manager stated all staff are trained to always use verbal interventions as the primary method to handle difficult situations with youth. A review of seven pre-service and seven in-service staff training records found each staff received PAR training as required by the administrative rule.

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 regarding pre-service training. The program maintains a pre-service training plan and calendar for all new staff. The plan was most recently submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020.

Pre-service training is provided through a combination of instructor-led classes, web-based courses, and on-the-job training. All floor staff inclusive of supervisory staff are considered direct care staff and are counted in the staff-to-youth ratio. Seven staff records were reviewed for pre-service training. All reviewed records found each of the seven staff completed the certification process within 180 days of hire. Required trainings included Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), Human Trafficking training, and active shooter training prior to having any contact with youth. All seven staff training records reviewed showed documentation to support each staff exceeded the required 120 hours of pre-service training. Documentation showed all training was delivered by qualified trainers and was documented in the Department's Learning Management System (SkillPro).

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

The program maintains a policy and procedures ensuring in-service training is conducted annually. An in-service training plan was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. The review of this document found it contained all required elements. Seven staff records were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff completed training in professionalism and ethics, standards of conduct, active shooter, six hours of suicide prevention training, and human trafficking, when applicable.

Three supervisor records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, and communications skills. Reviewed documentation supported each supervisor exceeded the required eight hours of supervisory training. All trainings were conducted by certified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days of completion. There are no additional in-service training requirements outlined in the program's contract. The program maintains an annual training calendar which is updated

to reflect any changes. All floor staff inclusive of supervisory staff are considered direct care staff and are counted in the staff-to-youth ratio.

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 outlining the grievance process for the youth to formally file complaints about conditions, treatment, services, the actions of program staff, and other youth which are in violation of their rights. The policy helps to ensure complaints are reviewed in a fair and expeditious manner and are resolved in the best interest of the youth, the program, and the Department. The grievance process includes three phases: informal, formal, and appeal. Program policy indicates staff are trained on the process during their pre-service training and annually thereafter. A review of fourteen staff training records confirmed seven staff were trained on the grievance process during their pre-service training, and seven staff were provided a follow-up grievance training annually during the year 2019. The program uses "Let's Talk" forms as part of their informal process. The policy indicates youth are encouraged to resolve questions, disputes, or complaints through informal communication with program staff. Staff are required to make a reasonable effort to assist the youth with their concern. If the youth does not feel comfortable speaking with staff, they can fill out a "Let's Talk" form which they can direct to whichever staff they would like to speak with. These requests are typically resolved within twenty-four hours, but no later than seventy-two hours after submission. If a youth is not satisfied with how their informal complaint has been addressed, or they feel the concern is more serious, they can fill out a formal grievance form. The informal and formal grievance forms were found to be available in the youth dormitory areas and in the cafeteria. There is a locked box in the cafeteria for completed "Let's Talk" and Grievance forms to be submitted in. The program requires formal grievances to be processed by the program's grievance officer, the assistant facility administrator (AFA) or designee, within seventy-two hours of submission. If the grievance is not able to be resolved with the youth, it will then go into the appeal phase. The facility administrator will address all appeals within seventy-two hours of the formal decision. Thirty-three grievances were submitted during the annual compliance review period, while sixty-two "Let's Talk" forms were filed during the same period. All grievances for the past year were maintained within a binder, separated by month, and documented as set forth in the grievance policy on their internal tracking form. Five grievances were reviewed. None of the reviewed grievances indicated the youth used the informal phase prior to using the formal step; however, each was addressed within seventy-two hours by the AFA. In each of the situations, the complaint was resolved during the formal phase with the AFA/designee. Interviews with eight youth confirmed the forms can be found in the cafeteria and other places in the program, along with the locked box to place them in. Four of the respondents indicated the process has three phases, and six of the youth were aware of time frames for the process. One of the youth stated staff can help them if needed, and they indicated there is a submission box in the cafeteria which is checked daily. All eight indicated they can ask for assistance in filling out a grievance form. Seven staff were interviewed regarding the grievance process. Each of the staff were clear about where the forms are available in the cafeteria and on the living units. Five of the respondents indicated youth are allowed to request help when filling out the forms, and two respondents were aware there are multiple phases to the process. Four of the staff were aware of the associated time frames with the grievance process, and they all knew a supervisor would

address them once submitted. Four of the staff knew the forms were retrieved by administrative staff and knew the AFA is the grievance officer who responds to address the concerns. An interview with the facility administrator confirmed the grievance process. They indicated youth place completed forms in the grievance box which is found in the cafeteria. This box is checked each day by the AFA or designee, who will attempt to resolve the concern as soon as possible.

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 maintains a policy and procedures ensuring youth are provided delinquency interventions through evidence-based principles. A review of the program's contract and an interview with the designated mental health clinician authority (DMHCA) confirmed the program utilizes Impact of Crime (IOC), Thinking for a Change (T4C), and Pathways to Self-Discovery and Change as the primary delinquency intervention programs. The Department of Juvenile Justice Sourcebook of Delinquency Interventions lists IOC and T4C as Promising Practices, and Pathways to Self-Discovery and Change as a Practice with Demonstrated Effectiveness. A review of facilitators and their training was conducted. The program has four facilitators trained in the delivery of IOC and four facilitators trained in the delivery of T4C. Pathways is delivered by their licensed and non-licensed clinical staff, all who have been trained in the delivery of this curriculum. A review of records for staff who facilitated these groups found the appropriate trainings in each applicable intervention were completed, and each staff had the applicable educational background for the group practices. Informal interviews with the DMHCA and facility administrator confirmed the program considers staff education, work experience, and rapport with youth to determine which staff deliver the delinquency intervention services. A review of the program's weekly schedule and group sign-in documentation confirmed the groups were taking place as scheduled. A review of sign-in sheets, observations of program activities, and a review of the program schedule confirmed the program is providing structured, planned programming and activities for at least sixty percent of the time youth are awake.

An interview with the director of case management revealed the goal is for each youth in the program to receive IOC, T4C, and Pathways to Self-Discovery and Change while they are in the program. A review of seven youth records and group sign-in sheets confirmed five of the seven youth received IOC delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans. The remaining two youth were scheduled to begin IOC groups October 12, 2020. A review of seven youth records and group sign-in sheets confirmed four of the seven youth received T4C delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans. The remaining three youth were scheduled to begin T4C groups October 12, 2020. All of the reviewed youth were participating in Pathways to Self-Discovery and Change as part of their treatment group schedule. Eight youth were interviewed regarding their personal participation in delinquency intervention groups. All youth indicated they attend groups within the program. Six of the eight respondents indicated they have attended IOC and T4C. Additional responses reflected attendance in teen relationship groups, anger management, substance abuse, and groups on coping skills.

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 maintains a policy and procedures ensuring youth receive life and social skills training. The program's policy ensures the youth receive life and social skills training to include decision making, communication, interpersonal relationships and interaction, non-violent conflict resolution, anger management, critical thinking, and problem solving. A review of the program's contract and interviews with the program's designated mental health clinician authority (DMHCA) and facility administrator (FA) confirmed the program identified Pathways to Self-Discovery and Change, Passport, Young Men's Work, The Boy's Council, Coping with Depression, Coping with Anxiety, Living in Balance, Teen Relationships Workbook, Anger Management, and Strategies for Anger Management as life and social skills curricula offered to the youth. An informal interview with the clinical director confirmed these groups provide youth with opportunities to learn decision making, communication, coping, and problem-solving skills, in addition to other life skills. A review of staff training records found all group facilitators were trained to deliver their respective curricula, with all facilitator's having at least a master's-level education. A review of the program's activity schedule and documentation of group sign-in sheets confirmed youth are participating in these groups as scheduled. A review of the staff who facilitate the groups validated they were trained to deliver the applicable curricula. Seven youth were interviewed, and each youth reported participating in groups and learning new coping skills, impulse control, and how not to blame others. Reviewed group documentation and youth feedback confirmed the youth role-play new skills which are learned in the groups.

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

The program maintains a policy and procedures ensuring youth are provided activities or instruction to increase youth awareness and empathy for crime victims and survivors.
A review of the program's contract identified the Impact of Crime (IOC) curriculum and community service projects as the restorative justice programming. The IOC curriculum includes victim impact, personal accountability, consequences of actions, introduction to harm, managing conflict, effects of crime, and the road to reparation. A review of the program's activity schedule confirmed IOC groups are scheduled for one hour, twice a week. A review of group sign-in sheets validated groups were held according to the dates on the activity schedule. A review of staff training records confirmed all four staff facilitators of IOC completed IOC training prior to facilitating groups. Documentation of sign-in sheets and records confirmed the program utilizes guest speakers to share personal stories to teach youth about victim impact and personal accountability. An interview with the program's facility administrator (FA) was conducted. The FA reported youth participate in IOC and projects as a part of the program's restorative justice practice. A review of seven youth records and IOC sign-in sheets confirmed five of the seven youth received IOC delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans. The remaining two youth were scheduled to begin IOC groups October 12, 2020.

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 maintains a policy and procedures outlining youth participation in gender-specific programming. The program provides delinquency interventions and treatment services which are gender-specific and focus on preparing youth to live responsibly in the community upon release. A review of the provider's contract identified the program utilizes the Young Men's Work, The Boy's Council, and Teens Relationship Workbook for gender-specific programming. Young Men's Work and The Boy's Council are groups for males ages fourteen to nineteen. Both groups are designed to teach young men to work together to solve problems without violence. The Teen Relationship Workbook teaches the young men to recognize the warning signs of relationship abuse and develop skills for healthy relationships which can help stop the cycle of violence. Handouts, videos, and group discussions are utilized in these groups to help instruct youth on gender-specific issues. A review of staff training records found all group facilitators were trained to deliver their respective curricula, with all facilitator's having at least a master's-level education. A review of the program's daily schedule indicated both Young Men's Work group and The Boy's Council are rotated every Tuesday and Thursday. Teens Relationship Workbook groups are scheduled every Saturday and Sunday. A review of group sign-in sheets and handouts confirmed gender-specific programming is being delivered according to the program's group schedule. An interview with the clinical director and facility administrator (FA) confirmed each youth participates in gender-specific groups while at the program. Eight youth were interviewed about their group participation. All eight youth reported having attended groups, but none mentioned any gender-specific services.

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

The program has a written policy and procedures addressing the internal alert system and alerts entered into the Department's Juvenile Justice Information System (JJIS). An interview with the program's facility administrator (FA) reflected JJIS alert reports and the program's internal alerts are reviewed daily by administrative staff at the daily morning management meeting. The program maintains alert boards in the conference room, where shift briefings are held. The alert board was found to contain key alert information, including youth who are a security or safety risk, youth with health-related concerns, youth with food allergies or special diets, and youth with suicide or mental health alerts. This board is updated as needed by medical, clinical, and case management staff. Additionally, the program maintains a medical alert log which is updated, when changes occur, by nursing staff. A review of documentation and observations during the annual compliance review confirmed a review of the alert board and medical alert logs are conducted by the shift supervisor at each shift briefing for oncoming staff. A review of

seven youth individual health care records, seven mental health and substance abuse records, and seven youth case management records indicated all youth with applicable alerts relating to mental health, suicide risk, medications, special diet, allergies, no strenuous activity, and gang member/gang association were entered, and removed when applicable, in JJIS. No discrepancies were identified when comparing the internal alert system with JJIS alerts for the seven reviewed youth. A review of the program's policy and an interview with the FA reflected suicide risk and other mental health alerts are only downgraded by clinical staff, medical alerts are only downgraded or changed by nursing staff, and security alerts are only adjusted by the FA, assistant FA, or supervisory staff. The review of alert information confirmed this practice. Logbook review found all pertinent alert information was recorded appropriately, with no exceptions. Interviews with seven staff confirmed youth alert information is shared daily through shift briefings and through the alert boards in the conference room.

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

The program has a policy and procedures regarding the creation, maintenance, and storage of Individual Healthcare Records, mental health and substance abuse records, and case management records for each youth at the program. The program maintains individual, color coated, hardbound binders utilized for case management, mental health and substance abuse, and healthcare records. Reviewed documentation of youth records found each was labeled "confidential" and were secured in file cabinets identified as "confidential" in the assigned locked offices and medical clinic, which are inaccessible to youth. Observations of the seven youth records reflected each youth record had the required documentation on the spine and on the front cover of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department of Juvenile Justice identification number. Reviewed records reflected all required information was maintained in chronological order within each record. Documents and information were organized into required sections and separated into designated sections with tabs for legal information, demographic and chronological information, case management, treatment team activities, correspondence, and miscellaneous.

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

The program has a policy and procedures regarding youth input. The program provides many avenues for the youth to provide input about the program. The program holds daily meetings for each dorm, in which they discuss daily progress of youth and any concerns which need to be addressed. The youth can use the "Let's Talk" forms to resolve any concerns they may have at any time. This is part of the program's informal phase of their grievance process. The program has a youth advisory board, which meets bi-weekly with the recreational therapist and/or the restorative justice counselor. A review of the meeting minutes and sign-in documentation reflected the youth advisory board has met every other week for the past six months, except for a large gap of time from July 3 through August 31. The program indicated they did not have youth advisory board meetings during this time due to the program being under quarantine due to COVID-19. The reviewed documentation reflected the youth provide input regarding what types of items are offered as rewards, different incentives which should be offered for youth,

and sharing ideas about different types of activities the youth can do to assist the local community. In addition, youth are given surveys each quarter. The information gathered from these surveys is shared with the management team to help make enhancements or changes based on input from the youth. This process was confirmed by the facility administrator. He spoke about the daily dorm meeting which is held, which includes an agenda item for youth to share their concerns. Each of the eight interviewed youth indicated the program has a process for them to provide input about what happens in the program. Responses from the youth indicated they can fill out "Let's Talk" forms, they can share information with the youth advisory board representatives, and they can fill out surveys when given by the program. The facility administrator indicated the youth advisory board allows youth to provide input regarding issues or concerns they may have with the program as well as providing input into new and different incentive ideas.

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 maintains a policy and procedures ensuring the program has a community advisory board which meets quarterly. A review of advisory board meeting minutes revealed three meetings (February 13, 2020, May 14, 2020 and August 27, 2020) were conducted about ninety days apart since the last annual compliance review.

The invitations to each board meeting were sent out about a month in advance and included all the required disciplines. Documentation reveals parents/guardians and representatives from the lesbian, bisexual, gay, transgendered, questioning, intersex (LBGTQI) community, and business community were invited to all three meetings. The supporting documentation included sign-in sheets, an agenda, and minutes of each meeting. The minutes separately addressed all three programs (Tampa Residential Facility, Lake Girls Academy, and Hillsborough Girls Academy) represented in the advisory board. The sign-in sheets indicated at least one board member outside of program staff attended the meetings. This practice of holding meetings together was approved by the Assistant Secretary of Residential Services on March 8, 2017.

Some invitations were sent by email and some by registered letter with return receipt requested. The program maintains records of board members who signed the registered letters and those who confirmed they would attend. Interviews with the facility administrator (FA) indicated if an invited board member does not result in a physical response, the program invites another person in the same area/discipline. An interview with the FA indicated recruitment efforts with a home improvement store, but there was no documentation on names of individuals recruited including date time and location of the store.

An interview with one advisory board member was conducted by phone. The board member indicated involvement for the past twelve years, including being a chaplain to the program. The member described an active board meeting quarterly at the corporate headquarters. In addition, described some activities to include celebrating birthdays of youth and staff, involvement with mentors participating in game night, and assisting when the program needed other support.

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

The program has a policy and procedures in place regarding program planning designed to establish a system of communication, facilitate staff involvement, discuss program issues, and the development of policies and procedures. The program solicits information from youth and their parent/guardians through surveys which can be completed electronically through Survey Monkey or through completion of a paper copy. Each youth's parent/guardian is sent an admission survey to complete after their child's intake. The program uses these to gather information and trends regarding the program's admission process and their customer service practices. Conversely, once a youth is discharged from the program, the parent/guardian for each youth is provided with a family satisfaction survey. Both the admission and discharge summaries are returned to the company's chief compliance officer. They review the survey results and distribute them to the facility administrator for the information and feedback for their team. Staff surveys are conducted on a quarterly basis. These are used to gather information regarding working conditions, program practices, and the general knowledge of staff regarding the requirements of their position. Youth surveys are completed on a quarterly basis. These gather information on how the youth feel about how well the program is functioning. The staff and youth survey information are compiled at the corporate level by the information systems project manager and is disseminated to the facility administrators. Reviewed documentation reflected the program conducts monthly all-staff meetings, monthly supervisor meetings, and daily management meetings to share information with program staff and to enhance program planning. Staff can communicate input and provide feedback on the program's operations during these meetings or at any given time with program's administrative staff. An interview with the facility administrator (FA) confirmed they hold these meetings. He reported administration holds a daily management meeting to talk about any current topics and to work on program planning. He reported handouts are given at the all-staff meeting with information supporting what is being discussed, and any staff who may miss this meeting are given this information, so they are aware of important information. Documentation of all-staff meeting minutes indicated the program reviews the Monitoring and Quality Improvement reports, any applicable major issues, medical updates, mental health updates, drill reviews, policy reviews, human resources issues, and safety and security issues with staff. Survey results from the staff, youth, and parents/guardians is shared at the staff meetings. The review of meeting minutes confirmed the review of the most recent Comprehensive Accountability Report (CAR), last year's Annual Compliance Report, and the TRACE results were done during this review period. A review of daily management meetings reflected the management team discussed programming issues, incident reports, grievances, Central Communications Center reports, youth issues, education issues, Protective Action Response (PAR) incidents, program trends, alert trackers, sick calls, and staff vacancies. The program has a policy and procedures in place for employment recognition. An informal interview with the facility administrator and the human resources representative confirmed they have practices in place to minimize staff turnover. They shared information regarding their TrueCore Way Recognition Rewards. This is a way for staff who go above and beyond to be recognized for their positive performance. Staff names are drawn from a bin in which all eligible nominees have been placed at each monthly all-staff meeting. The winners are allowed to order additional program polo shirts, button down shirts, or a jacket in recognition for their hard work. They have an employee referral bonus program in place to encourage staff to earn monetary incentives for helping bring new staff to the program.

Interviews with seven staff confirmed the program holds monthly staff meetings. The seven interviewed staff indicated they discuss operations, department topics, any issues in the program, staff recognition, training, and sharing of policy changes. Five of the seven staff indicated they are briefed on annual reports and parent/guardian survey results while two said they are not. Four staff reported the communication at the program is good, while the other three said it is fair. No additional feedback was given to explain why they felt this way. The

same seven staff were asked to explain their ability to provide input and feedback into the program operations. All seven respondents indicated staff can speak with administration to provide any feedback they want or suggestions they have at any time due to the open-door policy of administration. They indicated they can provide feedback during the monthly staff meetings.

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 in place which outlines requirements for evaluating staff performance annually and after the first ninety-days of hire. A review of position descriptions confirmed job duties are clearly outlined for each staff member. A review of seven in-service staff personnel records found each staff received an annual performance evaluation. Each of the staff were evaluated based on established performance standards outlined in their position descriptions which they received and signed upon hire. All required positions in the program's contract are maintained and performed as required based on the position descriptions and reviewed documentation. The human resources manager and facility administrator (FA) confirmed evaluations are completed after the first ninety days and annually thereafter. The FA reported the evaluations are completed by each department head before a review by the FA. Seven staff were interviewed, and four confirmed evaluations are conducted annually. Five of the respondents indicated evaluations occur quarterly.

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

The program has a policy and procedures outlining the provision for recreation and leisure activities which are appropriate for the youth at the program. A review of the program's activity schedule documents youth are given the opportunity to participate in a wide-range of indoor and outdoor recreation and leisure activities. During recreation time, the youth participate in the prescribed activity on the recreation calendar or an alternative indoor workout of the day if weather does not permit outside time. In the evenings and on weekends, youth are given a choice of leisure activities. Youth are encouraged to explore interests during recreation and leisure time. Youth are afforded opportunities to provide input into offered activities through the youth advisory board, daily dorm meetings, and "Let's Talk" forms. Observations during the annual compliance review and documentation in the master control logbook confirmed recreation being provided daily. An interview with the recreation therapist confirmed the youth give input on planned activities, and they work hard to follow the schedule which is put in place each month, weather permitting. Observations of recreation and an interview with the recreation therapist reflected the program is taking steps to prevent over-exertion, heat stress, or dehydration.

Interviews with seven staff revealed the youth are provided with at least one hour of outdoor recreation every day, weather permitting. Outdoor activities include kickball, basketball, football, and frisbee. One of the respondents indicated they sometimes get extra time outside if all youth have been behaving well. Indoor activities include board games, trivia games, and indoor workouts. Eight youth were interviewed, and each youth reported being provided at least one hour of recreation time each day. Outdoor activities were reported to include football, basketball, frisbee, and weight room time, while no specific indoor activities were reported.

The program's contract requires a recreation therapist. The program's recreation therapist has a bachelor's-level degree in physical education. A recreation schedule was found outlining daily activities. In addition, the recreation therapist created workouts for youth when weather conditions did not allow them to be outside. An incentive schedule was created by the recreation therapist and posted throughout the program to allow youth to see the daily activity they could participate in with good behavior. During the annual compliance review, the review team observed the youth engaged in outdoor activities of dodgeball and basketball. Reviewed documentation confirmed each of the seven reviewed youth had a wellness plan which was developed by each youth and the recreation therapist. These plans allowed the youth to set personal goals for their own physical wellbeing. Each plan was found to be incorporated into their Individualized Mental Health and Substance Treatment Plan, and their progress on their goals were reviewed at each formal treatment team meeting.

During an informal interview, the recreation therapist stated the facility had two very popular art and dog training programs which have been suspended since March 2020 due to COVID-19 preventative measures. The art program encouraged art appreciation to include impressionism and modernism, thus supporting the youth social and cognitive skill development, creativity, and mental stimulation. The dog program trained youth in the daily maintenance of dogs, thus emphasizing responsibility commitment and empathy.

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 ensure each youth's parent/guardian, committing court, and assigned juvenile probation officer (JPO) are notified of the youth's admission to the program within the required time frames. A review of seven youth case management records indicates the program notified each youth's parent/guardian by telephone within twenty-four hours of admission and in writing within forty-eight hours of admission. The reviewed records indicate each youth's committing court and assigned JPO were notified within five working days of their admission. All parent/guardian, committing court, and JPO notifications were made the day of admission. Notifications to the youth's post-residential counselor were not applicable in any of the records due to the post-residential counselor not being assigned at the time of admission.

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

The program has a policy and procedures stating each youth shall be provided an orientation to the program rules, procedures, schedules, and services applicable to youth, beginning on the day of admission. A review of seven youth case management records reflect each youth received orientation on the day of their admission. Each youth's orientation included all required topics including services available, daily schedule, expectations and responsibilities of youth, behavioral management system information, availability and access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline or Central Communications Center (CCC) for youth eighteen years of age or older, the program's zero tolerance policy regarding sexual misconduct, including how to report incidents or suspicions of sexual misconduct, special accommodations to ensure sexual misconduct policies are conveyed verbally to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled, right to be free from sexual misconduct, the right to be free from retaliation for reporting such misconduct, the agency's sexual misconduct response policies and procedures, contraband, performance planning process, dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, community access, grievance procedures, emergency procedures, facility tour, assignments to a living unit, room, treatment team, and medical topics. Each youth's record contains an orientation form signed by the youth which lists all covered topics and is dated the day of admission. Each record contained a signed form, dated the date of admission, confirming information on the program's sexual misconduct policies and procedures was provided to each youth. Eight youth interviews confirmed each youth received an orientation beginning within twenty-four hours of admission and each youth was able to explain the orientation process. No addmissions occurred while the review team was on-site, so their process was not able to be observed.

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 which require the program to obtain 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 any information related to the youth's physical or mental health screening, assessments, or treatment with the parent/guardian. Two of the seven case management records selected for review were for youth who were eighteen years of age at the time of admission or had turned eighteen since being in the program. One additional record was requested for review. All three youth records contained a written consent from the youth prior to providing or discussing information related to physical or mental health screening, assessments, or treatment with the parent/guardian.

2.04 Classification Factors, Procedures, and Reassessment for Activities	Limited Compliance
The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. Initial classification should be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. *Youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments 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 utilization of a classification system which promotes safety and security, as well as, effective delivery of treatment services, and ensures initial classification is used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. A review of seven case management records showed each youth received an initial classification the day of admission. Each record contained a classification form including physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, youth's perception of vulnerability, and youth's history of potential or verified human trafficking. Five of the youth did not have a new Victimization and Sexually Aggressive Behavior (VSAB) completed and entered into the Department's Juvenile Justice Information System (JJIS) prior to the youth's room assignment. One youth's VSAB was entered in JJIS a day late, one was entered seven days late, and three were not in JJIS at all. The program acknowledged the reviewer's findings and stated hard copies were being done, but they have now started doing them in JJIS. One youth's classification form indicated the youth did not have any gang affiliation; however, the youth had an open alert stating he is a documented gang member, which was entered into JJIS prior to his admission. All seven youth records revealed documentation of identified or suspected risk factors, including: suicide risk, medical risk, escape risk, and security risk on their classification forms. All identified alerts were immediately entered into the program's internal alert system and JJIS. The program's internal alert system was reviewed, and they have an alert board, listing each youth's alerts, located in the conference room. An interview with the facility administrator (FA) confirmed an admission classification meeting is held with each youth upon admission. The FA stated the youth,

parent/guardian, and someone from each department participates in the meeting and they review the youth's information and history. The FA stated the information is used by the treatment team to determine which living unit and room would be most appropriate for the youth.

A review of seven records showed each youth was reassessed prior to considering an increase in the youth's privileges or freedom of movement. The program completes monthly risk assessment forms on each youth, which are kept in a risk assessment binder. Each youth had a form completed monthly for consideration of an increase in program privileges. The program is a secure program and does not participate in work projects or off-campus activities.

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

The program has a policy and procedures for gathering information on gangs and sharing the information with law enforcement. The facility administrator (FA) oversees gang prevention and intervention. The FA assigns specific duties to different staff members. The director of case management is responsible for making notifications and maintaining documentation as it relates to gang-sharing information. One of the seven selected youth case management records was applicable for youth gang involvement or association. Two additional records were requested. All three records contained documentation of local law enforcement, education, and the youth's juvenile probation officer (JPO) being notified of suspected gang activity. Each reviewed youth's residential placement was not in their home county. Law enforcement in the home county of the residential facility was notified of gang involvement or association for each youth. Local law enforcement was not notified by the program, detention staff, or the youth's juvenile probation officer (JPO) upon identification of the youth's gang involvement for two of the youth. One of these youth was admitted with an alert stating he was a documented gang member; however, this was missed at classification, and law enforcement, education, and the JPO were not notified until approximately four months later. The other youth identified himself as a gang member on a Security Threat Group Questionnaire upon admission; however, law enforcement, education, and the JPO were not notified of the youth's gang involvement until almost six months later. A gang alert was entered for the youth in the Department's Juvenile Justice Information System (JJIS) the same date the notification was sent. The other two youth were not applicable for having gang alerts added in JJIS, as they had gang alerts added prior to their admission at the program.

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

The program has a policy and procedures for implementing gang prevention and intervention strategies. The facility administrator (FA) oversees gang prevention and intervention. The FA assigns specific duties to different staff members. The transition services manager is assigned to facilitate the gang groups. The program utilizes an ARISE curriculum titled, "Gangs: 50+ Stories of Fractured Lives" as their gang intervention curriculum. The program utilizes the Impact of Crime group and focuses on goals related to free time, relationships, and aggression

as an effort for gang prevention/awareness for all youth. Seven youth case management records were reviewed, which revealed one was applicable for youth gang involvement or association. Two additional records were requested. The program maintains a gang binder with sign-in sheets, youth's completed program activities, and all other gang information. A review of the gang binder confirmed all three youth are participating in gang interventions. All three youth's performance plans include relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. Two of the youth did not begin interventions upon admission and did not initially have gang goals on their performance plans; however, both youth now have gang goals on their performance plans and are participating in gang interventions. One youth was admitted to the program with a gang alert in February 2020 and his gang goal was added in June 2020. The other youth identified as a gang member when completing the Security Threat Group Questionnaire upon admission in November 2019 and his gang goal was added in May 2020. An interview with the FA indicated the program utilizes the ARISE curriculum and youth complete interventions on a bi-weekly basis. The FA stated sessions are completed with the youth independently to ensure they feel more open with their responses.

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 ensure an initial assessment of each youth is conducted within thirty days of admission and a reassessment of each youth is conducted within ninety days of the initial assessment. All assessments and reassessments should be maintained in the Department's Juvenile Justice Information System (JJIS). Seven youth case management records were reviewed and all had a Residential Assessment for Youth (RAY) completed within thirty days of admission which was completed in JJIS. Five of the youth records were applicable for reassessments, as ninety days had not passed since the initial assessment for the remaining two youth. All five records contained documentation showing reassessments were completed within ninety-days after completion of the initial RAY. Each record contained documentation showing a second reassessment was done within ninety-days of the first reassessment, when applicable.

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. A review of seven youth case management records indicate six youth had a YNAS completed within thirty days of admission. The remaining YNAS was completed eighteen days late; however, the director of case management indicated the YNAS was completed by the case manager within the required thirty days; however, the director of case management did not lock the form in the Department's

Juvenile Justice Information System (JJIS) to show it as complete until several days later. Documentation was observed showing the YNAS was initially created within the required time frame. Each YNAS was documented in JJIS. One meeting for the creation of the YNAS was observed while on-site. The meeting was held within thirty days of the youth's admission.

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 performance plan development and ensure each youth's individualized performance plan (IPP) is developed within thirty days of admission. Seven youth case management records were reviewed and all seven contained documentation showing their IPPs were completed within thirty days of admission. One youth's original initial IPP was not in the youth's record. The program acknowledged this and stated during an audit of the record by the director of case management they discovered the original plan had been mailed out and an original copy was not maintained at the program. When the error was discovered, a new IPP was printed, re-signed by the required parties, and placed in the record. Six IPPs were developed after the initial assessment was completed. The remaining IPP was developed a month prior to the youth's initial assessment being completed; however, the initial assessment was created prior to the development of the IPP, it just was not marked as complete and closed out by the director of case management until a later date. The creation of the IPP should include treatment team members including the treatment team leader, youth, administrative representative, treatment staff, educational staff, if applicable, Department of Children and Families (DCF) caseworker or Agency for Persons with Disabilities (APD) waiver support coordinator, if applicable, all parties who have significant responsibility in goal completion, and the parent/guardian. All required parties participated in the development of the IPP for each youth, except for education staff. Six youth records were applicable for educational staff participation, as one youth received his GED prior to admission. Educational staff participated in four of the remaining youths IPP development. For two youth there was no signature or indication of written input from education on the initial IPP. None of the reviewed youth were applicable for DCF or APD participation. All seven youth records contained correspondence of the IPP being sent to a parent/guardian with a request to sign the signature page and return it to the program. Each IPP included the required elements including individualized goals, incorporation of the three top criminogenic needs, specific delinquency interventions with measurable outcomes, target court-ordered sanctions, transition activities, youth responsibilities, staff responsibilities, target dates for completion, and the youth's recreation plan. The youth's recreation/wellness plan is included on the youth's individualized treatment plan, and each youth's IPP includes a goal to comply with their individualized treatment plan.

The program is required to send a transmittal letter and copy of the IPP to the committing court, juvenile probation officer (JPO), parent/guardian, and if applicable, the DCF caseworker within ten working days of the plan being completed. All seven records included documentation of the transmittal letter and IPP being sent to the required parties in the required time frame; however, one transmittal letter to the court and JPO had an incorrect date printed on it. The program acknowledged the incorrect date was printed due to human error, and the correct date was verified by looking at chronological notes. Eight youth were interviewed, and each youth stated they participated in the development of their IPP. Seven youth were able to identify their goals and stated they have a copy of their IPP. The remaining youth refused to answer the question and refused the remainder of the interview.

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 ensure each youth's performance plan is revised when determined necessary by the intervention and treatment team. A review of seven youth case management records indicated there was no need to revise six of the youth's plans based on their Residential Assessment for Youth (RAY) results, as the results did not change. The remaining plan was updated when the RAY reassessment reflected a new top criminogenic need to target. All seven plans were revised based on newly acquired information. All seven records verified each youth's performance plan was updated when they demonstrated progress or lack of progress towards completing a goal. The program's practice revealed the treatment team meets formally at least every thirty days to discuss each youth's performance plan, and any necessary revisions to the plan are made. None of the seven records were applicable for youth in transition. An additional three records were requested. All three records documented revisions were made to each youth's plan to facilitate transition activities during their last sixty days in the program.

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

The program has a policy and procedures to ensure the treatment team prepares a performance summary at ninety-day or less intervals following the signing of each youth's performance plan. A review of seven case management records indicated five records were applicable for performance summaries. Ninety days had not passed since the creation of the performance plan for the remaining two youth. All five applicable records had a performance summary completed at least every ninety days following the signing of their performance plan. Each summary included the youth's status on each performance plan goal, overall treatment progress, academic status, behavior, level of motivation and readiness for change, interactions

with peers and staff, overall behavior adjustment to the program, and any significant positive and negative events. None of the reviewed records were applicable for having a performance summary completed prior to the youth's release, discharge, or transfer from the program, so an additional three records were requested. All three records had a completed performance summary prepared prior to the youth's release, discharge, or transfer from the program, which included justification for release.

Documentation on reviewed performance summaries reflected all five youth were given the opportunity to read and add comments prior to signing their performance summaries. Documentation revealed each youth was provided a copy of their performance summary and the original summary was placed in their case management record. All five summaries were signed and dated by the treatment team leader, staff member preparing the summary, program designee, and youth. A review of transmittal documentation in all five records validated each summary was sent or provided to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian within ten working days. The date on one of the transmittal letters to the court, JPO, and parent/guardian was incorrect; however, the correct date was verified by reviewing the chronological notes. None of the five youth were involved with the Department of Children and Families. An interview of eight youth indicated, six stated they received a copy of their performance summary sent to the court. One youth said they did not, and the remaining youth refused the remainder of the interview prior to this question.

A review of three closed youth case management records indicated the original release summary, along with justification for release was sent to the assigned JPO with the Pre-Release Notification (PRN). All three summaries and PRNs were sent at least forty-five days prior to the planned release date and a signed copy was retained in each record. The court did not object to the release for any of the three youth. Each record contained documentation showing the program provided written notification to each youth's parent/guardian notifying them of their child's release. Two records contained documentation supporting the Residential Assessment for Youth (RAY) was completed for each youth following approval of their release. No exit RAY was located for the remaining youth. None of the reviewed youth were applicable for the Sexually Violent Predator Program (SVPP) or for victim notification.

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 ensure they are encouraging and facilitating the involvement of the youth's parent/guardian in the case management process, to the extent possible and reasonable. Each youth's parent/guardian participates in the case management process, including the assessment process, development of the performance plan, progress reviews, formal treatment team meetings, and transition planning. If unable to attend, the parent/guardian can participate by phone or give verbal/written input prior to the meeting. Reviewed documentation indicates a telephone call is made to the parent/guardian upon admission to gather information on the youth. An admission letter is sent to the parent/guardian, along with a parent/guardian handbook, and an intake packet to gather additional information on the youth and family to assist in the case management process. Letters are sent out to the parent/guardian informing them of the dates and times of youth treatment team meetings, youth needs assessment meeting, transition staffing's, and exit conferences and inviting them to participate. A review of documentation in seven youth case management records revealed the

parents/guardians were invited to all formal treatment team meetings and were able to provide feedback. Two treatment team meetings were observed, and the parent/guardian participated by telephone in both. An interview was conducted with the facility administrator (FA) who verified the program's process for encouraging parent/guardian involvement. The FA stated each youth receives a weekly call home. A review of the provider's contract confirmed the performance expectations are being met for parent/guardian involvement. Eight youth were interviewed, and six youth indicated their parent/guardian is involved in their case management services. One youth was not applicable as he is nineteen years old. The remaining youth refused the remainder of the interview prior to this question.

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 ensuring each youth's treatment 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. A review of seven youth case management records and two observed treatment team meetings while on-site verified each youth's treatment team includes a treatment team leader, the youth, an administrative representative, treatment staff, educational staff, juvenile probation officer (JPO), parent/guardian, and the transition services manager. The recreational therapist is part of each treatment team. Documentation reviewed in each case management record indicated each youth's JPO, parent/guardian, and other pertinent parties were encouraged to participate through advanced notification and were able to provide input if unable to participate. Each record contained letters to the JPO and parent/guardian informing them of the date and time for each treatment team meeting and inviting them to participate. Five of the reviewed records contained documentation showing all required participants attended each treatment team meeting. In one record, there was no program administration signature for one treatment team meeting, and in one record there were no signatures recorded for any attendees for one treatment team meeting. During the annual compliance review, an observation of two treatment team meetings revealed active participation by all required parties. None of the youth reviewed were involved with the Department of Children and Families.

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

The program has a written policy and procedures to ensure each youth's performance plan references or incorporates their treatment or care plan. A review of seven youth case management records reflect each youth had an additional plan addressing academics, medical, mental health, and/or substance abuse. All seven reviewed records contain documentation verifying each youth's performance plan references or incorporates their treatment plan. None of the reviewed youth were involved in the Department and Children and Families (DCF), so additional records were requested. The program only had two applicable youth with current DCF plans. Documentation in both records found the youths DCF case plans were incorporated in their performance plans. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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 informal and formal treatment team meetings. The meetings are to take place bi-weekly, formally and informally, to review each youth's performance. A review of seven youth case management records indicated each youth received a formal treatment team review at least every thirty days. The dates listed on the forms for two treatment team meetings in one of the youth records were incorrect. The correct dates for the treatment team meetings were verified through chronological notes, and the meetings were held within the required time frame. The program acknowledged the incorrect dates and explained it was due to dates being prepopulated from the previous meeting and staff forgetting to adjust the dates. A review of seven youth case management records indicate each youth received an informal treatment team review once bi-weekly each month. All formal and informal reviews were documented in the youth's case record and included the youth's name, date of review, comments from treatment team members, a brief synopsis of the youth's progress, any performance plan revisions, progress on goals, positive and negative behaviors, behaviors resulting in physical interventions, an opportunity for the youth to demonstrate skills, treatment progress, and Residential Assessment for Youth (RAY) results when RAY reassessments were completed. Two formal treatment team meetings were observed during the annual review. All required staff were present and participated, and all required information was discussed. Education was not present but provided information in writing prior to the meetings.
An informal interview was conducted with the director of case management, who stated when a youth is admitted to the program, the program will enter the anticipated release date for the youth in the Department's Juvenile Justice Information System (JJIS) as a year out from their date of admission. It was stated the release date is not updated in JJIS every ninety days but is updated at transition or when needed due to other factors. The director of case management stated they will update the release date on the performance plan review forms as needed. Eight youth were interviewed, and seven youth indicated they are provided an opportunity to demonstrate skills they learned in the program during treatment team meetings. These seven youth indicated they have used communication skills, anger management strategies, and impulse control to work through situations. Seven youth stated staff review their performance to include progress on treatment plan goals, positive and negative behavior, and treatment progress. The remaining youth refused the remainder of the interview prior to these questions.

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. The program provides Type 3 career education development which includes personal accountability skills as well as completing employment applications and developing a résumé summarizing their education, work experience, and/or career training. The lead teacher indicated that industry certification Career and Professional Education (CAPE) course Proso/016 is offered to become

a certified Internet Business. Enrolled youth receive state certification upon successful completion of the curriculum. This information was confirmed through an interview with the facility administrator. The courses are all age appropriate and aligned with the youth's educational goals and abilities. Three closed youth case management records were reviewed, and all included a completed employment application, résumé, and a calendar identifying an appointment with their local Career Source Center. There is no documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. There was no evidence of identification or social security cards due to the COVID-19, but applications to apply for identification cards and social security cards were present in two of the three closed files.

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 Hillsborough County Public Schools provides educational services which incorporates a 250-day calendar, spread over a twelve-month period. The district approved calendar, along with the daily class schedule, were reviewed and the six fifty-minute class periods daily provide for the minimum 25 hours of weekly instruction. All youth are enrolled in an academic schedule and receive credit, as appropriate, through the district. An interview with the lead educator indicated the school schedule is adhered to with little to no interruptions. A review of the logbook showed minimal interruptions to the daily school schedule. Eight youth were interviewed, and six youth indicated there are no interruptions to their school day. One youth was not applicable as he has his General Equivalency Diploma (GED), and does not attend school. The remaining youth refused the remainder of the interview prior to this question. During a follow-up interview with the facility administrator, it was indicated historically, the youth who had their GED had the ability to apply for jobs around the facility. If hired they would be able to shadow certain individuals, such as the maintenance staff, kitchen staff, recrational therapist during the school day. Education staff will at times allow youth who have completed their GED to continue attending school. Education staff also use the youth who have completed their GED as mentors and tutors for other youth struggling in class. Using the youth as a mentor is based on the youth behaviors or progress in the program. Program administration has recently discussed the ability to attend online classes through Hillsborough Community College with education staff.

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

Three closed youth case management records were reviewed. All three youth had an individual education transition plans created upon admission. All three youth had an Electronic Education Exit Plan (EEEP) which satisfies one component of the education transition plan. The program develops a transition plan for youth once they enter the transition phase. All three you had a transition plan. The transition plan indicates services and interventions to be implemented. The plan address services for the continuation of the Career And Professional Education (CAPE) courses. All three youth had a Youth Need Assessment Summary (YNAS) which addressed some of the components found on the

education plan. The YNAS indicates who is responsible for the provision of services and interventions while the youth is in the program.

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~~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 is planed for each youth's successful transition to the community upon release from the program, when developing the youth's performance plan and throughout its implementation during the youth's stay. A review of three closed case management records verified the program held a Transition Conference for each youth at least sixty-days prior to their targeted release date. Documentation in all three records confirmed the program invited each youth's parent/guardian, juvenile probation officer (JPO), educational staff, and other pertinent parties to the Transition Conference. All required parties participated either in person or by phone. Documentation in all three records verified the attendees signed and dated the transition plan and a copy of the plan was sent by mail to the parents/guardians and JPOs who participated by phone, with a request they sign the plan and return it to the program. Documentation indicated the Transition Conference included a review of transition activities, a revision of performance plan, if necessary, identification of additional transition activities as needed, and identification of target completion dates and persons responsible for completion. Reviewed documentation confirmed each youth participated in a Community Re-Entry Team (CRT) meeting with their JPO and other applicable community partners prior to their release from the program. Evidence in all three case records indicated an invitation to participate in the CRT was received from the JPO.

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 for assembling an Exit Portfolio for each youth to assist the youth once they are released back into the community. A review of three closed case management records confirmed an Exit Portfolio was discussed and initiated for each youth at the Transition Conference. Each portfolio was completed by the program, verified at the Exit Conference, and given to the youth upon release. One youth record had a check box stating the youth had not received a copy of his Exit Portfolio; however, it was checked by error and the

youth signed the Acceptance of Custody for Release form indicating he received a copy. Each record contained a copy of the youth's Exit Portfolio including a copy of the youth's transition plan, calendar with all upcoming community appointments, education or vocational certificates, education records, school transcripts, résumé, and sample job applications. None of the three records contained a state-issued identification card, birth certificate, or Social Security card. The program was unable to obtain state identification cards for each youth due to COVID-19 restrictions. The mobile Department of Highway Safety and Motor Vehicles bus was not operating during this time. The program was unable to obtain Social Security cards for the youth without a birth certificate and state identification. One youth was unable to get a birth certificate. The program applied for a birth certificate for the youth, but they were unable to get one because he was born out of state. Each record contained documentation of the case manager attempting to get the youth's documents from their parent/guardian. Each Exit Portfolio included instructions for getting a birth certificate and an application to receive a Social Security card. There was documentation in each record showing the Exit Portfolio information was forwarded to the youth's juvenile probation officer (JPO).

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

The program has a policy and procedures to make certain an Exit Conference is conducted for each youth, in addition to a formal or informal meeting, to review the status of goals developed at the Transition Conference and finalize release plans. Three closed youth case management records were reviewed, and documentation indicated each youth had an Exit Conference which was held after the program notified the juvenile probation officer (JPO) of release and at least fourteen days prior to the youth's release date. Each Exit Conference was documented in the case management record and included a summary of pending transition goals, the date of the conference, and names/signatures of participants. Reviewed documentation reflected educational representatives being invited to review youth progress and where the youth should be heading upon release. The status of transition activities established at the Transition Conference and finalized plans for the youth's release were reviewed. Participants included the treatment team leader, parent/guardian, education, JPO, and youth. Each youth's Exit Conference was separate from their transition and Community Re-Entry Team meetings. One Exit Conference was observed while on-site. All required parties were in attendance and all required information was discussed. Each youth's date of admission and date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS).

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

The program maintains a safety plan for each youth in a centralized location for all staff. There is a safety plan binder for each dorm which are kept in master control. Staff is informed where the binders are located, and they are reviewed with staff in debriefings. Each youth's safety plan includes warning signs, baseline behaviors, crisis recognition, coping strategies, intervention strategies, and debriefing preferences. A review of seven mental health records found each youth had a safety plan developed within fourteen days of admission. Each plan was jointly

prepared by the youth, parent/guardian, and clinical staff. Phone calls were made to parents/guardians on the day of admission, and input forms were sent out to gather information for the safety plans. Each youth's safety plan incorporated recommendations from assessments and/or screening instruments and incorporated trauma responsive practices. Documentation in all seven youth records found each youth's safety plan was updated every thirty days in their treatment team meetings. Eight youth were interviewed, and seven youth stated they were involved in the development of their safety plan. The remaining youth refused the remainder of the interview prior to this question. Seven staff were interviewed. Four staff stated the safety plans were in the clinical office, two stated they were in master control, and one reported not knowing what a safety plan is. Five staff were able to explain the development and review process for safety plans. During a follow-up interview with the facility administrator, it was verified safety plans are maintained in binders separated by dorm in master control. Prior to the construction at the facility, the safety plans were maintained in the control rooms on each dorm; however, due to construction and the destruction of the control room doors the plans were moved to master control. Maintaining the safety plans in master control gives the staff more access to review the plans when they want.

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 policy and procedure in place to ensure the program has a designated mental health clinician authority (DMHCA) who coordinates the mental health and substance abuse services in the program. The program has a licensed psychologist serving as the DMHCA. The DMHCA has a clear and active license which expires May 31, 2022. The DMHCA is on-site five days a week, for a minimum of forty hours a week, and is available twenty-four hours a day to guarantee the appropriate coordination of mental health and substance abuse services at the program. The DMHCA conducts Assessments of Suicide Risk (ASR) and Crisis Assessments, in addition to scheduling and training staff, the DHMCA performs quality assurance services including fidelity monitoring for evidence-based group interventions. The DMHCA confirmed being on-site Monday through Friday, forty hours per week, to oversee and provide supervision of the therapists and all treatment services provided to all youth in the program. The program has a licensed mental health counselor (LMHC) with a clear and active license expiring on March 31, 2021 who serves as the backup for the designated mental health clinician authority who meet the required qualifications to provide services based on education, training, and experience.

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

The program has a policy and procedures addressing licensed mental health and substance abuse clinical staff. The program has a psychiatrist, who is licensed under Chapter 459, Florida Statutes, meets all requirements outlined within the Florida Administrative Code with a clear and active license expiring on January 31, 2022. The program has three licensed mental health counselors (LMHC), two of which are assistant directors, who meet the required qualifications to provide services based on education, training, and experience. Each of the LMHCs have a clear and active license expiring March 31, 2021. The psychologist serves as the designated mental health clinician authority (DMHCA). The DMHCA supervises each of the three LMHCs and ensures the appropriate mental health and substance abuse services are provided. The program has a Chapter 397 license, which allow them to provide mental health and substance abuse clinical services. The Chapter 397 license expires April 7, 2021. Current clinical staffing is in accordance with the program's contract.

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

The program has a policy and procedures ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications, to include non-licensed clinicians. At the time of the annual compliance review, the program had four non-licensed clinical staff. All non-licensed clinicians hold a master's degree in mental health counseling, counseling education, or a related human services field. Documentation supported all non-licensed clinicians had two to six years of clinical experience assessing, counseling, and treating youth with serious emotional disturbance or substance abuse problems. The program has a licensed psychologist serving as the designated mental health clinician authority (DMHCA). The DMHCA provides weekly clinical supervision meetings with the non-licensed clinicians to address training, treatment team reviews, therapeutic concerns, case staffing reviews, scheduling, and administrative concerns. A review of clinical supervision notes for the past six months confirmed documentation in the form of sign-in sheets and training logs, support all clinical staff attended one hour of weekly clinical supervision. All non-licensed mental health clinical staff who conduct Assessments of Suicide Risk (ASR) have received the required twenty hours training including five ASR and/or crisis assessments in the physical presence of the DMHCA. All non-licensed mental health and substance abuse clinical staffing is in accordance with the current contract.

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

The program has a policy and procedures addressing mental health and substance abuse admission screening. Upon admission, a part of the screening process includes the administration of the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2). A review of seven mental health records found all MAYSI-2 assessments were completed on the day of admission by a clinician in its entirety and entered in the Department's Juvenile Justice Information System (JJIS). Documentation in each of the seven records support the clinical staff reviewed available collateral information. Each of the seven records indicated the MAYSI-2 assessments were completed by trained staff. Three of the seven reviewed MAYSI-2 assessments indicated further assessment was required, while the remaining four indicated no further assessment required. As part of the program's practice for the admission process, all seven youth were referred for a new comprehensive evaluation and an Assessment of Suicide Risk (ASR). A review of the interview of the designated mental health clinician authority confirmed the program's admission process.

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

The program has a policy and procedures addressing the process for completing mental health and substance abuse comprehensive evaluations. The program's practice involves each youth receiving a new or updated Comprehensive Mental Health and Substance Abuse Comprehensive Evaluation within thirty days of admission. The comprehensive evaluation includes all elements for both mental health and substance abuse evaluations. During the admission process, clinicians complete a Substance Abuse Subtle Screening Inventory (SASSI), Trauma System Checklist for Children (TSCC), Structured Assessment of Violence Risk on Youth (SAVRY), Reynolds Adolescent Depressive Scale 2 (RADS-2), and Adolescent Psychopathology Scale- Short Form (APS-SF). The findings from the assessment tools, along with the recommendations from the initial psychiatric evaluation, aid in the completion of the comprehensive mental health and substance abuse evaluation. A review of seven records indicated new comprehensive evaluations were completed for each youth by non-licensed clinical staff within thirty days of admission and were reviewed and signed by a licensed qualified professional within ten days. The new comprehensive evaluation includes reason for assessment, relevant background information, behavioral observations, methods of assessment, patterns of alcohol or other drug use, impact on major life areas and risk factors of continued abuse, in addition to, clinical impressions, and recommendations.

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

The program has a policy and procedures addressing mental health and substance abuse treatment. The program assigns each youth to a multidisciplinary treatment team. The treatment team consists of the youth and representatives from program administration, the residential living unit, other staff responsible for delinquency intervention and treatment services, and staff for medical, vocational, education, mental health, substance abuse, and when possible the youth's parent/guardian. A review of seven youth substance abuse and mental health records validated the treatment teams for each youth were made up of the above-mentioned individuals. A review of seven youth records for mental health and substance abuse treatment confirmed five of the seven records contained a properly executed Authority for Evaluation and Treatment (AET) form. Two youth were eighteen, therefore, did not contain an AET. All seven records contained a signed Youth Substance Abuse Consent for Substance Abuse Treatment form and a signed Youth Consent for Release of Substance Abuse Treatment Records form. Properly signed consents were completed for the youth eighteen years of age. The program is licensed by the Department of Children and Families to provide outpatient substance abuse treatment services under Chapter 397 of the Florida Statutes. The Chapter 397 expires on April 7, 2021. Services are provided by qualified licensed and non-licensed clinical staff and include daily group therapy, weekly individual therapy, and monthly family therapy all documented on the

correct form. A review of seven records documented mental health groups contained ten or fewer youth and substance abuse groups contained fifteen or fewer youth. All staff providing the services are qualified to provide substance abuse treatment. Six of the seven reviewed treatment plans confirmed all services are being provided to each youth as prescribed, however, one youth did not receive family therapy for the months of June or July. The program provided documentation the clinical staff attempted to contact the youth's family each week for both months. Each of the seven interviewed staff reported direct care staff do not facilitate mental health or substance abuse groups. All seven youth interviewed, report participating in group, individual and family therapy. A review of the designated mental health clinician authority's interview confirmed the various treatment services provided and who facilitates the services.

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

The program has a policy and procedures addressing treatment and discharge planning. The process includes each youth receiving an initial treatment plan upon admission and an individualized treatment plan within thirty days of admission. A review of seven youth mental health and substance abuse records confirmed each record contained an initial treatment plan completed on the day of admission, on the appropriate form, which included all required elements. The documentation requirements include the youth's demographic information, reason for treatment, initial diagnostic impression or presenting symptoms, current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis and symptoms, initial treatment methods, and initial treatment goals. Six of the seven initial treatment plans were signed by the clinician completing them and treatment team members who participated in creating the plan. One of the seven youth's initial treatment plan was never signed by the designated mental health clinician authority (DMHCA). Two of the seven plans were prepared by non-licensed clinical staff and were countersigned by the designated mental health clinician authority (DMHCA) within ten days of completion, while five of the initial plans were completed by the DMHCA. Documentation for psychiatric needs were included on all applicable initial treatment plans.

All seven records contained an individualized treatment plan completed within thirty days of admission. A review of seven mental health and substance abuse records confirmed each youth's individualized treatment plan was completed on a form which included all elements required by the Department. The individualized treatment plan information included documentation of youth demographics, current DSM diagnosis and symptoms, mental health and/or substance abuse treatment goals, mental health and/or substance abuse treatment methods or interventions, psychiatric services, and strength and needs of both the youth and family. Each of the individualized treatment plans were signed by the mental health/substance abuse clinical staff completing the plan and all other treatment team members who participated in the development of the plan. A review found three of the seven individualized treatment plans

indicated they were completed by a non-licensed clinical staff, and each were reviewed and signed by a licensed qualified professional within ten days of completion. The four remaining plans were completed by a licensed mental health clinician. Six of seven mental health and substance abuse records contained documentation each youth was receiving the services prescribed in their individualized treatment plan, while one youth was found to have not received family therapy for the months of June and July. The program provided documentation the therapist made weekly attempts each month to contact the family with no success. Reviewed documentation confirmed individualized treatment plan reviews are completed every thirty days in order to document the youth's progress towards their goals and objectives. All individualized treatment plan reviews contained the following required elements: documentation of a current DSM diagnosis and symptoms, mental health and/or substance abuse treatment goals with documentation of progress made by each youth in meeting each treatment goal, and any changes in mental health and/or substance abuse treatment methods or interventions, psychiatric evaluations, and recommendations, as required. A total of thirty-four treatment plan reviews which were all completed within the thirty-day time frame.

A total of three closed youth records were reviewed. All records contained documentation reflecting discharge instructions from the Mental Health/Substance Abuse Discharge Summary, were discussed at the exit conference, with all appropriate parties, were documented on the appropriate form, and copies of the mental health/substance abuse treatment discharge summaries were provided to each youth, juvenile probation officer, and the parent/guardian, as allowed, upon their release from the program. Each discharge summary considered the services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by each youth during treatment. None of the youth were considered at risk for suicide upon their release.

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 has a policy and procedures addressing Substance Abuse Treatment Overlay Services and Comprehensive Mental Health Services for specialized treatment services. Intensive mental health services are defined in the programs comprehensive plan for mental health and substance abuse services plan as youth with a Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5) diagnosis who demonstrate serious symptoms of the disorder and impairment in social, emotional, and/or adaptive functioning of substantial degree and duration. The functional impairment is expected to continue for at least six months and not a temporary response to a stressful situation. The designated mental health clinician authority (DMHCA) reported the program provides intensive mental health services and substance abuse overlay services as a means for specialized treatment services. The DMHCA is on-site five days a week, for a minimum of forty hours a week, and is available twenty-four hours a day to guarantee the appropriate coordination of mental health and substance abuse services at the program. The DMHCA conducts Assessments of Suicide Risk (ASR) and Crisis Assessments, in addition to scheduling and training staff. The DHMCA performs quality assurance services including fidelity monitoring for evidence-based group interventions. Each admitted youth participates in the development of an individualized mental health and/or substance abuse treatment plan. The treatment plans outline services for individual, group, and family therapy. The program offers each youth, at minimum, weekly individual therapy and group therapy seven days a week for fifty minutes. In addition, applicable family therapy sessions are provided

monthly. The program has mental health clinical staff readily available and on-site seven days a week for supportive counseling, therapy, and crisis interventions. An on-site recreational therapist is available to provide as-needed therapeutic activities for the youth. Each mental health clinician's caseload does not exceed twelve. The DMHCA confirmed during the annual compliance review period, the lower census of youth in the program, the mental health clinician's caseloads consist of five youth for each therapist. Therapists caseloads do not exceed more than sixteen youth for Substance Abuse Treatment Overlay Services. All seven mental health and substance abuse records confirmed each youth receives specialized treatment services. Nursing services are provided twenty-four hours a day, seven days a week. The program has full-time licensed mental health clinicians and who are on-site, seven days a week. The program has a psychiatrist who provides psychiatric services and is available twenty-four hours a day. The psychiatrist provides evaluations, medication management, participates in treatment planning for youth applicable who receive psychotropic medication.

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

The program maintains a policy and procedures addressing the provisions of psychiatric services. The provider contracts with a licensed psychiatrist to deliver services to the youth in the facility. The services provided include an initial psychiatric evaluation, follow-up evaluations, referrals, medication management, treatment planning, and supervision of treatment for youth on prescribed medications. The psychiatrist, who is licensed under Chapter 459, Florida Statutes, meets all requirements outlined within the Florida Administrative Code with a clear and active license expiring on January 31, 2022. A copy of the contract between the provider and the psychiatrist was available for review while on-site. The program's psychiatrist is required by their contract with the State of Florida to split forty hours between Tampa Residential Facility and Les Peters Academy. The program currently has their own contract for the psychiatrist to provide twenty-four hours of coverage, with an allowance for an additional four hours, if needed. The basic coverage expectation is for twenty hours at Tampa Residential Facility, and the remaining four hours a week for Les Peters Academy. An interview with the psychiatrist confirmed these are his contracted hours with the program. A review of key logs for sign-in and sign-out documentation reflected the psychiatrist is only on-site at Tampa Residential Facility for eight to fifteen hours a week. The program was unable to present any documentation to reflect more hours being worked. The documented hours the psychiatrist is on-site do not meet the requirements of the contract, or their individual contract with the psychiatrist. The program has a medical doctor (MD) with a clear and active license expiring on January 31, 2021 who serves as the backup for the psychiatrist.

Seven mental health records were reviewed and confirmed four of the seven youth entered the program on psychotropic medication and as a result, were seen within fourteen days of the mental health referral. The other three youth did not enter the program on psychotropic medication, therefore, each of the three youth received an initial psychiatric evaluation as part of the program's admission process. All initial diagnostic interviews were documented on the Clinical Psychotropic Progress Note (CPPN) and clearly identified as Initial Diagnostic Psychiatric Interview with the following information; youth history, mental status examination, a

Diagnostic and Statistical Manual of Mental Disorders (DSM–5) diagnosis, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring. Three of the seven youth entered the program on psychotropic medication with four youth being placed on psychotropic medication post admission. Page three of the CPPN was used to document the prescribing of or changes of prescriptions. The psychiatric evaluations for each youth taking psychotropic medications included a discussion on the required elements, prescribed medication, an explanation for the need of the medication, and the frequency of medication management. The program sent written parental notifications, as required, for all medical interventions. When medications were prescribed or altered, the program made telephonic contact attempts to the youth's parent/guardian in order to receive consent. All applicable youth's parents/guardians provided verbal and written consent for medications. All records contained the required consent for the provision of psychotropic medications. A review of the last six months of records and psychiatric progress notes verified the psychiatrist consistently conducted follow-up visits every thirty days for medication management on all applicable youth.

A review of each mental health and substance abuse record confirmed the psychiatrist provides input to the treatment team on the psychiatric status of each youth receiving psychiatric services; in addition; the psychiatrist's evaluation and recommendations for each youth is included in the youth's individualized mental health or substance abuse treatment plan. The program does not have a psychiatric advanced practice registered nurse. A review of all records revealed the psychiatrist actively participates in, manages, and supervises psychotropic medication services within the program.

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

The program has a suicide prevention plan in place detailing the program's suicide prevention procedures. The plan outlines how the program will safely assess and protect youth with elevated risk of suicide. The prevention of suicide plan received an annual review by the executive director and the designated mental health clinician authority on July 2, 2020. The plan included procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process.

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

The program maintains policy and procedures regarding the provisions of suicide prevention services which addresses the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. A review of seven youth mental health and substance abuse records found documentation each youth received a referral for an Assessment of Suicide Risk (ASR) upon admission, as part of the program's admission practice. Each of the youth remained on standard supervision based on the results of the initial ASR. One of the seven reviewed records confirmed one youth was later placed on precautionary observation since the time of the last annual compliance review. The six youth remained on standard supervision as a result of the initial ASR evaluation and were not applicable for precautionary observation, therefore, the program provided two additional applicable youth records for precautionary observation review. All three applicable ASRs were completed within twenty-four hours using the Department's ASR form. Each youth on precautionary observation was screened and subsequently maintained on precautionary observation. All three youth were placed on constant supervision and the precautionary placement was authorized by the designated mental health clinician authority (DMHCA), mental health staff provided supportive services, and a conference between the licensed mental health professional and DHMCA was documented to reduce the level of supervision, when applicable. When the youth's follow-up ASR indicated suicide precautions may be discontinued, the youth was stepped down to close supervision prior to transition to normal routine/standard supervision. All follow-up ASRs included all required elements and the discontinuation of close supervision was documented. The parent/guardian and juvenile probation officer (JPO), if applicable, were notified of each youth's potential suicide risk and an alert was entered and updated as required in the Department's Juvenile Justice Information System (JJIS). The ASR and all follow-up ASRs were completed by a non-licensed mental health clinical staff, which were subsequently reviewed by the program's DMHCA within twenty-four hours. Each youth maintained on precautionary observation could participate in select activities with other youth in designated areas of the program and was not limited to an individual cell or restricted to their room.

The program has four suicide response kits, one located in each of the buildings. Each of the suicide response kits contained a knife-for-life, wire cutters, and needle nose pliers. The program's written suicide prevention plan, written mental health crisis intervention plan, and written emergency mental health and substance abuse services plan addresses the review process for every serious suicide attempt or serious self-inflicted injury and mortality review for a completed suicide. A multidisciplinary team review includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant 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. All seven interviewed staff responded they would notify either the mental health staff, medical staff, or the supervisor should youth express suicidal thoughts, and each staff were able to identify the location of the program's suicide response kits.

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

The program has a policy and procedures addressing the suicide precaution observation logs. A review of three records supported each were supervised, with this supervision being documented on a Suicide Precaution Observation Log, for the duration each youth was on suicide precautions. Each record contained when warning signs are observed, with appropriate notifications made to the program director/designee, and mental health staff. Each reviewed form had safe housing areas documented. A review of one of the three applicable youth precaution observation logs confirmed one of the youth's close supervision checks log did not have or was missing the step-down from suicide precautions and/or mental health alert status box, the Department of Juvenile Justice identification number, date of birth and race completed on the form. The other two youth forms were completed in their entirety, as required. Informal interviews with each of the youth placed on suicide precaution confirmed each always had staff with them at all times and none were never left alone for any period of time.

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

The program has policy and procedures in place addressing suicide prevention training for staff to recognize verbal and behavioral cues for suicide risk, prevention, and implementation of suicide precautions. Each of the seven pre-service and in-service staff training records were reviewed and confirmed each staff received at least six hours of suicide prevention training in the Department's Learning Management System (SkillPro) with four of the hours being instructor led and the other two hours as web-based. Since the last annual compliance review, the program had a total of twenty-six mock suicide drills. A total of four separate quarters of mock suicide drills were reviewed. The program operates on three shifts. The first quarter (January-March 2020), third shift, a mock suicide drill was not conducted, however, first and second shift in the same quarter completed the required mock suicide drills. The second and third quarters for all shifts completed all required mock suicide drills. The fourth quarter has not concluded; therefore, the program still has time to complete their mock suicide drills. The mock suicide drill training documentation supported staff participated in drills, as required. The program reviewed drills during the monthly all-staff meetings for those staff who missed the last drill conducted. Interviews with seven staff confirmed the program is conducting mock suicide drills one to three times per month.

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 utilizes a crisis intervention plan which includes a notification and alert system, means of referral, including youth self-referral, supervision, documentation and review. The crisis intervention plan was signed on July 2, 2020 by the designated mental health clinician authority and the facility administrator to meet the annual review requirement.

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

The program has a policy and procedures addressing crisis intervention services. Procedures include staff should utilize the Department's Crisis Assessment form. None of the seven original youth were applicable for crisis assessments; therefore, the program provided the only two available applicable youth records for review. The provided assessments included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, initial clinical impressions, recommendations for supervision, treatment, follow-up for further evaluation, and notification to each parent/guardian of follow-up treatment. The supervision was documented on the Mental Health Alert Observation Log, and an alert was entered in the Department's Juvenile Justice Information System. Both crisis assessments were conducted by the designated mental health clinician authority (DMHCA) within two hours. Each youth remained on alert until the follow-up mental status exam was completed by the DMHCA and the facility administrator to confer with the step-down of each youth within the twenty-four hour time frame.

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

The program has a detailed emergency care plan which addresses mental health and substance abuse emergency care. The plan was reviewed and signed by the executive director

and the designated mental health clinician authority (DMHCA) on July 2, 2020 to meet the annual review requirement. The plan contains all the required elements outlined in the Department's Rule and includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, staff training to include mock drills, Baker Act and Marchman Act, and program administration review of each incident.

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

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

Standard 4: Health Services

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

The program has a written policy and procedures ensuring a health authority be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on October 13, 2017. The DHA holds a clear, active, and unrestricted license in the state of Florida, with a license expiration date of January 31, 2021 and is a medical doctor with specialty training in internal medicine. The certificate of liability insurance expires November 17, 2020. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications, and chronic medical medications. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately six hours weekly. Reviewed physician sign-in logs for the past six months supported the DHA was on-site weekly, as required. An interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, periodic evaluations, sick call, reviews healthcare policies and procedures, and nursing protocols. In the event the DHA is unable to be on-site, duties have been delegated to a medical doctor to provide coverage. The medical doctor assigned to provide coverage holds a clear, active, and unrestricted license in the state of Florida, which expires on January 31, 2021. This medical doctor has a specialty training in family/general practice.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported the DHA signed all healthcare policies and procedures on June 19, 2020 and the facility administrator documented a review on June 17, 2020. The psychiatrist documented a review of psychiatric facility operating procedures on June 17, 2020. New policies and changes in policies made during the year were reviewed and signed by each nurse. The program maintains seven full-time registered nurses (RN) and two part-time registered nurses. One RN serves as the program's health services administrator (HSA). The program provides on-the job training where newly employed healthcare staff receive a comprehensive clinical orientation to the Department's healthcare policies and procedures. The program hired two new nursing staff since the last annual compliance review. Reviewed training records supported both staff received the required pre-service and orientation training to include on-the-job training. The program maintains a nursing protocol manual last approved by the DHA on June 19, 2020. Current treatment protocols were last reviewed by the DHA on June 19, 2020.

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

The program has a policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent/guardian and serves as consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as documented on the Release of Information Authorization for Youth Eighteen Years of Age and Older form. The form addresses to whom the information can be released and shared. A review of seven youth healthcare records found each was applicable for a signed AET. Each reviewed youth healthcare record contained a copy of the signed AET and the word “Copy” was clearly stamped on each. There were no original AETs maintained in the youth’s individual health care records (IHCR) reviewed. Each reviewed AET and/or Release of Information form was filed in each youth’s healthcare record in the appropriate section. Three additional records of youth who were in the custody of the Department of Children and Families were reviewed. All applicable consents were obtained by the court. The interview with nursing staff indicated the registered nurses validate AETs prior to admission through the Department’s Juvenile Justice Information System. The program’s case manager would contact the youth’s juvenile probation officer if the AET is not valid.

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 policy and procedures ensuring the parent/guardian is informed of significant changes in the youth’s medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. All seven reviewed healthcare records were applicable for parental notification. Five reviewed youth healthcare records required parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent. Reviewed documentation of the seven records supported each parent/guardian was notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic condition.

Verbal parental/guardian consent is obtained by medical staff as soon as possible after an order is written. Documentation supported verbal consent was obtained for any over-the-counter medication which has not been previously approved. Written notification was sent to the parent/guardian after the verbal consent was obtained or there were attempts to obtain the verbal consent. Verbal and written notification to the parent/guardian was documented for new prescriptions, significant dosage change, or for discontinuing a medication, a parental notification is completed. Two reviewed youth healthcare records were applicable for off-site emergency care and reviewed documentation supported the parent/guardian were notified. The program had no other youth applicable for emergency care since the last annual compliance review. Documentation supported attempts were made to verbally contact the parent/guardian

prior to a youth leaving for the emergency room (ER). The parent/guardian was contacted upon the youth's return with the results of the ER visit. Written notification was completed after the return from the ER. Two youth required dental procedures and documentation supported medical staff contacted the parent/guardian to obtain consent. All seven healthcare records contained documentation to support consent was obtained whenever the psychiatrist prescribed a new medication or a new psychotropic medication was prescribed, discontinued, or the drug dosage was significantly changed. Documentation supported the required parent/guardian consents were obtained for each youth. The reviewed healthcare records documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parents/guardians received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Documentation in all seven youth healthcare records supported the nursing staff obtained each youth's immunization record from the Florida Shots website. There was one youth requiring immunizations. Documentation in the youth's healthcare record supported nursing staff attempting to obtain consent to provide the immunization. There were no applicable reviewed healthcare records of the parent/guardian not consenting due to religious reasons.

The interview with nursing staff indicated parents/guardians are notified within twenty-four hours with a written parental notification of all youth doctor's visits, off-site visits, and emergency situations. Verbal notification is made as soon as possible in addition to the written notification when any emergency medical incidents take place. The nursing interview indicated the procedure regarding obtaining parent/guardian consent for psychotropic medication includes completing a witnessed verbal consent before medications are administered. The parental notification/consent form is mailed certified.

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 policy and procedures ensuring each youth is screened upon admission for healthcare concerns and to ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the program. A review of seven youth healthcare records supported each youth received an initial admission screening, utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). All seven youth healthcare records, documentation supported the RN notified the designated health authority (DHA) by telephone or verbally, if on-site. During the notification, the DHA was informed of the youth's current medical condition, youth who were admitted taking medication and those with chronic conditions. Notification was documented on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. The interview with nursing staff indicated the nurse begins the admission process within ten to fifteen minutes of the youth's arrival to the facility. The nurse indicated when there is a change in physical custody since the youth's admission, a new FEPHS would be completed to include the body chart. One of the seven reviewed healthcare records were applicable for a change in custody with the one youth having two incidents. An additional record was reviewed, and the youth had two separate incidents. Each record found both youth received a rescreening upon admission utilizing the FEPHS form for all three re-admissions back to the program.

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 establishing a system for all youth to be oriented to the facility's healthcare system upon admission or the next available opportunity. A review of seven youth healthcare records validated each youth received a healthcare orientation on the day of admission. This two-page orientation was signed by the nurse and the youth. Each youth received a health education packet specifically designed for male adolescents. The training topics included in this packet was documented on the Department's Health Education Record form in all seven records.

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 practice for the designated health authority (DHA) to be notified by telephone or verbally, if on-site, of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is notified by telephone. A review of seven youth records supported the registered nurse (RN) notified the DHA by telephone or verbally, if the DHA was on-site during the admission process. During the notification, the DHA was informed of the youth's current medical condition, youth who were admitted taking medication and those with chronic conditions. Notification was documented on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. Documentation in three of the seven youth healthcare records supported the psychiatrist was notified about youth being admitted taking psychotropic medication. The psychiatrist made a verbal order to maintain the medication until they completed the initial psychiatric evaluation.

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 policy and procedures ensuring nursing staff complete the Department's Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA). A review of seven youth healthcare records supported a new HRH form was completed for each youth on the same day of each admission. The nursing staff who completed the form provided their electronic signature on the HRH forms. The DHA documented a review of the HRH forms on the completed CPAs. There were four youth who had their HRH updated when significant medical changes took place. The updates on the HRH were made by nursing staff. An interview with nursing staff confirmed the HRH is completed upon intake and whenever any new significant medical event or change occurs.

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

The program has a policy and procedures ensuring youth receive a comprehensive physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program has a policy and procedures indicating each youth receive a routine healthcare screening and evaluation for latent or active tuberculosis. A review of seven youth healthcare records supported the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. The designated health authority completed a new CPA for each youth during the initial intake evaluation. All sections of the CPA were completed in full utilizing the required symbols of "O" with no applicable symbols of "X" and included the appropriate medical grade of one through five. All seven reviewed CPAs did not complete sections numbers twenty-three, twenty-four, twenty-five, and twenty-six and each documented these were deferred by the clinician on the CPA. The reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable. A review of the seven youth healthcare records supported six youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. The nursing staff utilized the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening as part of the healthcare admission screening. All tier I tuberculosis screenings were conducted on the day of admission for each youth. One youth required an updated TST during the admission process. The completed test was documented as required. The reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. There were no youth in the program with symptoms suggestive of active TB. Program procedures outline if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the designated health authority. Nursing interviews indicated nursing staff review TST results prior to the youth's admission. If the youth has a negative reading within the last year, then the youth will not be screened. Youth are screened annually.

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 ensuring all youth receive sexually transmitted infection (STI) screenings, evaluations, and testing. The designated health authority (DHA) shall decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of seven youth healthcare records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation, testing was ordered, and was performed for four of the seven youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all four youth. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews confirmed the program's practice.

The program maintains a policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling and testing. A review of seven youth healthcare records supported each youth was offered the opportunity to receive counseling and testing for HIV. Of the seven records reviewed, four youth consented for testing. The program utilizes the community provider Metro Wellness to provide pre-counseling, testing, and post-counseling services. All four reviewed youth healthcare records contained documentation on the youth's Health Education Record to support youth received pre-counseling, testing, and post-counseling. The results were placed in a sealed envelope marked "confidential" with the youth's name and test date documented on the outside of the envelope. Nursing staff maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, and post-testing date.

Nursing staff interviews indicated the youth are asked upon admission if they want testing. The youth signs a consent form which is added to the HIV log. Metro Wellness comes on-site and administers testing and counseling. Youth may put in a request anytime to be retested. Youth confidential results are given to the youth upon discharge. The interview indicated Metro Wellness would contact the DHA if the youth required further treatment. All seven interviewed youth indicated they can request HIV testing.

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

The program has a policy and procedures ensuring there is a system in place to respond to the complaints of a youth illness or injury of a non-emergent nature. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA).

The program offers youth the opportunity to make a sick call request, seven days a week, three times daily at 7:30 a.m., 11:30 a.m., and 5:00 p.m. Sick call is conducted by the registered nursing staff. A review of seven youth healthcare records found three youth completed a Sick Call Request form at least once during their stay. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. Reviewed healthcare records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed in the program's healthcare record. The program has nursing staff available twenty-four hours a day, so there is no need for program staff to review Sick Call Requests. The program maintains Sick Call Request forms in the cafeteria. Youth are able to submit Sick Call Requests through a mail slot located in the clinic door, located in the cafeteria. Documentation supported youth who submitted a Sick Call Request were seen within twenty-four hours of submission. There were no Sick Call Requests submitted during the week of the review; therefore, the Sick Call Process could not be observed. Nursing staff interviews indicated youth

can submit a sick call at any time by placing the form in the locked box. The box is monitored by the nurses at regular intervals. Sick Call Requests are prioritized and addressed within twenty-four hours. All seven interviewed staff indicated nursing staff conducts Sick Call. All seven staff indicated they can call 9-1-1 if needed. Seven youth were interviewed and two reported being seen within twenty-four hours of submitting the Sick Call Request and five youth stated they would be seen immediately.

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 policy and procedures addressing episodic and first-aid care. The plan addresses providing twenty-four-hour emergency medical, mental health, and dental care to youth, as needed.

A review of seven youth healthcare records found six youth requiring episodic and/or first-aid care during their stay in the program. All treatment services were provided by nursing staff. The nursing progress notes documented treatment services provided in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff maintained an Episodic/First-Aid/Emergency Care Log. All incidents of care were documented in the log. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log. Nursing interviews confirmed the program's practice. All seven interviewed youth indicated they are able to see a dentist and doctor when needed.

The program maintains four automated external defibrillators (AED). An AED was located in each of the three dorms and in master control. Nursing staff ensure the AED is functioning adequately by completing a monthly self-test. Documentation supported monthly tests were completed to include the inspection of the batteries and pads to ensure they are in working order. The AED procedures were observed to be attached in a booklet located on the inside cover of the AED. Reviewed AED batteries expire on September 20, 2024 for one AED and February 8, 2021 for the other three. Reviewed AED pads expire July of 2021 for all the AEDs. The AED batteries were last changed February 18, 2017 and August 21, 2018. The AED pads were last changed June of 2020.

The program maintains four first aid kits located in each dorm, and master control. The first aid kit for the vehicle is maintained in master control when the vehicle is not in use. An inspection of three first aid kits supported each contained the required items and all items were current and within their expiration period. A list of the items contained in each first aid kit was in the inside cover of the first aid kit. Documentation supported each first aid kit was inspected by nursing staff on a weekly basis.

The program maintains four suicide response kits located in each of the three dorms and master control. All three first aid kits reviewed contained the required contents. Observation of one suicide kit found it contained a knife-for-life, wire cutters, needle nose pliers, and first aid supplies. The suicide response kits are checked monthly by nursing staff.

Seven staff pre-service training records and seven staff in-service records were reviewed. The reviewed training records of the non-healthcare staff who have direct contact with youth

contained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current certifications in CPR and AED.

The program conducts announced and unannounced emergency medical drills monthly on each shift. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. Observations made during the annual review found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in master control, the medical office, and clinic areas making the lists accessible to staff but inaccessible to youth.

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 policy and procedures ensuring timely referrals and coordination of medical services to an off-site healthcare provider. A review of seven youth healthcare records found four youth received off-site dental care and one youth requiring off-site emergency care. All off-site care events were documented in the healthcare records. One of the five youth who received off-site care was eighteen years of age and parental notification was not required. The other four youth were under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care form was completed for each youth and filed in the appropriate section of the healthcare record. Each Summary of Off-Site Care form and applicable discharge paperwork was reviewed by the designated healthcare authority as evidenced by signature and date. Two youth who went to the dentist required follow-up care and appointments. Documentation supported all follow-up care and appointments were provided to the youth after the program received parental consent. The youth who required emergency care required follow-up care which was provided by the program's nursing staff. An interview with nursing staff indicated they track youth who require follow-up care using the episodic log and trackers.

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

The program has a policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. A review of seven youth healthcare records indicated one of the youth were admitted with an identified chronic condition; however, all seven youth were classified with a medical grade of two through five. Four of the seven youth were taking psychotropic medication. Two youth were receiving treatment for a body mass index greater than thirty. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. The reviewed records supported each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated chronic conditions are monitored at a minimum every sixty days and some youth will be monitored more frequently if needed. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth. The DHA indicated formal meetings are conducted with the facility administrator on a quarterly basis. The purpose of the meeting is to discuss the youth. There was no indication of lapses in care or missed periodic evaluations. The

reviewed documentation supported the Department's Problem List was updated as required. An interview with nursing staff reported youth identified with a chronic condition are placed on the medical tracking log and follow-up evaluations are completed based on the periodic tracker.

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 policy and procedures addressing medication management. The policy requires medical staff to verify any medications arriving with a newly admitted youth. A review of seven youth healthcare records indicated four youth were admitted into the program on prescribed medication. Nursing admission notes documented each youth's current medication and verification with the pharmacy. There was documentation to support the designated health authority (DHA) and psychiatrist, when applicable, was verbally notified of the youth's medication. Reviewed documentation supported the DHA or psychiatrist resumed the prescribed medication for each youth. A review of the youth's Medication Administration Records (MARs) verified the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian.

All seven reviewed youth healthcare records were currently taking medications at the time of the review. The reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. All seven healthcare records contained all the practitioner's orders documenting the medication and dosage. All MARs reflected when a prescribed medication was continued, discontinued, changed, or a new medication was ordered. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side-effect monitoring on the MAR daily each time medication was administered. When youth refused medication, it was clearly documented on the MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. The psychiatrist signed and dated all Refusal of Treatment forms. All over-the-counter medications provided to the youth were approved through the Authority for Evaluation and Treatment (AET) form and nursing protocols. The program utilizes a pre-printed pharmacy MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All seven interviewed staff indicated the nurse dispenses medication to the youth. Observation of medication administration validated the program's practice. Medication administration was conducted by nursing staff. The Six Rights of Medication Delivery/Administration was maintained for each youth. The program does not utilize restrictive housing. All seven interviewed youth stated they receive their medication from the nurse.

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 policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter (OTC) medications were placed in the locked medical cart for trained authorized non-licensed staff to administer, if needed. Narcotics and other controlled medications are securely stored in the medication cart. The program practice is to store controlled mediations in a locked box located in the locked medication cart. The program had youth with prescribed controlled medications during the annual compliance review week. The controlled medications were observed to be locked in a locked box located within the locked medical cart. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There was one medication requiring refrigeration during the annual compliance review week and was observed in the refrigerator. The program securely stored sharps and syringes separate from medications. Reviewed documentation and nursing interviews confirmed all OTC medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly, usually on Sundays. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN). If there is only one RN on-site, the inventory is completed by the RN and the shift supervisor. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires September 30, 2021. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. All expired medication is returned to the pharmacy or destroyed once a month when the pharmacist visits the program. A review of the Medication Destruction Log supported this practice.

Observations found the medications are procured through a pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. Observations found the medical equipment classified as sharps were secured and inventoried using a routine perpetual inventory descending count. A comparison was made of the documented inventory of two youth medications, three over-the counter medications, and three sharps with the actual number in stock. No exceptions were noted. Observations of the medication cart found it clean and organized with medications separated. The program maintains one refrigerator in the medical clinic for the storage of medication. There was no medication requiring refrigeration during the annual compliance review week. A review of the program's counts of medication from the past six months validated no discrepancies were identified with the counts. Observation of medication administration by nursing staff validated the medical staff followed the Six Rights of Medication Delivery/Administration for each youth. An interview with the nursing staff validated the practice of the medication storage and inventory process.

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 be provided at the time of intake and subsequently when the need is identified.	

The program has a policy and procedures ensuring there is an approved plan for exposure and infection control. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Center for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The program's plan has a comprehensive process for needle stick post-exposure. The plan was reviewed and approved by the current facility administrator (FA) on February 10, 2020 and designated health authority (DHA) on July 10, 2017. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans.

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

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

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

The program utilizes a total of nine registered nurses (RN) to provide medical care at the program. One RN serves as the health services administrator (HSA). There are seven RNs who work full-time and two RNs who work part-time. Each RN has a clear and active license in the state of Florida, seven of which expires on April 30, 2021, one which expires April 30, 2022 and one which expires July 31, 2022. Each RN has a current cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED) certification. The contractual requirements are being met.

Standard 5: Safety and Security

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

The program has a written policy and procedures stating how the program will maintain active supervision of youth at all times. Observations of staff during the annual compliance review found staff supervising youth appropriately during all observed activities. According to the policy and procedures provided to the annual compliance team, staff-to-youth ratios are as follows: one to seven during awake hours, one to eight during sleep hours, and one to five for off-site activities. Observed activities made during the four-day annual compliance review included: supervision of youth during school hours, in the cafeteria, upon return from a youth transport, and youth movement through the facility. A video review of supervision during sleeping hours found the required staff-to-youth ratio was maintained. The daily schedules were posted in the dorm and cafeteria. At no time during the annual compliance review, were youth observed wandering freely about the program. Each of the seven interviewed staff confirmed their understanding of the procedures when there is a discrepancy with the head count. All the staff indicated the count is reconducted until the count is reconciled. Observations found the counts were conducted at scheduled and unscheduled times and the shift supervisor was able to give an accurate count when asked. Informal interviews with two staff found they were aware of the number of youth under their supervision immediately without having to stop and count.

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 to address the behavior management system (BMS) or positive performance system (PPS). The PPS fosters accountability for behavior and compliance with the residential community's rules and expectations. The PPS was observed posted in the dorm, administration, and cafeteria. The PPS is clearly explained in the resident handbook, which is accessible to youth and a copy provided to the youth upon admission. The program's PPS details the rules and the positive and negative consequences for actions. Seven pre-service training records and seven in-service training records were reviewed, and these reflected staff are trained on the PPS upon hire and annually thereafter. All seven interviewed staff confirmed they received training and understanding of the PPS. All seven staff stated the PPS is a point system with six levels. Staff reported the PPS system is updated daily in the dorms with youth progress earning points and levels. Informal interviews with staff during the annual compliance review week confirmed their understanding and implementation of the PPS. The orientation checklist documents the PPS is reviewed with the youth. All seven reviewed youth case management records contained a complete orientation checklist. The PPS promotes

youth rights, positive and negative consequences, constructive disciplinary action, opportunities for reinforcement, positive dialogue, and peaceful resolutions; as well as providing youth with pro-social acceptable alternative behavior to help maintain order and security and minimize the separation of youth from the population. Youth have an opportunity to explain their behavior. The PPS is connected to each youth's individual performance and treatment plan goals. The PPS includes a variety of rewards including daily snacks, meals, point store, fun days, movies, verbal praise, and special privilege activities. Youth who earn the top level, can petition to live in the honors dorm; however, during the review, the honors dorm was down for repairs. The facility administrator interview stated the program utilizes a positive performance system. He indicated it is a level system which allows youth to advance on levels and receive increased privileges by earning positive days. Youth earn points for each positive day earned and these points are then able to be used as part of the point store. A daily, weekly, and monthly incentive is provided to youth who earn them. Seven of the eight interviewed youth indicated they earn snacks or meals, recreation time, television time, daily incentives, weekly incentives, and monthly incentives. One youth stated positive re-enforcement of the PSS does not offer enough incentives because everyone gets snacks and meals, not many other incentives offered. The remaining youth refused the remainder of the interview prior to this question. Seven staff were interviewed for their understanding of the PPS. Each of the respondents were able to explain the six different levels of the system and how the youth move through the program. The seven staff shared information regarding the incentive's youth can earn as a reward for positive behavior. These included snacks, dorm parties, extra phone time, water balloon fights, and other special activities. The seven staff indicated nothing is taken away from youth as a consequence for negative behavior.

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 policy and procedure stating the program does not use room restriction which was confirmed by youth and staff interviews and observations. The recreation therapist tallies weekly points earned by youth. At the end of each week, the point sheets are posted in the dorms for youth to review and are filed in each youth's case management record. Youth and staff interviews confirmed their understanding of the positive performance system (PPS). An interview with the facility administrator (FA) confirmed rewards are tracked daily and the program tracks the number of youth making their day/week in the PPS database. The facility administrator interview reflected consequences are monitored during the morning management meeting, as well as during special and regular treatment teams. The program's PPS does not include increasing a youth's length of stay, denial of basic rights, promotion of group punishment, or disciplinary confinement. Eight youth were interviewed; four of them rated the PPS as good, one rated the PPS as very good, and two youth rated the PPS as fair. The remaining youth refused the remainder of the interview prior to this question. All seven

respondents stated they have a good understanding of the PPS levels, and all knew the rewards and incentives they can receive for positive behaviors. Each of the seven respondents stated staff use the rewards consistently and they are not allowed to punish other youth. Each of the seven interviewed staff indicated they received feedback on their implementation of the PPS daily and as needed. The program's PPS includes a process where staff explain to the youth the reason for any sanction imposed. They indicated youth are given an opportunity to explain their behavior, and staff and the youth discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behavior. All seven interviewed staff confirmed training and understanding of the PPS and indicated there are a variety of rewards and incentives for good behavior.

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

The program has 120 cameras. All cameras were operational at the time of the annual compliance review. The video coverage is stored for thirty days. The program's practice is to conduct checks of youth in their rooms every eight to ten minutes. Video recordings and ten-minute check sheets were reviewed for six nights for different dorms finding no more than ten minutes passed without the staff actively observing each youth. Staff document their checks in writing to reflect when checks are completed. Two dorms were not operational at the time of the review and a review of the video confirmed there had been no youth housed in these dorms. Seven staff were interviewed; all indicated room checks are completed every six to ten minutes. The facility administrator interview confirmed the program has 120 cameras with video coverage stored for thirty days. The FA confirmed the program's practice of conducting room checks more frequently than every ten minutes. An interview with a master control staff indicated they will call a check time to staff to ensure they complete their check on time. If a staff does not get up and complete the called check, master control notifies the shift supervisor who in turn checks in on the staff to ensure the called check is completed prior to the next check.

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 maintains a policy and procedures which address population census, counts, and tracking of youth. The program's policy indicates headcounts will occur and shall be documented at a minimum of six times within a twenty-four-hour period. The program utilizes the master logbook to document youth counts and movements. The logbook is utilized to maintain a chronological record of events as they occur. The program headcounts are conducted by master control staff at the beginning of each shift to verify accuracy and document counts in the program's master logbook. Counts are conducted at beginning of shift, after outdoor activities, and emergency situations. The logbook tracks youth intakes, releases, and movements outside of the facility. The program utilizes alert boards located in the program's conference room and the master control room to track the daily count of all youth in and out of the program. "Warm Body" counts, which is how the program refers to a head count, were observed being conducted during the week of the annual compliance review, with no discrepancies being seen. Staff were aware of all youth whereabouts and were able to provide the proper counts to the annual compliance review team members during the review week. Seven staff were interviewed, and each was aware of count procedures, including what to do in the case of an unsuccessful count.

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

The program maintains a policy and procedures addressing logbook entries and shift report reviews. The program maintains a chronological record of events, incidents, and activities in a master control logbook in accordance with Florida Administrative Code. Logbooks utilized by the program during the last six months were reviewed. Each reviewed logbook is bound with numbered pages and entries were made in ink with no white-outs or logbook entries being removed or missing. Logbook entries included youth movements, admissions, releases, emergencies, security risks, incidents, transports, and staff assignments. The program completes shift reports which are based on relevant information from each shift. On-coming staff participate in a shift briefing and sign shift reports acknowledging they are aware of all

information from the last two shifts and any alert changes. The shift reports for at least the previous forty-eight hours are maintained in the sub-control area in each of the three buildings which house youth. This was confirmed by a review team member. Each reviewed logbook entry was legible and included the time and date of the entry, printed name, and the signature of the staff making the entry. The logbook is maintained by the master control operator and is available for all staff to review whenever needed. Five randomly selected Central Communications Center (CCC) reports were chosen, and each call was found documented within the reviewed logbooks.

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 procedure to address key control. The policy and procedures addressed distribution, tracking, storage, and overall control and security of keys. A review of the inventory matched the key rings in use. The keys are kept in secure storage boxes in the master control area, which is not accessible to youth. Each set of keys has an assigned key hook. Keys are assigned to staff according to their department. Restricted keys, temporary keys, and visitor keys are all kept separate from each other. There were no reports of broken or damaged keys. There were no incidents of lost keys during this review period, which was verified by the review of internal incident reports and Central Communications Center (CCC) reports. A random check of three staff key rings confirmed the keys matched the inventory. The physical plant manager is responsible for replacing broken or damaged keys. Informal interviews with staff confirmed staff's knowledge of the key rings and assigned keys. All observations during the annual compliance review week found personal keys were secured and staff were aware of program keys in their possession. Key control logs documented the issuance and return of keys on a consistent basis. All seven interviewed staff confirmed their knowledge of and implementation of key control policies and procedures. Additionally, staff reported if keys were damaged, they would notify their supervisor and submit a maintenance request. An informal interview with the master control operator indicated assigned keys are only assigned by the facility administrator, restricted keys are kept apart from non-restricted keys, and only assigned staff can access restricted keys. Master control tracks keys as they are signed out and back in by staff prior to receiving their personal keys.

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 system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth, which is clearly explained in the program's policy and procedures and resident handbook. The policy states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal as defined in Florida Statutes. The program's policy and the youth handbook define items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes 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, which are prohibited in the secure area. Staff were able to explain the contraband procedures. The contraband notice is posted on the front gate, which indicates law enforcement will be contacted for anyone bringing in contraband. The facility administrator stated contraband would be logged into a binder for reference and illegal contraband if brought into the facility would result in law enforcement being called for disposal. All searches are documented in search binders (visitation, room, and youth). The binders were reviewed and found searches were documented appropriately. There were two incidents of staff bringing in contraband and giving it to youth during the past six months. These incidents both involved the use of a cell phone and electronic smoking devices. Both incidents were called into the Central Communications Center and the staff were terminated.

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

The program maintains a policy and procedures addressing frisk searches and full body visual searches. The program conducts searches as a method to prevent the introduction of contraband and unauthorized items into the facility. Policy indicates searches of youth are conducted after off-site transports, after visitation, before moving youth from an outside area

into the building, and prior to moving youth from the building to an outside area. The program conducted several off-site transports during the week of the annual compliance review. The review team observed properly conducted searches and full visual searches before and after each transport. The review team observed several youth searches during the week of the annual compliance review. Searches were conducted with each movement of youth from each area of the building, such as the classroom, groups, and dorm. Search procedures and expectations were properly explained to all youth before searches were conducted. Searches were conducted by staff of the same gender as the youth, while a second and third staff member assisted with supervision. Searches were thorough and done in a manner which did not degrade the youth. All searches were documented in the program's master control logbook. Full body visual searches were conducted in the nurse station when each youth returned from transports. Both staff conducting the full body visual searches were the same gender as the youth. Each observed full body visual search was conducted properly, according to policy. All seven interviewed staff reported youth are searched prior to each movement. Each respondent indicated these searches were only done by male staff. Seven of eight interviewed youth indicated searches are conducted for each movement. One of the respondents indicated some staff are more consistent than others on searches. The remaining youth refused the remainder of the interview prior to this question.

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

The program maintains a policy and procedures addressing vehicles and maintenance. The program utilizes one vehicle for youth transports. The vehicle passed an annual inspection on February 10, 2020 and a second inspection was conducted on the same vehicle on September 07, 2020. The vehicle is inspected weekly by the maintenance manager and/or the facility transporter. Results of weekly inspections are documented and stored in the program's vehicle maintenance log/binder. A member of the annual compliance review team inspected the vehicle and all required equipment was observed, which included a seat belt cutter, window punch, and fire extinguisher. The first aid kit is not stored in the van to preserve the items inside of the kit. Staff check out a first aid kit prior to a transport and returns the kit to the program upon return. Staff are required to check out a first aid kit each time the program van is utilized for transport. All seatbelts in the van were in proper working condition. The vehicle had a safety screen separating the youth passengers from the driver. A random check of personal vehicles and the van was conducted during the annual compliance review, and all were found to be locked. A transport was observed by a review team member during the annual review. Staff were observed following proper procedures, including conducting a vehicle inspection before transport and ensuring all passengers were wearing seat belts.

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

The program maintains a policy and procedures addressing transportation of youth. The policy outlines staff to youth ratio during transports as one to five; however, if there are five or less youth, a minimum of two staff perform all transports. The program's transport vehicle was inspected by an annual compliance review team member and the vehicle's rear door could not be opened from the inside, as required. The transport vehicle is equipped with a safety screen separating the driver from the passenger's compartment. The program has an approved transporter list which is updated monthly to ensure staff driver's licenses are valid. This approved driver's list is located in the administrative hallway by the facility administrator's office. An annual compliance review team member observed the assistant facility administrator and facility transporter conduct a routine check of all personal vehicles in the parking lot, including the program's transport vehicle. All vehicles were found locked and secured. Members of the annual review team observed several transports during the annual review. The facility transporter was issued a cellular phone before each observed transport. At least one transporter was the same gender as the transported youth on each trip. The vehicle was inspected before transport and all youth and transporter's wore seatbelts. Interviews with seven staff confirmed they are issued a cellular telephone before transport and staff do not conduct transports in personal vehicles. Each of the seven respondents were aware the vehicle has a first aid kit. The other six respondents were aware of other emergency equipment, to include a fire extinguisher and window punch with a seatbelt cutter. Six of the seven interviewed staff indicated vehicles are searched prior to transport, while the other staff did not indicate this occurs. Six of the seven staff respondents indicated they would call the program if there was an emergency during a transport. Three of these staff indicated the program would send another vehicle to their aid. The other respondent indicated they were not aware of emergency transport procedures, as they had only assisted on one transport. All seven staff indicated they would have at least two staff for all transports. Eight youth were interviewed regarding the transport vehicles. Seven of the youth reported never having seen anyone place contraband in a transport vehicle and all reported feeling staff are safely driving the transport vehicles. The remaining youth refused the remainder of the interview prior to this question.

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

The policy and procedures designate the physical plant manager as the person responsible for conducting the weekly safety and security audits. Observation and review of the weekly safety audits found they are kept in a binder, which was reviewed weekly during the safety committee meeting held on Fridays. The review confirmed this is completed every seven days, and is done on Fridays. This committee consists of the facility administrator, assistant facility administrator, the physical plant manager, and another member of the management team. Findings are discussed and a corrective action plan is implemented to fix any deficiency noted. During the annual compliance review period, there were no inspections missing. The forms documented safety and maintenance repairs needed and the date and time the repairs were completed or were due to be completed. The program has documentation reflecting on-going efforts to get extra keys from the Department since they cannot make copies of them anywhere. All forms were reviewed and signed by the facility administrator. The weekly safety and security audit forms cover radios, cameras, keys, telephones, mechanical restraints, the generator, flashlights,

fire safety equipment, alarms, ensuring no anchor points for youth to be able to self-harm, youth rooms, recreation area, grounds, corrective action needed, and corrective action completed. The interview with the facility administrator confirmed the weekly safety audits are conducted in accordance with program policy and procedures.

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 maintains a policy and procedures to address tool inventory and management. The policy addresses the issuance, inventory, and control of equipment and tools. The program has identified their plant manager as the program's tool control manager. The policy classifies tools into two categories: Class A tools and Class B tools. Class A tools are hazardous with sharp edges or points and with a high potential to be used as a weapon to inflict serious bodily harm such as knives, hammers, screw drivers, and electric drills. Class B tools do not have sharp edges or points such as brooms, mops, and scrub brushes. All tools are secured behind a locked door and are placed beside a photo of the tool to identify proper placement. Class A tools are secured in the plant manager's office. Upon observation, the plant manager's office was neat, clean, and organized. All class A tools were neatly stored on the maintenance office walls with a photo of the tool to identify the tool belonged in the proper place. All class A tools were in good repair and accounted for. All program's class A tools are inventoried daily by the plant manager except on days when the maintenance office is not accessed during the weekends and holidays. Class B tools are inventoried daily by program staff. All program tools are signed out by staff before use and signed back in once they are returned to their proper location. All tools were properly identified during inspection by the reviewer. A review of seven staff training records reflected each of the staff were trained on the safe use of tools. A review of seven youth case management records indicated each youth has been trained on the proper usage of tools during their orientation process, which is reflected with the youth signature on an acknowledgement of tool training. During an interview, the program's plant manager was aware of the proper procedures to follow if tools are missing or damaged, in accordance with the program's policy and procedures. The plant manager stated there were no tools which were currently damaged or out of use. The seven interviewed staff confirmed youth will only use a scrub brush, mop, or broom while under supervision. Seven of eight interviewed youth confirmed they are only allowed to use mops, brooms, and scrub brushes. The remaining youth refused the remainder of the interview prior to this question.

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 maintains a policy and procedures addressing youth tool handling and supervision. The policy outlines proper procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries to youth and staff. The policy indicates the program will use a staff to youth ratio of one to five during any work projects. Seven youth case management records were reviewed, and all records indicated youth have been trained on the proper usage of tools during their orientation process. Youth signed an acknowledgement of tool training during the orientation process. The signed acknowledgement form is filed in each youth's record. Although each youth receives a risk assessment monthly, during the week of the annual compliance review there were no work projects which involved youth and the use of

tools; therefore, no youth were observed handling tools. Seven of eight interviewed youth confirmed they are only allowed to use mops, brooms, and scrub brushes. The remaining youth refused the remainder of the interview prior to this question. The seven interviewed staff confirmed youth will only use a scrub brush, mop, or broom while under supervision. Staff interviews and interview with assistant facility administrator revealed youth are not allowed to use Class A tools.

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 maintains a policy and procedures which address outside contractors. The program has established guidelines for outside contractors which includes information regarding tool control and restrictions. The program has a form to be signed by outside contractors which addresses how tools will be checked upon arrival to and departure from the program, restrictions to youth work area access, immediate reporting of missing tools, restriction of personal cellular telephones and/or equipment capable of taking pictures and/or recording audio/video in secure areas. The form requires contractors to list each tool brought into the facility. This list is reviewed by the plant manager or designee before the contractor has access to a secure area. This list is again reviewed before the contractor exits the program. The contractor's failure to sign this form prohibits access to work within the program. Outside contractors are escorted and supervised by the plant manager or designee any time they are within the facility. The review team was able to observe this process during the annual review and proper procedures were followed according to program's policy. A random sample of five program invoices were cross checked to ensure outside contractor agreements were signed on the date of service. All invoices and contractor agreements matched and there were no discrepancies found.

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 maintains a policy and procedures to address fire, safety, and evacuation drills. The program conducts fire, safety, program disturbances, Continuity of Operations Plan (COOP), and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster. Drills are consistent with the program's COOP. All drills were properly documented in the facility's master control logbook and were each documented on the facility's designated drill form. Each drill form contained the type of drill, a description of the drill, the date the drill was conducted, the time of the drill, and participants' signatures. A review of drills revealed forty various drills were conducted over the past six months. At least one fire drill was conducted on each shift each month. Fire evacuation routes and egress plans were posted throughout the facility. All fire extinguishers were inspected on an annual basis. An interview with the assistant facility administrator verified fire drills are conducted monthly on all shifts. COOP drills are completed monthly. Interviews with seven staff revealed staff have participated in fire, escape, weather, major disturbance, mental health/suicide, and medical drills. Eight youth were interviewed and seven stated they have been instructed on what to do in case of a fire. Four of the youth reported fire drills occur at least once a month, one indicated they are conducted twice a month,

one felt they were done each quarter, and the other youth could not remember any since admission. The remaining youth refused the remainder of the interview prior to this question.

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 policy and procedure addressing the Continuity of Operations Plan (COOP). The policy states the COOP is located in master control and administration. The plan addresses alternative housing plans approved by the applicable Department regional director/designee. The COOP addresses: fire prevention and evacuation, severe weather, disturbances or riots, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protection. The program conducts COOP drills on each shift. The drill documentation included: type of drill, date and time of the drill, participants, brief scenario and findings/recommendations, and pictures. The drills included escape, missing tools, fire, evacuation due to severe weather, lightning, program disturbances, active shooter, and chemical spills. The program has food and necessary supplies readily available in case of an emergency evacuation. The program maintains an administrative hard-copy file for each youth in case of an emergency with all required information which are located in the director of case management office. The facility administrator reported the COOP is located in master control and administration.

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

The program maintains a policy and procedures addressing storage and inventory of flammable, poisonous, and toxic items and materials. The program's flammable, poisonous, and toxic materials are stored in a flame-resistant cabinet. The program maintains proper inventory of these items. The program's plant manager is the only individual authorized to handle flammable, poisonous, and toxic items. A binder is stored in the flame-resistant cabinet containing the Safety Data Sheets (SDS) for the items located in the cabinet. The program stores cleaning supplies in a locked storage room in the administrative hallway. The storage room is locked at all times and can only be accessed by plant manager, supervisors, and canteen operator. The items in this storage room are inventoried and have an accompanying SDS sheet located in the binder. Reviewed documentation confirmed staff sign these items in and out with each use.

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

The program maintains a policy and procedures addressing youth handling and supervision of flammable, poisonous, and toxic materials. The policy prohibits youth using those items and materials. The flammable, poisonous, and toxic materials are stored in a storage room located in the administrative hallway. Youth do not have access to these items and are supervised by staff during daily cleaning. Although youth were not observed participating in facility clean-up during the week of the annual compliance review, youth interviews indicated they are prohibited from using chemicals/cleaning products. Staff spray chemicals and youth wipe the area. Interviews with eight youth revealed one assisted with repainting the living units. It was reported youth on higher levels can assist with certain projects if they are on a high level and can pass the risk assessment. None of the youth reported ever handling any cleaning chemicals.

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 maintains a policy and procedures addressing disposal of all flammable, toxic, caustic, and poisonous items. The policy prohibits chemicals from being poured on the ground or being disposed of by any method other than what is outlined by the biohazard guidelines. The program's plant manager is the only individual authorized to handle flammable, poisonous, and toxic items. The program's plant manager was interviewed on the proper procedures of disposing chemicals and stated all items for disposal are collected by Hillsborough Heights Solid Waste. The plant manager further stated the program has not needed to dispose of any chemicals since the last annual compliance review. An interview with the assistant facility administrator validated this practice.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has policy and procedures to allow visitation and communication for youth while in the program. The visitation procedures are posted at the front door and on the wall in the lobby. The visitation and communication procedures are covered in the resident handbook, parent handbook and addressed on the orientation checklist. Six of the eight interviewed youth confirmed they have opportunities to contact their family by telephone, mail, and during visitation but have not had visitation for several months due to COVID-19. One of the eight youth interviewed said no, they have not had the opportunities to contact their family by phone and mail and during visitation and one withdrew from the interviews prior to answering this question;. The visitation schedule was posted throughout the program; however, due to the COVID-19 pandemic, visitation has been postponed. The visitation, telephone and correspondence logs were reviewed. The logs showed prior to the COVID-19 pandemic, youth

had contact with only approved persons. Incoming and outgoing mail is searched and recorded in the correspondence logs, then given to the youth's case manager who delivers the mail to the youth and has them open the mail in front of them. There were no youth applicable for a history of human trafficking, therefore, the program is not required to request clarification from youth's juvenile probation officer (JPO) about any parent/guardian past or current human trafficking investigation involvement.

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 for the search and inspection of the controlled observation room. The program utilized controlled observation fourteen times in the past six months. The rooms used for controlled observation meet all the requirements. Three controlled observation reports were reviewed. In all three reports, staff documented an inspection of the room, and a search of the youth, before the youth was placed in the room.

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 for controlled observation. Three controlled observation reports were reviewed. In all reports, the supervisor or higher-level staff authorized placement. In all instances, the youth were displaying active aggression, violent behavior, physically out-of-control, and staff advised the youth the reason of placement in controlled observation and expected behavior for removal. In all three reports, a healthcare professional or staff of the same gender as the youth completed the health status checklist. There were no samples of a youth being in controlled observation over two hours. Policy sates the assistant facility administrator or designee would need to grant an extension every two hours.

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 for controlled observation safety checks and releases. Three controlled observation reports were reviewed. In all three reports, the staff making the placement completed the first page of the controlled observation report stating the reason for the controlled observations and submitted it to the supervisor. Staff documented safety checks at least every ten minutes and observations of the youth's behavior. Staff documented all safety checks and observations on the controlled observation safety checks form. The facility administrator (FA) or supervisor who has delegated authority gave written approval before the youth was released from controlled observation in all three reports. The controlled observation report, health status checklist, and controlled observation safety checks were maintained in an administrative file. The assistant facility administrator (AFA) or designee reviewed and approved all three controlled observation reports within fourteen days of the youth's release from controlled observation.