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): July 30 - August 2, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions 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:

Jamila Bacchus, Office of Program Accountability, Lead Reviewer (Standard 2)
Brenda Comadore, Office of Program Accountability, Regional Monitor (Interviews)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 1)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 4)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 5)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 3)
Sherri Wilson, Office of Program Accountability, Technical Assistance Specialist (SPEP)

Program Name: Tampa Residential Facility
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Hillsborough County / Circuit 13
Review Date(s): July 30 - August 2, 2019

MQI Program Code: 1281
Contract Number: 10098
Number of Beds: 60
Lead Reviewer Code: 174

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
1.09 Grievance Process	1.12 Restorative Justice Awareness for Youth
2.06 Gang Identification: Prevention and Intervention Activities	3.11 Suicide Prevention Services *
5.04 Ten Minute Checks *	4.04 Parental Notification/Consent
5.08 Contraband Procedure	5.05 Census, Counts, and Tracking
5.15 Outside Contractors	5.07 Key Control*
	5.22 Visitation and Communication

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	Limited
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Failed
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Tampa Residential Facility is a sixty bed, high-risk secured residential program for males ages fourteen to eighteen years old, 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: substance abuse treatment overlay services (SAOS) and comprehensive mental health treatment services for major disorders. In addition, the program fosters each youth by providing delivery of three evidence-based intervention: Impact of Crime (IOC), Thinking for a Change (T4C) and Pathways to Self-Discovery and Change. The program also delivers Life Skills Training (LST), Living in Balance, Strategies for Anger Management, Teen Relationships, Anger Management for Substance Abuse and Mental Health, Young Men's Work, Social Skills, Don't Let Your Emotions Run Your Life, Adolescents Coping with Depression, Coping with Stress, and Council for Boys and Young Men a practice with demonstrated effectiveness. Additional treatment services provided includes family, group, individual and recreational therapy.

Program administration is comprised of the facility administrator, the assistant facility administrator, human resources manager, director of clinical services, director of case management, and a health services administrator. Other administrative staff includes an administrative assistant and physical plant manager. Case management services are provided by the director of case management, four case managers and a transition service manager. Mental health staff at the program includes a licensed psychologist who is the designated mental health clinician authority, one licensed mental health counselor, one recreation therapist, and six non-licensed master's-level therapists. The program contracts with a psychiatrist, which is contracted to be on-site at least twenty-four hours a week and on-call for emergency consultation twenty-four hours a day. Medical services are offered on-site for the youth twenty-four hours a day, seven days a week by seven registered nurses (RN), and one is the health service administrator. The program has a contract with a licensed physician, who acts as the program's designated health authority (DHA) and is scheduled to be on-site three times a week, and on call twenty-four hours a day, seven days a week. The program is contracted with an outside food vendor, which provides meals daily for the youth. 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, education portables and separate classrooms, and three youth living unit/dormitory buildings. The program has a basketball court covered by a pavilion. The program has 140 security cameras of which 100 are operational and providing coverage. Forty cameras are not functioning and plan to be repaired. At the time of the annual compliance review, the program has twenty-two vacant positions; thirteen are youth care workers I, one physical plant worker, behavior analyst behavior, master control operator, transporter, youth care worker II and four licensed therapists. There are currently four youth care worker I and one youth care worker II in training.

Strengths and Innovative Approaches

- Tampa Residential Facility is providing parenting skills and fatherhood education groups to youth identified as a parent/guardian. This group is co-facilitated by a mental health therapist and a case manager with the assistance of a board-certified behavior analyst. This group addresses basic sexual education, discipline techniques, developmental expectations as well as teaching hands on skills required by a parent, such as, changing diapers, feeding, and bathing.
- A music studio is also available to youth to record their musical compositions and to learn basic production skills. A compact disc of their creation is provided to the youth upon release from the program.
- The transition service manager works with youth prior to release on teaching and developing independent living skills such as budgeting, first aid, cardiopulmonary resuscitation (CPR), job interviewing, writing résumés, and obtaining a Department of Highway Safety and Motor Vehicles state-issued identification card.

Standard 1: Management Accountability

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

The program has a written policy and procedures addressing background screenings for newly hired staff. The program has procedures which include completion of a background screening request for all new hire staff, contract staff, and volunteers and receipt of an eligible screening prior to hire. The program had thirty-four new hires requiring an eligible screening from the Background Screening Unit (BSU). The annual compliance review team completed a review of twenty-three staff, two volunteer, and nine contract dietary worker records. Twenty-eight records contained an eligible background screening completed prior to hire. Three direct care and three dietary contract workers were hired prior to the program receiving an eligible background screening. However, each of the six applicable staff were in training until the program received an eligible background screening. The program provided a printout of the Staff Verification System (SVS) report for the staff assigned. The SVS printout documented new hire staff were entered into the system. Each of the new hire staff records documented completion of the pre-employment assessment tool Ergometric Impact Test with a passing grade. The program established a score of sixty as the required minimum.

The program completed the Annual Affidavit of Compliance with Level 2 Screening Standards forwarded to the BSU on January 23, 2019. The program also held a copy of the Hillsborough County Public Schools' Annual Affidavit with Level 2 Screening Standards for school board personnel completed December 7, 2018.

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

The program has a written policy and procedures addressing five-year rescreening. The program has a system in place for human resources to rescreen each applicable staff prior to the five-year anniversary of hire or the Clearinghouse established due date. A review of seven in-service records and program roster revealed none of the staff were applicable for a five-year rescreening.

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

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

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

The program has a written policy and procedures addressing standards of conduct required for provision of an abuse free environment. During the facility tour the review team observed postings of contact information for the Florida Abuse Hotline and the Central Communications Center (CCC) in prominent places throughout the program. The youth handbook included procedures for reporting allegations of abuse or neglect. The program provided a copy of a completed Trauma Responsive and Caring Environment (TRACE) self-assessment including statistics dated April 8, 2019, for review. A review of twenty-three staff records found each contained a signed copy of the code of ethics. The code of ethics communicates the expectation for ethical and professional behavior; however, did not address expectations for staff to interact with youth incorporating trauma responsive practices. Twenty-seven CCC incidents were reported since the last annual compliance review. None of the reviewed reports indicate allegations or substantiated incidents relating to physical, psychological, emotional abuse to youth. The program's procedures require any occurrences in the program with suspicion or knowledge regarding an incident of abuse or harassment shall be immediately reported. If a youth requests to call the CCC or Florida Abuse Hotline, staff will give the youth readily access to a telephone and privacy to conduct the call. If a request by the youth is requested during a scheduled structured activity, the program will provide readily access to the youth when the activity concludes.

Seven staff were interviewed regarding the process for allowing staff and youth to call the Florida Abuse Hotline or CCC (if youth is 18 years or older) to report suspected abuse. All seven interviewed staff reported they notify the supervisor and allow the youth to make the call. Five staff reported they the facility administrator and staff are also allowed to call. None of the seven staff reported hearing a co-worker tell a youth they could not a call the Florida Abuse Hotline. All seven staff reported when a youth requests to make a call to the Florida Abuse Hotline or CCC the youth are given the opportunity to call. Six of seven interviewed staff

reported never observing a co-worker using profanity, threats, intimidation, or humiliation when interacting with youth. One staff indicated correcting a younger staff about using profanity around youth; however, use of profanity as intimidation was never heard.

Seven youth were interviewed regarding safety and abuse reporting. All seven youth indicated they felt safe at the program and had never been stopped from reporting abuse. Six of seven interviewed youth had never heard staff use profanity when speaking to youth; one youth reported while they might joke with staff and say something with profanity, staff might say something back to them using profanity in a joke. An interview with the facility administrator was completed, which confirmed the program's policy and procedure relating to the reporting and tracking of incidents to the CCC.

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

The program has a written policy and procedures addressing management response to abuse allegations. A review of incident reports from the last six months revealed one allegation of abuse from an unknown staff reported by a youth. The youth declined to identify the staff or give time of the incident. The program was unable to further identify a subject or date/time of the alleged abuse violation; however, following the Prison Rape Elimination Act a call was conducted to the Florida Abuse Hotline and local law enforcement regarding the allegation. Investigations was conducted by the local law enforcement and child protective investigator, which was completed with no findings. Interviews with administration revealed all allegations are investigated promptly and if necessary staff are suspended pending the outcome of the investigation.

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

The program has a written policy and procedures addressing Central Communications Center (CCC) reporting. The program made twenty-seven reports to the CCC since the last compliance review. All were made within the required timeframe. Five reports were selected at random for review. Each was reported within the required timeframe and each was documented in the program logbook in a timely manner. The program has not had an increase in the number of reportable incidents since the last annual compliance review. During the annual compliance review, the team did not observe any incidents/grievances which should have been reported to the CCC.

Interviews with administration revealed all staff and volunteers of the program shall adhere to the Department's Rule 63F-11 relating to the reporting of incidents, as well as corporate procedures for reporting incidents which are not required to be called in to the CCC. The facility administrator (FA) ensures any matter requiring reporting to the CCC shall be verbally reported within two hours of the incident or within two hours becoming aware of the incident. If there is doubt at any time as to whether an incident or event is reportable, the presumption shall be the

incident or event is reportable and shall be reported. The FA ensures the program maintains a separate file of all incident reports and has a system in place for tracking incidents. Program staff are required to: notify the shift manager of any event which meets the definition of an incident and complete their written incident report or statement prior to exiting the program at the end of their shift.

In addition, when staff complete an incident report, they ensure to include information such as program name, date, time, location, staff/youth ratio, activity in progress at the time of the incident, nature of incident, incident narrative (to include names of staff involved, witnesses, names of youth involved, and a thorough explanation of the incident), and name of staff completing report, with position/title. All completed incident reports are forwarded to the shift manager prior to the staff leaving at the end of their shift.

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

The program has a written policy and procedures addressing Protective Action Response (PAR) procedures. The program's PAR Plan was updated and submitted to Office of Staff Development and Training and central region operations director on May 14, 2018 and approved on May 23, 2018. The annual compliance review team reviewed the PAR incident summaries for the last six months. The program had a total of four PAR incidents, which were reported in the required timeframe to the Department. Four PAR reports were selected for review and each report was completed prior to the end of the shift by the person initiating the PAR. Each report included a statement by all parties involved, was reviewed by a supervisor, received a post-PAR interview, and a review by the facility administrator (FA) within the required timeframe. None of the incidents required a PAR medical review, involved use of mechanical restraints, or the youth alleged abuse. However, two of the PAR incident reports included a review section (either review of PAR procedures or FA review) completed by the same staff who initiated the PAR. Although this is not forbidden by the Florida Administrative Code the practice is considered an exception. The program's PAR rate during the annual compliance review period was 0.21, which is below the statewide Residential PAR rate of 1.59.

Interviews with administration revealed staff inquire in the daily management meeting if any PAR have occurred. Staff document findings on daily morning management meeting minutes. The management review includes the PAR report, including the post-PAR interview and if applicable, the PAR medical review findings, and the shift manager's review within seventy-two hours, excluding weekends and holidays, to determine if the use of interventions followed the PAR policy.

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 written policy and procedures addressing pre-service training/certification requirements. Pre-service trainings are provided through a combination of on the job training,

web-based, and instructor-led courses. A review of seven staff training records found all exceeded the required 120 hours of pre-service training. Each staff received training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), human trafficking, and active shooter training. All staff successfully completed forty-hours of Protective Action Response (PAR) training. Each staff completed the required trainings and certifications within 180 days of their hire date; in addition, to completion of specific mandated trainings prior to having any contact with youth. Documentation review in the Department's Learning Management System (SkillPro) confirmed all program instructors are qualified to deliver pre-service and in-service trainings. The program maintains a list of pre-service training and calendar for all new staff. The program submitted the pre-service training plan to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019.

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

The program has a written policy and procedures addressing in-service training requirements. In-service trainings are provided through a combination of web-based and instructor-led courses. Seven staff training records were reviewed, which included three supervisors. All staff exceeded the twenty-four hours of in-service training requirements. All staff had updated certifications/trainings in Prison Rape Elimination Act (PREA), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), Protective Action Response (PAR) eight hour refresher training, human trafficking, and professionalism and ethics. Each staff completed six hours of suicide prevention training, which included two hours of training in the Department's Learning Management System (SkillPro), and four hours of instructor-led training. All reviewed training records contained current certifications/trainings in professionalism and ethics, including standards of conduct, suicide prevention, emergency response and the behavior management system. The program has seven licensed nursing staff, which all had updated certifications in CPR and AED. A review of three supervisor training records found two exceeded the required eight hours of annual supervisory training in the following areas: management, leadership, personal accountability, employee relations, and communication skills. The remaining supervisor record did not meet the number of hours requirement due to completion of only five hours. A review of the program instructors' qualifications and training records, confirmed all instructors were qualified to deliver trainings, as provided. The program maintains an updated in-service training plan, which was submitted to the Department's Office of Staff Development and Training on March 13, 2019 and approved on April 12, 2019. The program provided supporting documentation of an annual in-service training calendar which was able to be updated if any changes occur.

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

The program has a written policy and procedures addressing grievances. Program procedures include three phases for grievances: informal, formal, and appeal. The timeframes include twenty-four hours for informal phase and within seventy-two hours for formal grievances. Procedures include all grievances shall be maintained for twelve months. A total of 118 grievances were documented since the last annual compliance review period. A review of five grievances revealed one was not resolved by the grievance officer and was elevated to the appeal phase. Two of the five grievances indicated the youth agreed with the resolution; however, one of the agreed resolutions did not document the grievance officer's signature or date to indicate it was resolved. One of the five grievances indicated the youth disagreed with the grievance officer's resolution. The grievance went into the appeal phase, which requires it to be forwarded to the facility administrator (FA). However, there is no supporting documentation on the grievance being forwarded to the FA or an attempt by the FA to resolve the grievance. In review of the two grievances, each youth did not indicate agreeing with the resolution, or an attempt completed either by signature or date. Three of the five grievances left blank dates of action taken.

Interviews with administration revealed there is no time limit for a youth to file a grievance, and there is no requirement which prohibits a youth from filing a grievance without first using the informal complaint and resolution steps. The grievance process includes an external level of control. Program staff encourages informal resolution of complaints at the lowest possible level including two-way communication between staff and the youth; however, all youth have access to formal grievance procedures allowing them to grieve actions, errors, and omissions which violate their rights. The FA ensures youth requesting to file a grievance are provided with the proper forms, assistance and instructions on the preparation and submission of the grievance. The FA ensures all staff are trained on the requirements of this policy. Youth shall not be subject to reprisal for use or participation in the grievance procedure. Any allegations of this nature are thoroughly investigated by the FA. A designated staff person or FA serve as the program's grievance officer responsible for receiving and investigating grievances. A youth may submit an informal request at any time, as an informal alternative to filing a formal grievance. A formal, written grievance may be filed with the grievance officer (assistant facility administrator of administration) at any time. Grievance forms are made available in each housing area. The grievance process is reviewed and provided to each youth within twenty-four hours of admission during the youth orientation. Documentation review of pre-service training for seven staff revealed all were trained in the grievance process.

Seven staff were interviewed regarding the grievance process. All staff reported forms are placed throughout the program and youth can request assistance in completing the form. Five of the seven interviewed staff reported each phase has associated timeframes, the supervisor and the program director review grievances. Three interviewed staff indicated the process includes the informal, formal, and appeal phases. Six staff expanded on their responses including the clinical director and administration are involved in resolving grievances, while five staff indicated grievances are responded to within twenty-four hours.

Seven youth were interviewed regarding grievances. All youth reported grievance forms are placed in accessible areas, there are timeframes for resolving grievances, and they could ask for assistance in completing the form. Four of the seven youth indicated there are three phases to the grievance process. One youth indicated knowledge of how to complete a form but has not submitted one. Six youth reported the exact timeframe for the phases, and four youth indicated there was an informal and formal phase and they could use the "let's talk" form as part of the grievance process.

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

The program has a written policy and procedures addressing delivery of delinquency intervention and facilitator training. The contract includes the requirement for delivery of three interventions: Impact of Crime (IOC) and Thinking for a Change (T4C) both of which are considered a promising practice of evidence-based intervention and Pathways to Self-Discovery and Change is a practice with demonstrated effectiveness. The program also delivers Life Skills Training (LST) an evidence-based intervention, Living in Balance a promising practice, Strategies for Anger Management, Teen Relationships, Anger Management for Substance Abuse and Mental Health, Adolescents Coping with Depression, Young Men's Work, Social Skills, Don't Let Your Emotions Run Your Life, Coping with Stress, Council for Boys and Young Men a practice with demonstrated effectiveness. A review of eight staff records confirmed each facilitator had received the required training in the delivered intervention. A review of the program schedule and group sign-in sheets was completed and supported all groups scheduled were delivered within youth awake hours.

Interviews with administration revealed the program utilizes two delinquency intervention curricula. The first is T4C, which focuses on how thinking controls actions and behaviors. The other is IOC, which focuses on helping a youth identify how their criminal activity has affected themselves, their family, and their community. IOC focuses on restorative justice and repairing the impact of their crime had on their victim. Youth are identified for placement in a delinquency intervention group based on their Residential Positive Assessment Change Tool/Residential Assessment for Youth (R-PACT/RAY) scores, including protective and risk factors, as well as based on feedback from each youth's treatment team and staff feedback.

Seven youth were interviewed regarding participation in groups. All seven interviewed youth indicated they have group daily. Two youth further indicated they have mental health groups, one of which also included substance abuse groups.

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

The program has a written policy and procedures addressing life and social skill training for youth. Case management staff deliver the Life Skills Training (LST) and Thinking for a Change (T4C) interventions. The therapists deliver all the other interventions including Life Skills Training (LST), The Council for Boys and Young Men, and Pathways for Self-Discovery and Change. An interview with the designated mental health clinician authority revealed the program has a monthly schedule of twelve different life and social skill groups. These groups are ongoing and administered by trained facilitators on designated days during each week.

A review of seven youth records revealed each youth was receiving the Pathways to Self-Discovery and Change, a practice with demonstrated effectiveness intervention on a weekly basis. A review of the sign-in sheets for the LST classes revealed one group was being delivered by a trained facilitator; however, none of the seven youth were enrolled in the LST class. Each of the seven youth were receiving skills training through other curricula, including Teen Relationships, Social Skills, and Coping with Stress and Adolescents Coping with Depression.

Seven youth were interviewed regarding the types of groups they received, and skills learned during group. Youth listed the following types of groups: Anger Management, Teen Relationships, Young Men's Work, substance abuse and mental health groups, current issues, coping skills, positive speaking, and art group. Youth indicate skills learned include breathing exercises, coping skills, patience, anger management, managing temper, coping with issues by reading and pacing, think about acting, being responsible, being respectful, and treating others the way you want to be treated. Youth expressed situations in which they practice these skills included talking with other youth outside of group, before and after phone calls home, during group sessions, when hearing unpleasant news, taking time to answer, role play in groups, and while engaged in outside activities.

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

The program has a written policy and procedures addressing restorative justice awareness. The program policy indicates Impact of Crime (IOC) is the identified delinquency intervention provided to address restorative justice awareness for youth. The program also provides opportunities for youth to plan and participate in reparation activities intended to restore victims and communities such as restitution activities and community service projects by completing community service hours. All designated program staff implementing IOC groups are trained IOC facilitators.

A review of seven youth records revealed none of the youth were enrolled in the IOC intervention group since their admittance to the program. A review of the IOC interventions completed in the past year revealed one group of ten youth was completed January 30, 2019. Two new groups began in April 2019 with eight youth in one group and six youth in another

group, for a total of fourteen youth. Four of eight youth in the first group were discharged prior to delivery of all required sessions. Five of six youth in the other group were discharged prior to delivery of all required sessions. These two group were not completed prior to the beginning of the annual compliance review week. The program currently has fifty-five youth, which only ten youth completed the IOC restorative justice intervention in twelve months. Administrative interviews revealed staff vacancies have affected provision of the IOC intervention. There was no supporting documentation of the program exposing youth to victims' perspectives through victim speakers, in person or on videotape or audiotape, or through victim impact statements. In addition, no engagement of youth in follow-up activities to process their reactions to each victim's accounting of how crime affected his or her life. Interviews with program staff revealed there were no victim speakers, videotape, audio tape, or victim impact statements engaging youth in follow-up activities. A review of seven youth interviews indicated all participate in various scheduled groups with provided opportunities to practice learned skills and behaviors within and outside the group. An interview with the designated mental health clinician authority revealed the program schedules ongoing IOC groups to be facilitated twice a week for the youth.

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 has a written policy and procedures addressing gender-specific programming. A review of seven youth records found each youth participates in the Young Men's Work curriculum delivered by the therapist weekly. The group schedule also includes the gender-specific intervention, Council for Boys and Young Men, weekly. Reviewed documentation indicated there was one cohort currently receiving the intervention; however, none of the seven youth records documented engagement in Council for Boys and Young Men intervention.

The nursing department provided sign-in sheets for gender-specific training on three specific dates in the annual compliance review period. The sign-in sheets for each training event, documented six of the seven selected youth attended one or more sessions. There was no documentation for one youth receiving the provided gender-specific training.

Interviews with administration revealed the mental health department conducts two groups which are focused on gender-specific curriculum, specifically Council for Boys and Young Men and Young Men's Work. Additionally, the remainder of the curriculums focus on gender issues during various group topics or lessons. The medical staff complete a monthly education meeting with youth which addresses various gender-specific topics. The medical department has an educational bulletin board which addresses various health issues including sexually transmitted diseases, testicular health, and healthy relationships. These are documented in the youth's health education record monthly. A monthly pancake breakfast is provided by a volunteer agency and delivered by male mentors. A review of seven youth interviews indicated all participate in various daily scheduled groups covering an assortment of topics around coping skills and positive behavior patterns. All youth reported the ability to practice learned skills and behaviors within and outside the group.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance

The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status.

When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.

The program has a written policy and procedures addressing internal alert systems and the Department's Juvenile Justice Information System (JJIS) alerts. The program has an internal alert system, which documents all alerts on three dry-erase boards in the conference room. A review of the program internal alert boards in comparison with seven youth JJIS alerts revealed each applicable JJIS alert was documented accordingly. Six of the seven youth records revealed a total of fourteen new JJIS alerts were opened by program staff following admission. One youth had no documentation requiring a new JJIS alert. Eleven of the fourteen new alerts were placed in JJIS in a timely manner. One youth placed on suicide alert, received an Assessment of Suicide Risk (ASR) the next day, was stepped down to close supervision, and the following day stepped down to standard supervision; however, the suicide risk alert was not placed in JJIS until the day following the step-down to standard supervision. One youth was placed on dietary supplement April 4, 2019; however, the JJIS alert was entered forty-eight days later. Another youth was referred to the physician May 30, 2019; however, the alert for the condition was entered fifty-three days later.

An interview with administration revealed internal alerts are reviewed daily and updated as appropriate. Each department director is responsible for managing alerts applicable to their respective department. The internal communication board displays current, open, applicable alerts, and is updated as needed. Internal alert trackers are maintained by each department. All internal alert trackers are reviewed on a weekly basis during the morning management team meeting for fidelity monitoring. Seven staff were interviewed regarding how they learn of youth alerts. All seven staff included the daily shift briefing as providing updates on alerts. Four of seven interviewed staff indicated an alert sheet is printed and available at shift briefings to inform them of updated alerts.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance

The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files:

- *An individual healthcare record*
- *An individual management record.*

The program has a written policy and procedures addressing youth records. A review of seven youth case management records revealed each included a file tab listing the youth name, Department of Juvenile Justice identification number, date of birth, county of residence and committing offense. Each record was organized in the required sections including legal

information, demographic information, correspondence, case management and treatment team activities, and miscellaneous. The program maintains a separate record for mental health treatment and for healthcare documentation. All records were consistently labeled confidential. A review of storage procedures confirmed cabinets were locked or located in a locked room labeled confidential.

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

The program has a written policy and procedures addressing youth input. The program provided documentation of monthly meetings of the youth advisory board maintained in a loose-leaf binder by months. A documentation review of youth advisory board meetings did not include the date of the meeting, agenda and minutes of activities. The youth advisory board documentation for February, March, and April 2019, did not include an agenda or meeting minutes, the month date the meeting was conducted. However, sign-in sheets of each youth in attendance at the meeting was filed under the respective month tab. The documents for May, June, and July 2019, included sign-in sheets, an agenda, and meeting minutes. The minutes documented youth input with determining the dissemination of monthly incentives for youth completing a positive day. The reviewed documentation for staff support of the youth advisory board was inconsistently included. In addition, the program consistently documented a community meeting conducted in each unit monthly for provision of youth input; however, the documentation consisted of a youth sign-in sheet with no indication of subjects discussed or staff involved.

Interviews with administration revealed youth have the opportunity to ask questions or provide feedback by using the “Let's Talk” and grievance forms. While this is primarily used to address individualized concerns, it can be used for more systemic concerns as well. A daily meeting is held on each dorm, each afternoon at approximately 2:10 p.m., with all assigned youth, therapists/case managers on the assigned dorm, and an administrative representative. During this meeting, youth are provided an opportunity to voice any comments, concerns, and/or questions related to issues on their dorm or the program. Each month, a community meeting is held with all youth and staff on-site for the day. This meeting is conducted by the youth advisory board and the unit manager. New and/or updated information is shared with the youth and are provided the opportunity to ask questions and/or concerns at this meeting. In addition, youth surveys are completed on a quarterly basis.

Administration clarified the youth advisory board is primarily utilized to receive input from their peers regarding programming and events. For example, they help to determine the items available on the canteen menu as well as the fast food restaurants used each month for the fast food canteen. Additionally, they assist in planning the program's next fun day menu and activities. The youth advisory board requested to have a basketball tournament with other programs and helped plan and develop this activity as well as planning the upcoming obstacle course challenge with other corporately managed Department contracted programs. Youth can utilize the “Let's Talk” forms to speak with staff about ideas as well as sharing suggestions in daily meeting and monthly community meetings.

Seven youth were interviewed regarding the process of allowing youth to provide input about what occurs at the program. All seven interviewed youth indicated they were allowed to provide input in the program. Youth responses indicate the process includes during peer group, through the youth advisory group/board, and talking to staff.

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

The program has a written policy and procedures addressing the program advisory board. A review of advisory board meetings revealed three meetings 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 most of the meetings included all the required disciplines. There was no documentation of outreach to recruit a representative from the lesbian, bisexual, gay, transgendered, questioning, intersex (LBGTQI) community, or business community invitation to the February 2019 meeting. Invitations to persons identified by staff as parent/guardian of a youth formerly in Department custody were inconsistently identified in the documentation. However, the program provided other documentation identifying the parent/guardian were invited.

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 one board member outside of program staff attended the November 15, 2018 and May 16, 2019, meetings and two outside board members attended the February 21, 2019 meeting. Some invitations were sent by email and some by registered letter with return receipt requested. The program maintained records of board members who signed the registered letters and those who confirmed they would attend.

Staff interviews indicated if an invited board member does not result in a physical response, the program invites another person in the same area/discipline. Interviews also 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 on-site. The board member indicated involvement for the past eleven years, including being a chaplain to the program. The member described an active board meeting quarterly at the corporate headquarters. In addition, to describe some activities included 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 written policy and procedures addressing program planning. Interviews with program staff indicated the program conducts surveys of ten youth and ten staff on a quarterly basis. Documentation provided indicates the number of youth and staff surveys completed included twenty-one youth and twelve staff surveys completed from April 1 to June 30, 2019. Staff interviews indicated they provide results of the surveys to staff at the all staff meetings; however, there was no documentation provided to support when this information was passed to all staff or the way the results were utilized in program planning.

The program provided documentation they provided the results of the Department's annual Comprehensive Accountability Report (CAR) to staff at the all staff meeting July 23, 2019. However, the documentation did not include how the program utilized the results in the program planning process. The program has established a morale committee comprised of direct care

staff and supervisors. The committee plans staff appreciation events throughout the year honoring staff, remembering birthdays, and providing special meals to the staff. The program has a staff recognition rewards program in which staff nominate peers who can receive incentive awards which can be redeemed for prizes on a quarterly and annual basis. Staff awards are given at the monthly all-staff meetings. Staff can also receive a cash referral bonus for referring a new staff for hire, including successive financial bonuses at each stage the new hire completes ninety days, 180 days and one year of continuous service. Staff awards include above and beyond awards for service excellence, productivity or cost reduction, or new program related ideas. Each of the reviewed all staff meeting minutes included a section for awards staff received.

Interviews with administration revealed the program has experienced staff turnover in all departments including clinical, case management, medical, and operations. The case management and medical departments are once again fully staffed. The clinical department has recently had an influx of resignations and currently has four full-time positions available. Much of the turnover has been due either to financial reasons or the opportunity to explore new fields of work. The program has attempted to develop staff incentives and appreciation days to address and help build staff morale. These days are reflected in the brag book and have included a spirit week, jeans day, fish fry, and barbecues. Additionally, the company has implemented Employee Appreciation Day, which occurs on an annual basis.

Seven staff were interviewed regarding the frequency of meetings. All seven staff indicated meetings are held daily and monthly, while two staff indicated weekly. Six staff indicated some other time including supervisors meet with staff weekly, daily shift briefing, community meetings weekly, and staff meetings monthly. The topics discussed at meetings included staff tardiness, punch-in-out procedures, dress code, proper completion of forms, behavior management system, drills, red-flag/boundary issues, training refreshers, upcoming youth and staff events, updates on in-service, how things are going/progress, goals of the program, security and medical alerts, and training refreshers. Seven staff were interviewed regarding briefings. Six of seven interviewed staff denied receiving briefings on any annual reports and/or youth and parent/guardian survey results. One staff indicated they received briefing on annual reports. Three staff indicated the communication process was very good, three indicated it was good and one staff indicated it was fair. Seven staff were interviewed regarding their ability to provide input and feedback to program operations. Three staff mentioned an open door/communication policy. Six staff mentioned they could talk to one or more of the following: supervisors, administration, shift supervisor, facility administrator, assistant facility administrator, or human resources. One staff included briefings and monthly meetings as places they could provide input.

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

The program has a written policy and procedures addressing staff performance. Procedures include each staff being evaluated once annually. A review of seven in-service staff records revealed each staff had signed a position description appropriate to her/his position. Each of the performance standards matched the job descriptions. Each record contained a performance evaluation based on the performance standard completed since the last annual compliance review. All contractually required position descriptions were maintained and filed at the time of the annual compliance review. Seven staff were interviewed regarding frequency of formal

performance evaluations. Two staff indicated they receive performance evaluations every six months, two monthly and three had other frequencies including every three months, every ninety days, and not being on-site long enough to receive one. An interview with the facility administrator (FA) revealed the program conducts annual staff evaluations, which is completed by each department director/supervisor for their assigned staff. Each submitted evaluation is reviewed and approved by the FA.

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

The program has a written policy and procedures addressing recreation and leisure activities. The contract includes the provision of recreation therapist with a degree in recreational therapy or related field such as recreation, leisure studies or physical education, including an internship, or practicum. A minimum of one-year experience is required. The current recreational therapist received a bachelor's-level degree in sports and fitness from an accredited university. The recreational therapist has eight years of experience in the field including physical education teacher, health and activities specialist, and outdoor program specialist.

The annual compliance review team observed outdoor recreation two days of the review week. One day of the annual compliance review outdoor recreation was cancelled due to inclement weather, which the program implements an indoor recreation schedule for these instances. One day of the annual compliance review included a scheduled family day. Activities included family members participating in games, a meal, and extended visitation at the program. Approximately twelve youth had family members participate in the family day. Family members consisted of parent/guardian, siblings, and grandparents. The program posted an outdoor recreation schedule and an alternate indoor recreation schedule. Outdoor activities include an obstacle course, tug of war, ring toss, exercises, frisbee, four square, scavenger hunt, and the common ball-related sports. Alternate indoor activities included workout, stretches, jump rope, calisthenics, and weight lifting. A comparison with the schedule and logbook for the last six months revealed the program consistently followed the schedule including an hour daily of large muscle activity.

Seven youth were interviewed regarding the frequency and type of recreation provided. All youth indicated at least one hour of recreation is provided daily. The types of activities include recreation, relay races, basketball, weight lifting, workout, and games.
Further, seven youth were interviewed regarding the program provision of varying degrees of mental and physical exertion throughout the day and all responded positively to the question. Some of the youth listed additional indoor activities to include board games and card games.

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 on initial contact to parents/guardians with court notification regarding a youth's admission to the program. The program requires, upon a youth admission, notification to the youth's committing court within five days, a phone notification to the parent/guardian within twenty-four hours and mailed notification within forty-eight hours. Seven youth case management records were reviewed. All records revealed the case manager required communications were completed to each youth's parent/guardian, juvenile probation officer (JPO), and committing court on the date of each youth's admission to the program.

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

The program has a policy and procedures to address provision of a youth orientation to the program on initial day of admission. Seven youth case management records were reviewed. Each youth was provided a youth handbook detailing all the required elements as outlined in the program's policy. The program utilizes an orientation checklist to outline the program rules, schedules, and services available to the youth. All records contained a signed acknowledgement orientation checklist confirming completion of an orientation within twenty-four hours of arrival to the program. During the annual compliance review period, there were no new admissions scheduled; therefore, no observation of an orientation process was completed. Seven youth were interviewed, which confirmed the program's implementation of an orientation within twenty-four hours of admission.

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

The program has a policy and procedures to address obtaining written consent of youth who are eighteen years of age or older. Seven youth case management records were reviewed, which one was applicable for written consent. Two additional youth case management records were reviewed for written consent. All three youth records contained consent forms signed by the youth providing the program permission to release confidential information with the parent/guardian on any information related to the youth's physical or mental health screening, assessment, or treatment. One of the three records revealed the consent form was completed by the youth one day after the youth's eighteen birthday.

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

The program has a policy and procedures to address utilization of a classification system with inclusion of factors and procedures for effective delivery of treatment services and reassessments for activities to ensure safety and security. During a youth's admission a standard classification form is completed. The gathered information collected is utilized for assigning a youth to a living unit, sleeping room, and youth group or staff advisor. This form outlines pertinent information, such as the youth's demographics, physical characteristics, maturity level, and identification or suspected risk factors for suicide, medical, escape and/or security. Seven youth case management records were reviewed. All records included a standard classification form completed with required initial classification factors. One exception was noted. Florida Department of Juvenile Justice Prison Rape Elimination Act (PREA) policy and procedures FDJJ 1919 signed April 16, 2019, requires program's to complete a new Victimization and Sexually Aggressive Behavior (VSAB) in the Department's Juvenile Justice Information System (JJIS) prior to a room assignment. Two of the seven youth records were applicable for implementation of this new process. An additional youth record was reviewed for VSAB completion in JJIS. In all three records the VSAB was completed; however, was not completed in JJIS. The program acknowledged the reviewer findings and requested the required access from the Department's Data Integrity Officer System for future completion of newly admitted youth.

All seven youth records revealed documentation of identified or suspected risk factors, which all alerts were entered into the JJIS and program's internal alert system. The program is a high-risk, secure program, which does not participate in work projects or off-campus activities. The program maintains a risk assessment binder, which includes monthly reassessments of all youth in the program. All seven youth had a monthly risk reassessment completed for consideration of an increase in program privileges. An interview with the facility administrator (FA) discussing the process for assigning a youth to a living unit and sleeping room was completed. The FA indicated upon admission various assessments are completed to collect historical information and suicide risks to determine the youth's level of risks. The program's internal alert system on youth risks was reviewed, which is continually updated and readily accessible to program staff for review.

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 addressing gang identification and notification to a youth's local school district and law enforcement. Seven youth case management records were reviewed, which revealed five were applicable for youth gang involvement or association. Each

youth's record contained a completed gang assessment and documented gang-related alert in the Department's Juvenile Justice Information System. Each youth record included mailed notifications to the youth's juvenile probation officer, Hillsborough County School Board, youth's home county law enforcement agency, and applicable post-residential counselor.

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

The program has a policy and procedures to address gang identification and youth participation in prevention and/or intervention activities. The program has two trained staff utilizing the ARISE curriculum as the selected gang prevention and awareness curriculum. The program maintains a gang binder documenting a youth's completed program activities. The program provides each youth the opportunity to develop a plan to disassociate with the gang during needs assessment and performance plan meetings where youth are given the opportunity to provide input into the specific goals. Seven youth case management records were reviewed, which revealed five were applicable for youth gang involvement or association. Three youth were identified as a suspected gang affiliate and two identified as a documented gang members upon admission. The program began offering weekly gang groups in June 2019. One youth was admitted to the program in February 2019, and four admitted in April 2019. There were no gang interventions provided for all five youth upon their admission. A review of four out of five youth records contained each youth's individual performance plan with inclusion of relevant gang-related goals and objectives; in addition, to documented participation in the ARISE group since June 2019. One youth identified as a suspected gang affiliate in April 2019, gang-related goals and objectives were not added to the youth's individual performance plan until July 2019 as well as no assignment to a gang group. The program acknowledged the review team findings and added the youth to the next scheduled gang group.

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

The program has a policy and procedures to address completion of a Residential Assessment for Youth (RAY) assessment and reassessment. The program is required for completion of this assessment within thirty days of a youth admission and a reassessment within ninety days thereafter. The Department launched a new assessment tool entitled Residential Assessment for Youth (RAY). The previous tool used by the program was entitled Residential Positive Achievement Change Tool (R-PACT). The program was mandated to discontinue the use of the R-PACT for any youth admitted to a program after April 8, 2019. However, the RAY could not be utilized by all programs until May 6, 2019. Seven youth case management records were reviewed, revealing five were applicable for an initial RAY completion. Two youth were admitted to the program prior to the implementation of the new tool; however, an initial R-PACT was completed as required. Upon the Department's launch of the RAY, an initial RAY was

completed for the two youth. All seven youth initial assessments were conducted within thirty days of admission as required. None of the seven records were eligible for a ninety-day RAY reassessment. Due to the new assessment tool launch going live around the timeframe of reassessments of the R-PACT, an initial RAY assessment was completed by the program for two applicable youth. All seven youth initial RAY assessments were completed in the Department's Juvenile Justice Information System, and a copy was maintained in each applicable record.

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

The program has a policy and procedures addressing the completion of a Youth Needs Assessment Summary (YNAS) within thirty days of a youth's admission. Seven youth case management records were reviewed. Each youth record contained a completed YNAS within the required timeframes after admission to the program. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System.

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, goals, and transmittal. An Individualized Performance Plan (IPP) is required to be completed within thirty days of a youth admission. Seven youth case management records were reviewed. Four youth IPPs were completed within the required timeframes. One record was completed nine days late due to technical difficulties between the new Residential Assessment for Youth (RAY) implementation in May 2019, and youth referral numbers not being identified for web-based input. The program provided email correspondence between the program and Department's Data Integrity Officer (DIO) System in rectifying the issue. One record was seven days late due to the same issue as relayed above; however, the email correspondences with the DIO noted the resolution of the issue on May 9, 2019, and the IPP was not completed until May 15, 2019. One record was completed ten days late with no explanation for late submission.

The program acknowledged the reviewer findings for two of the three youth. The program noted the director of case management conducted audits of the two case management records and discovered the late documentation. The program provided documentation on two case managers receiving a coaching session addressing their late documentation. The performance

plan shall include input from the youth, treatment team leader, administrative representative, living unit representative, treatment staff, and if applicable educational staff, Department of Children and Families (DCF) case worker or Agency for Persons with Disabilities (APD) support coordinator. All seven youth IPPs documented required elements, such as, the youth responsibilities, staff responsibilities, and target dates for goal completion. In all six applicable youth records, the parent/guardian participated in the development of the IPP. The one youth under the care of DCF, the case worker was not present. Each youth IPP included signatures from all applicable treatment team members and one parent/guardian. Signatures were missing for the parent/guardian in five youth records and one DCF case worker. All seven records contained a correspondence of the IPP being mailed to parent/guardian and DCF case worker with a request to return to the program with signature page signed.

The program is required within ten working days of a completed IPP to send a copy to the committing court, juvenile probation officer (JPO), parent/guardian, and if applicable the DCF case worker. Each of the seven records contained supporting documentation of a mailed correspondence regarding the plan within the required timeframe. Seven youth interviews were conducted, which revealed five reported having a copy of their IPP and recall participating in developing their IPP. Two youth reported not having a copy of their plan.

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

The program has a written policy and procedures to address performance plan revisions of each youth based upon the Residential Assessment for Youth (RAY) reassessment results. Seven youth case management records were reviewed for revisions to the performance plans. All performance plans demonstrated progress toward completing a goal. Due to the Department's new RAY assessment tool launch going live in May 2019, an initial RAY assessment was completed by the program for five youth due to each admission between May and June 2019, which did not require a RAY reassessment. Two youth admitted into the program in February 2019, were eligible for the discontinued Residential Positive Achievement Change Tool (R-PACT) reassessment; however, as mandated an initial RAY was completed.
Three closed youth case management records were reviewed. Each performance plan included the required facilitation of transition activities during the last sixty days of the youth's stay. None of the closed records performance plans required revisions based upon initial RAY results. Each youth record performance plan was updated to reflect newly acquired information and progress toward completions of respective goals.

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

The program has a policy and procedures to address the completion and transmittal of performance summaries. Seven youth case management records were reviewed and four youth were applicable for the completion of a ninety-day summary. Each record contained a performance summary completed within the required ninety calendar day timeframe. All four performance summaries included the essential elements; such as, level of motivation and behavior, written education input, and overall treatment progress. Opportunities were provided for each youth to review their respective performance plan and provide comments. Each summary was maintained in a record with signatures by the treatment team leader, youth and facility administrator or designee. Supporting documentation in all four youth records indicated copies of the performance summaries were sent within ten working days to the committing court, juvenile probation officer (JPO), youth, and parent/guardian.

Three closed youth case management records were reviewed. All youth records contained a justification for release sent within an appropriate timeframe and a signed copy of a Pre-Release Notification from the JPO. None of the records were applicable for rejection of release by the court or applicable for the sexually violent predator program. Each record contained mailed letters to parents/guardians of the anticipated release dates upon approval from the court. The program completed the required Residential Assessment for Youth (RAY) at each youth's approval of release from the program. Seven youth were interviewed, which two applicable youth noted having copies of their summaries sent to the court.

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

The program has a policy and procedures to encourage and facilitate the involvement of the youth's parent/guardian in the case management process. The program invites each youth's parent/guardian to participate in intervention purposes and treatment team meetings for development of a performance plan. Additionally, the program mails treatment team letters, which provides advanced notice to parents/guardians, inviting them to attend each youth's monthly treatment team meeting. Parents/guardians unable to attend in person are given the opportunity to participate by telephone or provide a written input prior to the treatment team meeting. Seven youth case management records were reviewed. Each record contained documentation of program attempts through phone contacts and mail to involve the parent/guardian in case management processes, family days, treatment team meetings and family therapy. An interview with the facility administrator revealed staff contacts the parents/guardians verbally and written in advance. In addition the program communicates with

parents/guardians regarding a youth's accomplishments and limitations within the program. Seven youth were interviewed and all confirmed the program's practice of parent/guardian involvement in treatment team meetings and other case management processes. Two youth reported not requiring parent/guardian participation due to being eighteen years old. During the annual compliance review, three youth treatment team meetings were observed. All required program pertinent parties were present for each youth's treatment team meeting. The juvenile probation officer participated by telephone in two of three observed youth treatment team meetings. In the three observed treatment team meetings, ne youth is eighteen years old, which did not require parent/guardian participation, one parent/guardian was available to participate in person and one parent/guardian was unavailable to participate.

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

The program has a written policy and procedures to ensure each youth is assigned a treatment team. The treatment team members consist of the youth, treatment team leader, transitions services manager, representatives from the program's administration and residential living unit, education staff, mental health therapist, recreational therapist, juvenile probation officer (JPO), the Department of Children and Families (DCF) case worker when applicable, and parent/guardian. Seven youth case management records were reviewed. All records contained supporting documentation of each youth required treatment team members actively participating in the process. During the annual compliance review, an observation of three treatment team meetings for three youth revealed active participation by all required program staff, in addition, to available parties' telephone participation by two youth supervising JPO and one youth parent/guardian. The director of case management left messages for return calls to contact for further discussion of youth progress.

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 address performance plans reference or incorporate a youth's treatment or care plans. Nine youth case management records were reviewed. Each youth respective performance plan included a reference of the youth's academic and mental health treatment plans. Three of the nine youth were involved with the Department of Children and Families (DCF). One youth DCF care plan was referenced in the individualized performance plan. Two youth did not have an DCF care plan incorporated into their performance plans. The program acknowledged reviewer findings and provided email correspondence between the program and the DCF case worker regarding the two youth. One youth does not have a DCF care plan; therefore, does not require incorporation into the plan. One youth does have a DCF case plan; however, the program did not incorporate it into the performance plan. 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 meeting reviews. The program's policy indicates informal treatment team meetings occur once bi-weekly each month and formal treatment team meetings occur every thirty days. Seven youth case management records were reviewed. All youth received their informal and informal treatment team meetings in the required timeframe. Each youth treatment team documentation included the following: youth's demographical information, date of review, members in attendance with required signatures and written input from the education staff. Two youth formal meetings, one in May and in June 2019, noted the youth did not feel safe at the program with no explanation. The program acknowledged findings with notation of a human error by staff with the drop-down menus; in addition, to provision of a note from the youth stating feeling safe at the program. One youth formal meeting in June 2019, did not confirm the type of parent/guardian attendance. The program acknowledged reviewer findings and provided an email correspondence between the program and youth's parent/guardian confirming attendance in the meeting by telephone. All seven youth treatment team meetings included the applicable revisions based on the initial Residential Assessment for Youth (RAY) tool, performance plans goals, treatment progress and youth's overall program progress. During the annual compliance review, an observation of three youth treatment team meetings demonstrated all were provided the opportunity to demonstrate learned skills acquired from the program. During each treatment team meeting, the team discussed the youth's overall performance in the program. All pertinent staff for each youth's treatment team was in attendance; including written input from education staff. One youth's parent/guardian was present and actively participated. One youth aged eighteen did not require a youth parent/guardian in attendance. One youth's parent/guardian was unavailable to participate. The juvenile probation officers participated by phone in two of three youth treatment team meetings. One youth's JPO was unavailable for the meeting and a message was left for a return follow up call. A copy of all three youth treatment plans was obtained, which included all the required elements and signatures. Each youth anticipated release dates were reviewed in the Department's Juvenile Justice Information System confirming required updates of information. Seven youth were interviewed, which confirmed their treatment progress is reviewed with them and opportunities are available to demonstrate acquired skills leaned while in the program.

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

The program has a policy and procedures in place addressing career education. The program collaborates with the Hillsborough County School Board to provide academic access and Type 3 educational programming. The program provides age appropriate vocational programming services for each youth while ensuring focus on educational abilities and goals of the youth in accordance with the length of stay and custody characteristics. Additionally, the career education program includes communication, interpersonal, and decision-making skills. An interview with the facility administrator revealed the program offers an Agroponics course to youth through the school system as part of their regular school day requirements. In addition,

the program offers Microsoft and Occupational Safety and Health Administration (OSHA) certifications to youth in the program. An interview with a Hillsborough County Public Schools teacher instructing at the program and lead teacher confirmed implementation of career education assessments and tests to determine the aptitude of the youth. Education staff assess a youth's educational needs through daily lessons and recommendations from exceptional student education teacher and the guidance counselor. Education staff communicates the youth's academic progress monthly, in writing, with the multi-disciplinary treatment team. All academic work completed is documented and maintained in the student's education record.

Three closed youth case management records were reviewed. Each youth was eligible for employability as one of their goals. All three records included a résumé summarizing education, work experience and/or career training, state issued identification card, and contact information of a local Career Source Center. Two of the three records included a sample employment application. All three records contained documentation on youth's parent/guardian and juvenile probation officer awareness of the youth vocational plan.

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 in place to ensure youth have access to educational services. On a year-round basis the Hillsborough County School Board provides academic services to the youth in the program. A review was completed of the program's schedule, daily school schedule, and the school year calendar. The program provides 253 days of instruction for educational and career-related programs over a twelve-month period. When end of semester exams are being conducted for applicable youth, other youth are provided with coursework to complete on the dorms. Ten days or less of the 253 days are set for teacher training and/or planning. The program conducts their quarterly family day activities on the first Friday of the month to accommodate training of educational staff being provided off-site by the Hillsborough County School Board. Each youth in the program is provided credits for educational and training experience. An interview with seven youth, a review of the program's logbooks and activity schedule for twelve various days confirmed education classes take place as scheduled with minimal interference of educational instruction.

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

The program has a policy and procedures in place regarding educational transition plans. The program has a certified guidance counselor and registrar through the Hillsborough County School Board to assist with completing educational training plans. Three closed youth case management records were reviewed. None of the youth had an individual education plan created at admission. Prior to admission to the program, two of the three youth already completed their academic studies. One youth obtained a high school diploma and one youth completed their general equivalency degree and was completing online college courses in the program. All three youth had a developed education plan upon each expected release notification. Each youth educational plan involved the youth, education representative, and juvenile probation office (JPO). One youth's parent/guardian participated in transition activities.

One youth was eighteen years; therefore, not requiring parent/guardian involvement. One youth did not have a parent/guardian documented in participating. All three records included employability as a transition goal. Each educational transition plan addressed all applicable required elements, services and interventions during program stay and release, with inclusion of recommendations for post-release education plans and/or employment. Additionally, each youth educational transition plan included designated staff responsible for provision of specific youth support and reintegration services. All three youth had a respective exit portfolio, which included a copy of their state issued identification card, a résumé, calendar with dates, times, and locations of follow-up appointments in the community. Two of the three youth records included a completed employment application. All three records contained documentation on youth's parent/guardian and JPO awareness of the youth's education plan post-release.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	**Satisfactory Compliance**
A residential commitment program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay. *During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.* *Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*	

The program has a policy and procedures in place regarding transition planning, conferences, and Community Re-entry Team (CRT) meetings. A review of three closed youth case management records revealed the transition conferences were held at least sixty days prior to targeted release date. All three records included advance notification invites to all parties to request participation. Each record documented attendance of the following individuals at the youth's transition conference: youth, parent/guardian, treatment team leader, program director or designee, and other applicable team members, including the youth's juvenile probation officer (JPO) and written input from education staff. One youth over the age of eighteen years did not require attendance of a parent/guardian. All three records included documentation of attendees' review of the youth's transition activities on the performance plan and revised performance plans. In addition, identification of additional transition activities, target completion dates, and individuals responsible for completion were documented. The treatment team leader obtained all attendees present onsite at the program signature acknowledgement of a review of each youth transition goals and accountability for completion. All three records documented a copy of the transition plan was sent to individuals not in attendance with a request for with signature and return to the program. All three closed records documented the transition plan being transmitted electronically to the JPO; however, the program only obtained an email acknowledgement receipt for two of the three youth and filed with the transition plan. All three youth received a CRT meeting prior to the youth's release, which included the youth and case manager and confirmed invitation to participate through an email/outlook invite.

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

The program has a policy and procedures to address the completion of an exit portfolio for youth being released back in the community. Three closed youth case management records were reviewed for completion of an exit portfolio. All three youth court committed status was determined as a maximum risk youth, which their transition plan entailed designated parties to assist each youth in obtaining documents for an exit portfolio, and clear instructions and assistance with completing forms. Each youth exit portfolios included a transition plan, a résumé, vocational certifications, and if applicable educational records. Two of the three youth prior to admission to the program had obtained their educational credentials. One youth obtained a general equivalency education and one youth obtained a high school diploma. Two of three youth's exit portfolio included a completed job application. All three youth exit portfolios contained a copy of their state issued identification card, birth certificate, transition plan, calendar with dates, times, and locations of follow-up appointments in the community. Two of three youth's exit portfolio contained a copy of their respective social security card. One youth exit portfolio contained a copy of a social security card application and program chronological case note communication with parent/guardian on attempt to obtain the card. Reviewed documentation revealed program staff mailed a copy of each youth exit portfolio to their respective juvenile probation officer. All three youth records contained signature acknowledgement for receipt of their exit portfolio upon discharge as well as participation in their transition and exit conference.

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

The program has a written policy and procedures to address the requirements for each youth's exit conference. Three closed youth case management records were reviewed. The exit conferences were separate from the Community Re-entry Team meetings. Each record included documentation of an exit conference after the program notified the juvenile probation officer (JPO) of release within at least fourteen days prior to release of the youth. Each youth record documented a review of transition activities established at the transition conference and finalized plans for the youth's release. All three records contained a summary pending transition goals and documented on-site attendees with required dates, signatures, and individuals participating by phone. Two of the three youth had no education and parent/guardian confirmation of attendance or input acknowledgement on signature page. One youth of the age of eighteen years did not require parent/guardian participation. A review of all three youth closed records documented the correct date of admission and termination. Each closed record documented a review of transition activities established at the transition conference and finalized plans for the youth's release. All three exit conference forms documented the following participated in the exit conference: the youth, treatment team leader, JPO, parent/guardian for one youth, education representative for one youth, and other pertinent parties. A review in the Department's Juvenile Justice Information System correlated with each youth date of admission and termination documented in each record.

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 procedures to ensure the designated mental health clinician authority (DMHCA) coordinates the mental health and substance abuse services in the program. The program has one licensed psychologist serving as the DMHCA and the license expires May 31, 2020. The DHMCA supervises six staff with a master's-level degree and two licensed mental health counselors. The DMHCA is on-site forty hours a week (on call twenty-four hours a day) and ensures the appropriate coordination of mental health and substance abuse services at the program. In addition, the DMHCA conducts Assessments of Suicide Risk (ASR) and Crisis Assessments. The DMHCA schedules staff, ensures services are provided, schedules group, performs quality assurance services including fidelity monitoring for evidence-based group interventions, and conducts training for staff. The DMHCA confirmed being on-site Monday through Friday for forty hours and as needed. In addition, the DMHCA oversees and provides supervision of the therapists and treatment services provided to the youth, ensuring all services are provided according to Department Rule and program contract In addition, the DMHCA collaborates with operations and case management staff to coordinate services to meet the needs of the youth and the program.

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

The program has two licensed mental health counselors (LMHC). Each clinician holds a clear and active State of Florida license expiring on March 31, 2021 with the Department of Health, Division of Medical Quality Assurance. The psychologist serves as the designated mental health clinician authority (DMHCA). The DMHCA supervises each of the two LMHCs and ensures the appropriate mental health and substance abuse services are provided.

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 to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications. The program has a licensed psychologist which serves as the designated mental health clinical authority (DMHCA). The DMHCA supervises six staff with a master's level degree. All the non-licensed clinicians graduated from accredited universities, with master's degree in social work, human services, counseling psychology, counselor education and two staff in counseling. There was documentation to support all the 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 DMHCA conducts weekly clinical supervision meetings with the non-licensed clinicians to address training, treatment team reviews, therapeutic concerns, case staffing reviews, scheduling, and administrative concerns. The clinical supervision notes for the past six months were reviewed. There was documentation in the form of sign-in sheets and training logs, to support all clinical staff attended weekly clinical supervisions. The licensed clinician reviewed and signed all progress notes and initialed the individual treatment plans completed by non-licensed clinicians within ten days of completion.

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 regarding mental health and substance abuse admission screening. The program uses the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) to screen youth upon their admission to the program. Each MAYSI-2 is administered in the Department's Juvenile Justice Information System (JJIS) by trained staff. There was documentation in each of the seven youth records to indicate the clinical staff reviewed available collateral information. Each of the youth were administered the MAYSI-2 on the day of admission. Five of the seven youth MAYSI-2's indicated further assessment was needed, the remaining two youth records did not require further assessment. The five youth MAYSI-2 indicated for further assessment, which the program director was notified, and a referral was made for further assessment. Each of the seven youth records reviewed included referrals for comprehensive evaluation. The facility administrator stated upon admission, all youth receive an ASR to obtain historical information regarding suicide, as well as, assess the level of current risk. Assessments are administered as needed during the remainder of the youth's stay in the program.

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 to ensure a comprehensive mental health and substance abuse evaluation is conducted within thirty days of the youth admission. The program completed a new comprehensive mental health and substance abuse assessment on each of the seven youth upon their admission to the program. The comprehensive evaluations included all require elements. A licensed mental health professional reviews and signs any evaluations of non-licensed staff within ten days. The assessment was completed within thirty days of each youth's admission to the program.

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 regarding mental health and substance abuse treatment. Seven youth records were reviewed and contained documentation of the youth being assigned to a treatment team upon arrival to the program. The program's multidisciplinary treatment team is comprised of program administration, the director of case management, the youth's assigned therapist, youth, and the parent/guardian if available. The seven interviewed staff reported direct care staff do not facilitate mental health or substance abuse groups.
A review of seven youth records found documentation to support each youth received individual, mental health and substance abuse groups, and family counseling. Each youth had a signed a Youth Consent for Release of Substance Abuse Treatment Records form and Authority for Evaluation and Treatment (AET) form. Each youth record reviewed contained an Individual Mental Health and Substance Abuse Treatment Plan including how often the youth was to receive individual, family, and group therapy. All seven youth received individual and family counseling monthly for one hour duration. However, there were reviewed events where a youth session was provided in shorter increments, such as thirty minutes one day and another thirty minutes on another day. Documentation review of sign-in logs for mental health (MH) and substance abuse (SA) groups supported all SA groups were limited to fifteen youth or less and all MH groups were limited to ten or less youth. Observation of a MH/SA group was not conducted by review team. An interview with the DMHCA indicted there are twenty-eight youth receiving comprehensive mental health treatment and eighteen youth receiving substance abuse overlay 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 the treatment and discharge planning for youth. A review of seven youth records found all included an Initial Treatment Plan upon admission to the program. Each plan was developed and signed by each youth at admission. The Initial Mental Health and Substance Abuse Plans were documented on a form which included all required elements. Four of the seven youth entered the program on medication, the remaining three did not enter the program with medications. All four applicable youth plans included psychiatric services which included medication monitoring.
The licensed mental health professional (LMHP) reviewed and signed all seven plans. When the plan was developed by a non-licensed clinical staff, the LMHP signed within ten days. Each plan was signed by required treatment members such as the youth, licensed clinician, and program staff. The designated mental health clinician authority reported currently conducting most of the intakes, supportive sessions and/or individual sessions as needed. The other therapist fills in these areas when the DMHC is not available. The Individualized Treatment Plans were completed within thirty days of each of the seven youth admissions. Each of the plans included the required elements. Individualized Treatment Plans were subsequently reviewed every thirty days for all seven youth. Each youth record contained documentation of each youth receiving individual, family, and group sessions in accordance with their Individualized Treatment Plan. The plans were signed by all members of the treatment team. The program mailed a copy of the plan to the parent/guardian for review and signature.

Three closed youth records were reviewed for discharge planning. Each youth received a Mental Health and Substance Abuse Discharge Summary prior to discharge. None of the three youth were discharged from the on suicide risk alert/suicide precautions. Each youth Mental Health and Substance Abuse Discharge Summary included detailed information of recommended services upon discharge and was discussed with the youth, parent/guardian and juvenile probation officer (if available) during the exit conference. The parent/guardian signed each plan on the day of discharge and was provided a copy. In addition, the program emailed a copy of the plan to each of the youth’s juvenile probation officers.

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 on providing Substance Abuse Treatment Overlay Services and Comprehensive Services for Major Disorders for specialized treatment services. The facility administrator reported the program provides substance abuse treatment services and comprehensive services for major disorders substance abuse overlay services and comprehensive mental health services. The designated mental health clinician authority reported ensuring services are delivered according to the Administrative Rule and the program's contract. This is accomplished through weekly supervision with mental health staff and regular review of compliance with contract requirements. At the time of the annual compliance review, there were twenty-eight youth receiving comprehensive mental health treatment and eighteen receiving substance abuse overlay services. The program has a Chapter 397 license which expires April 4, 2020. The program does not provide juvenile sex offender treatment services. The program services include mental health and substance abuse evaluation, treatment planning, therapy, psychiatric services, and crisis intervention (when needed). The program has two local designated crisis stabilization units. The psychiatrist is on-site five times a week and on call twenty-four hours a day. The psychiatrist license expires January 31, 2020. The psychologist serves as the designated mental health clinician authority (DMHCA), who is on-site forty hours a week and on call twenty-four hours seven days a week. Each of the seven youth had documentation of urinalysis drug testing in their youth records. Each of the seven youth records had progress notes indicating youth received individual, family, and group services according to their individual treatment plan. None of the groups had more than ten youth.

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

The program has a policy and procedure regarding psychiatric services. The program contracts with a psychiatrist to provide psychiatric evaluation, consultation, medication management and medical supportive counseling for youth. The psychiatrist holds a clear and active license with the Bureau of Medical Quality Assurance, Department of Health which expires January 31, 2020. A review of the last six months (twenty-five weeks) of sign-in and out logs revealed the psychiatrist was on-site an average of fourteen and a half hours a week to conduct evaluations and medication management. The psychiatrist reported being on-site three times a week; however, will come on another day for special occasions or to facilitate a meeting with parents/guardians. According to the program's contract, the psychiatrist is to be on-site not to exceed twenty-four hours a week. The psychiatrist stated evaluating every new youth within a week of arrival and diagnose and treat psychiatric disorders with medications and other modalities. In addition, the psychiatrist works with mental health therapist and case management staff to implement the full range of treatment recommendations.

Of the seven youth records reviewed, four entered the program on psychotropic medications. The remaining youth did not enter the program on medication; however, one of the remaining three youth was placed on medication after admission. Each of the seven youth had an initial diagnostic psychiatric interview in each of their records. The initial diagnostic psychiatric interview forms included all required elements. Each youth prescribed psychotropic medication after admission, received a psychiatric evaluation within thirty days of the intake. All initial diagnostic interviews were documented on the Clinical Psychotropic Progress Note (CPPN) including the history on a Department of Juvenile Justice form, mental status examination, Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR), treatment recommendations, prescribed medications if applicable, explanation of need for psychotropic medications, and medication monitoring/management. All five youths received monthly medication management from the psychiatrist. The psychiatrist meets with the youth along with a mental health representative and the representative reports any updates to all counselors.

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

The program has a written plan detailing suicide prevention procedures. The plan was dated July 2, 2018, and included staff training, identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The suicide prevention plan was signed by the facility administrator and the designated mental health clinician authority (DMHCA). The facility administrator stated training or mock drills are conducted monthly across all shifts.

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

The program has a policy and procedures regarding suicide prevention services. The program's practice is to complete an Assessment of Suicide Risk (ASR) on all youth upon admission to the program. Each of the seven youth records included documentation of a referral for ASR. Of the seven youth, three were placed on Precautionary Observation (PO) and the four remaining youth were not placed on PO. Each of the three applicable youth were placed on Constant Supervision and were provided mental health supportive services. The facility administrator (FA) and license mental health counselor (LMHC) or psychologist held a conference before level of supervision was reduced. A Follow-up ASR was completed for each youth prior to the removal from PO. Each of the ASR's were completed by either the LMHC and/or non-licensed clinician. The juvenile probation officer and parent/guardian were notified of each of the three youth

placements onto PO, each were documented in facility logbook, and an alert was entered in the Department's Juvenile Justice Information System. In addition, the alerts were distributed to staff through the logbook and internal alerts.

Youth are given the opportunity to participate in select activities with other youth while on PO and are not restricted to their individual rooms. Each PO log was completed as required, for each youth. The program staff documented supervision on the Constant Supervision visual checks log. There was documentation of the licensed mental health professional assessing the youth and conferring with the FA on recommendations for supervision. Each of the ASR's were completed within twenty-four hours of screening/concern. The program had one youth for review for Secure Observation for the annual compliance review period. The youth was placed in Secure Observation for a period of approximately two hours. Staff completed the Health Status Checklist and used the Secure Observation Log to document observations. The youth ASR was completed by the clinical staff the next morning and youth was then provided mental health support services. However, there was no documentation of the Secure Observation being authorized; in addition, to no documentation of the room being searched prior to youth being placed on observation, or notation of assigning youth to a designated secured room in writing.

The program has a total of four suicide response kits located on dorms and in the administration building. Seven staff interviewed reported when a youth expresses suicidal thoughts they are to notify mental health staff, conduct a search of the youth, maintain constant sight and sound, and document youth supervision. Each of the seven staff interviewed reported the suicide response kits are in master control, sub control, medical, and dorms.

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 regarding suicide precaution observation logs. Five of the seven youth had Precaution Observation (PO) Logs for review. Each youth had a PO Log completed for the duration of their placement. The staff documented observations not exceeding thirty minutes; however, they were not documented in real time. None of the youth had any warning signs. Each log was signed by the licensed mental health clinician and shift supervisor. The logs included safe housing areas in each case. Three youth who were placed on PO were interviewed, they reported staff was with the youth at all times.

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

The program has a policy regarding staff receiving suicide prevention training. Each of the seven pre-service and in-service staff received at least six hours of suicide prevention training in the Department's Learning Management System (SkillPro). Since July 2018, the program had a total of twenty-eight mock suicide and medical drills which were held no less than quarterly on each shift, for all staff who were in contact with youth. All drills included the required life saving measures, such as cardiopulmonary resuscitation (CPR), first aid and use of the suicide response kit. More than fifty percent of the staff participated in a minimum of one quarterly drill

semi-annually. The program reviews all drills during staff meetings for those staff who missed the last drill conducted.

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

The program has a crisis intervention plan, which includes a notification and alert system, means of referral, communication, supervision, documentation, and review. The crisis intervention plan was signed on July 2, 2018 by the designated mental health clinician authority and the facility administrator.

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 in place regarding the crisis assessment process. The evaluation will be conducted by a non-licensed staff working under the direct supervision of a licensed mental health professional. The assessment incudes the reason for assessment, mental status examination and interview, determination of danger to self/others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation and notification to parent/guardian, and juvenile probation officer. The program provided three crisis assessments during the last six months. Each of the crisis assessments included the required elements. Each of the crisis assessments were completed by either the psychologist or licensed mental health counselor. The crisis assessments were conducted immediately due to emergencies in each situation. Mental health alerts were entered into the Department's Juvenile Justice Information System and the staff documented supervision on the Mental Health Alert Observation Log. In one of the three applicable youth the crisis assessment is related to an alleged Prison Rape Elimination Act (PREA), which a Mental Health and Substance Abuse Referral Summary was submitted immediately and provided mental health services. The remaining two youth were related to mental health issues.

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 an emergency mental health and substance abuse services plan. The emergency mental health and substance abuse services plan included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency under Chapter 394 Florida Statutes (Baker Act) or Chapter 397 Florida Statutes (Marchman Act), documentation, training, and review. The plan was signed on July 2, 2018 by the designated mental health clinical authority and the facility administrator.

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

The program has a policy and procedures regarding the Baker and Marchman Acts. Since the last annual compliance review, the program has not had any youth referred for a Marchman Act; however, one youth was referred for a Baker Act. The program staff submitted a referral to mental health staff due to youth expressing suicide thoughts. The licensed mental health staff completed the Assessment of Suicide Risk (ASR) within two hours. The youth was on placed on one-to-one supervision upon determination youth was in need of a Baker Act. The mental status examination was conducted by the licensed mental health counselor. The youth was placed on constant supervision upon return to the program from Baker Act. The licensed clinical staff and the facility administrator conferred with each other prior to youth being stepped down from close supervision to standard supervision.

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 contract with a licensed physician, who acts as the program's designated health authority (DHA), and is responsible for providing oversight and supervision of all health and medical services, including general supervision of all medical personnel. The DHA is responsible for the overall clinical direction, policies, and protocols for medical services at the program. A review of the Department of Health Medical Quality Assurance License search website revealed the DHA's license is clear and active in the State of Florida and expires on January 31, 2021. The DHA is scheduled to be on-site three times a week, and is on call twenty-four hours a day, seven days a week. A review of the medical sign-in/out-logs for the last six months confirmed the DHA was on-site three times a week every week with the exception of one week. The DHA uses the services of another licensed physician, as a back-up when they are unable to provide services to the youth at the program. A review of the medical sign-in/out-logs indicated the back-up physician was on-site three days during the one week the DHA was unable to provide services. A review of the Department of Health Medical Quality Assurance License search website revealed the back-up physician's license is clear and active in the State of Florida and expires on January 31, 2021. A review of seven youth Individual Healthcare Records (IHCR) indicated the DHA conducts sick calls when they are on-site, as well as, provides routine medical care, and periodic evaluations for youth with chronic conditions. The DHA provides all follow-up medical care when a youth is referred by nursing staff. An interview with the DHA confirmed they are on-site three days a week and confirmed they are responsible for the initial admission physical exam, periodic evaluations, sick calls, and referrals to specialists.

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 has Facility Operating Procedures (FOP) for all health-related procedures and protocols used at the facility. A review of documentation indicated both the facility administrator and the designated health authority conducted an annual review and signed off on the FOP's and protocols on June 18, 2019. As part of the program's nursing pre-service training plan, all new medical staff are required to review the medical FOP's and protocols and sign the cover sheet indicating their review. All seven nursing staff who work at the program signed an FOP cover letter acknowledging their review. A review of the psychiatric FOP's revealed the program's psychiatrist conducted their annual review and approval of the psychiatric FOP's on June 19, 2019.

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

The program has a policy and procedures in place to ensure parents/guardians are afforded the right to give or withhold consent with regards to the healthcare provided to their children while

in the program. Seven reviewed youth Individual Healthcare Records (IHCR) confirmed all signed an Authority for Evaluation and Treatment (AET), with the word 'copy' stamped or printed on the form. One of the reviewed records was a youth who arrived at the program under the age of eighteen; however, when the youth turned eighteen shortly after arrival the youth signed the program form entitled, Authority for Evaluation and Treatment for Youth Over Eighteen Years of Age, which granted permission for the program to release only emergency medical information to a parent/guardian. All reviewed youth IHCRs were applicable for having parental notifications maintained behind the AET and all records contained these notifications. The youth who had turned eighteen while at the program did not have any parental notifications sent after following the youth's eighteenth birthday. One youth was being served by the Department of Children and Families; however, the parental rights were not terminated and there was no need for a court order authorizing medical treatment.

An interview with the program's health services administrator (HSA) indicated the program nurses review the youth's AET in the Department's Juvenile Justice Information System prior to the youth's arrival to validate accuracy. If the nurses find the AET is not valid contact is made to the youth's assigned juvenile probation office to receive a valid AET. The HSA indicated if the youth is eighteen upon arrival the youth signs the proper release of information form. Furthermore, if the youth turns eighteen while in the program the youth will review and sign the release of information form on their eighteenth birthday, and the form will be filed on top of the original AET in the youth's IHCR.

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

The program has a policy and procedures in place to address parental notification and consent for treatment. Seven youth Individual Healthcare Records (IHCR) were reviewed for parental notifications and consent for treatment. Six of the seven records required parental notification for the entire annual compliance review period; however, the seventh record was only applicable for parental notifications for a little over a month. A review of the seven records revealed each youth's parents/guardians received parental notification for over-the-counter medications beyond those covered by the Authorization for Evaluation and Treatment (AET). One record was applicable for notification of a vaccination not consented for on the AET. Three of the seven records were applicable for notification when significant changes to existing medications occurred. Four of the records were applicable for discontinuation of medication prescribed prior to the youth entering the Department's custody. Two of the records did not contain verbal consent from the parent/guardian prior to the discontinuation of the medications, while two contained verbal consent. The two youth who did not have verbal consent prior to the discontinuation of medications were on psychotropic medications and verbal consent is required prior to the discontinuation of the medication. In these two records, the nursing staff and the psychiatrist did not get verbal consent prior to stopping the medications. Three of the records were applicable for changes in condition/medication for youth with chronic conditions. Three records were applicable for parental notification for some invasive dental procedures. Six youth were taken off-site for medical treatment, and their records contained notification to the parent/guardian when these events occurred. Two of the seven records were applicable for off-site emergency notifications. All six applicable records contained documentation in the nursing progress notes verbal attempts, and parental consent was received for all new medications. All six records contained written notifications regardless if verbal consent was received. All six

records contained documentation a second staff member witnessed all telephone call attempts and conversations regarding parental consent.

One youth was in the care of the Department of Children and Families (DCF); however, there was no termination of parental rights. The program sent written notification and consent to the DCF case worker at the same time notification was sent to the parent/guardian. Four youth were applicable for written consent for the administration of psychiatric medications and all four records contained written notification with an attached Clinical Psychotropic Progress Note (CPPN), which was sent to the youth's parent/guardian. The health services administrator (HSA) was interviewed about parental consent and indicated parents/guardians are contacted by telephone to inform them of new medications, emergent care, and other situations which arise. The HSA also indicated written parental notification is completed within twenty-four hours of the request for treatment or medications. Furthermore, verbal consent is obtained as soon as possible after an order is written by a physician. In the interview with the HSA, it was confirmed notifications occur as stated above for medications and emergent care. The HSA indicated the designated health authority, regional health services administrator, parents/guardians, and facility administrator are also notified of emergent care. The HSA indicated during the interview when initiating new psychotropic medications, the psychiatrist calls the parent/guardian to obtain verbal consent with the nurse as a witness. Upon receiving consent from the parent/guardian, the medication orders are implemented.

The program has a policy and procedures in place to ensure a youths' immunization history is obtained and all youth have received proper immunizations. The program obtains the youth's immunization records from the youth's electronic commitment packet and from the electronic Florida Shots database. A review of seven youth IHCRs contained immunization and vaccination records confirmed by the program within thirty days of each youths' admission. One of the applicable records revealed the youth needed three vaccinations. The nursing staff verbally notified the parent/guardian of the need for the vaccinations and sent out the required written consent paperwork; however, the parent/guardian only signed consent for one vaccination, as they missed the other two consent forms in the packet sent to them. The nursing staff has since been in touch with the parent/guardian and resent the consent paperwork for the other two vaccinations. The nursing staff indicated the youth will be sent to the local health department for all three vaccinations, when they receive consent paperwork for the other two vaccinations. None of the reviewed records contained a refusal for consent of immunizations for religious reasons. An interview with the program's HSA indicated the youth's parent/guardian is required to provide the program with the appropriate signed exemption form from the Department of Health if they refuse vaccinations for religious reasons.

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 in place for the completion of the Facility Entry Physical Health Screening (FEPHS) form on all youth on the date of their admission. A review of seven youth Individual Healthcare Records (IHCR) contained a FEPHS completed on the date of the youth's admission. All reviewed FEPHS were completed by a registered nurse. Two of the seven youth had a change in their physical custody. One of the youth had three changes in custody and the other youth had one. Upon each youth's re-admission to the program a registered nurse completed a FEPHS re-screening form.

An interview with the health services administrator (HSA) indicated newly admitted youth are seen for a nursing assessment following their initial search upon entering the facility. The HSA further advised the nursing staff complete the FEPHS. The HSA indicated the designated health authority is notified on the same day as the youth's admission by telephone or in person regardless of their medical condition.

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

The program has a policy and procedures in place indicated all youth will receive orientation to the program's healthcare services on the day of their admission. A review of seven youth Individual Healthcare Records (IHCR) contained documentation the youth received a healthcare orientation upon admission. The program documents each youth's orientation to healthcare services on a program form entitled, Healthcare Services Orientation. There was documentation in all reviewed records the youth were oriented to the sick call process, access to medical care, what constitutes an emergency, the medication process and side-effect monitoring, the right to refuse care and how to document it, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care staff. Each youth's orientation form indicated they were advised of who the designated health authority (DHA) was, as well as the who was the program's assigned psychiatrist.

The program has a list of healthcare staff contacts in the medical clinic and it was in an area inaccessible to youth. A review of the list had the correct DHA, nursing staff, and psychiatrist listed. All seven IHCRs also contained a completed Health Education Record form indicating all the topic's each youth had or will receive education on while at the program. Topics the youth will be education on are prevention of accidents, alcohol/substance abuse, sexually transmitted diseases, smoking cessation, prevention of communicable diseases, cardiovascular health, physical fitness, human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) general information, nutrition basics, dental hygiene, personal hygiene, breast self-exam, testicular self-exam, family planning, parenting skills, anxiety reduction, coping with depression, and coping with anger.

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 policy and procedures in place regarding notification to the designated health authority (DHA) upon all newly admitted youth regardless of medical conditions. The purpose of the notification is to provide a comprehensive overview of the youth's medical conditions to the DHA and to obtain initial admission orders, initial medication orders, preliminary laboratory studies, diet orders, activity release or restrictions, and any other specific treatment orders or instructions for the youth with a health-related condition.

A review of seven youth Individual Healthcare Records (IHCR) revealed the DHA was notified of each youth's admission to the program and their medical history was shared with the doctor. There was documentation in all reviewed records of the date and time the DHA was notified. In three of the records a nursing progress note indicating the DHA was notified by telephone; and

in the remaining four records there was a progress note indicating the DHA was notified in person of the youth's admission. None of the reviewed records reflected the youth were in need of emergency services upon their admission. Documentation in all reviewed IHCRs confirmed each youth was referred to the doctor for their Comprehensive Physical Assessment. An interview with the health services administrator indicated the DHA is notified on the same day as the youth's admission by telephone or in person regardless of their medical condition.

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 in place indicating a Health-Related History (HRH) form will be completed within seven days of a youth's admission. A review of seven youth Individual Healthcare Records (IHCR) revealed the program completed an HRH form on all youth on the same day of admittance to the program, which met the required seven days of admission timeframe. All HRH forms were completed by a registered nurse. All HRH forms were reviewed by the designated health authority (DHA) and completed prior to the Comprehensive Physical Assessment. An interview with the health services administrator (HSA) indicated the HRH is completed by healthcare staff upon a youth's admission. The HSA further indicated each youth's HRH is updated annually.

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 in place to ensure each youth receives a Comprehensive Physical Assessment after their admission. A review of seven youth Individual Healthcare Records (IHCR) revealed each youth had a Comprehensive Physical Assessment (CPA) completed by the designated health authority (DHA) within seven days of their admission. Each CPA documented the youth's medical grade assessed upon admission. Six of the reviewed records had the CPA completed in accordance with the Department Rule 63M-2.0044; One exception reviewed for one youth indicated there was no notation made by the DHA by the male genital exam. All ll reviewed records required an update to the youth's problem list and there was documentation in each of the applicable records the problem list was updated as necessary. An interview with the health services administrator (HSA) indicated the DHA completes an initial CPA, on the Department's form, upon each youth's admission and annually thereafter.

The program has a policy and procedures in place to ensure youth receive routine healthcare screenings and evaluations upon admission to the program for latent or active tuberculosis, as well as environmental condition within the program. The program's policy follows the Centers for Disease Control and Prevention, as well as the Occupational Safety and Health Standards. Each of the reviewed IHCR revealed a current verified tuberculin skin test (TST) test. The tier 1 tuberculin (TB) screening portion of the FEPHS form was completed in all records. All records had the TST results documented on the Infection and Communicable Disease (ICD) form, as well as the CPA form. One youth record required an updated TST test while the youth was in the program, and the youth's IHCR reflects a new TST test. An interview with the HSA indicated a youth's previous medical record is reviewed prior to their arrival and then again upon admission to ensure a current TST test is documented. The HSA further advised new TST tests

are administered annually based upon the previous test date and the program tracks when each youth's annual TST test is due.

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 in place to ensure youth receive sexually transmitted disease/infection screening, evaluations, and testing. A review of seven youth Individual Healthcare Records (IHCR) revealed all youth were screened by nursing staff upon admission for sexually transmitted infections (STI). The designated health authority (DHA) ordered STI testing for three of the seven youth based on the youth's answer to the STI screening. There was another record which revealed the DHA ordered STI testing on the youth three months after admission based on the youth's medical complaints. A review of the four applicable records indicated STI testing was preformed and the results of the testing was documented on the Infectious and Communicable Disease (ICD) form, and the lab results were found in the lab section of the youth's IHCR. All records also contained the order for testing, which was found in the DHA and nursing progress notes. None of the reviewed records were youth who were out of the Department's custody for more than thirty days and did not require a re-screening for STIs. An interview with the health services administrator (HSA) indicated youth are interviewed upon admission about their sexual history and are tested based on the results of the screening and the DHAs order. The HSA further indicated if there were need for further evaluation based on the testing the youth would be referred to the DHA for examination. The HSA indicated the results of STI screening, evaluations, testing, and referrals are all maintained in three separate sections of the youth's IHCR; the screening and referral section, evaluation section, and testing documentation section. The HSA further indicated if youth are out of the custody of the Department for more than thirty days or symptoms are present the youth will be referred for testing and each youth is rescreened upon their re-admission using the Facility Entry Physical Health Screening (FEPHS) form, body chart, and sexually disease screening form.

The program has a policy and procedures in place to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, and referred for medical treatment. The program uses an approved vendor with staffed employees certified by Florida Department of Health, Division of Disease Control and Health Protection to conduct their pre- and post-HIV testing. This vendor also conducts HIV prevention counseling, and referrals regarding services for youth. The program was able to supply the annual compliance review team with the vendor individuals 501 HIV/AIDS certification by the Florida Department of Health, which was updated on June 20, 2019. A review of seven youth IHCRs revealed all youth were offered HIV testing, counseling, and received general education about the disease. Four of the seven youth records revealed each youth consented to HIV testing and the consent was documented on a program consent form. All four youth received pre- and post-test counseling from the vendor certified HIV counselor and the testing was documented in each youth's IHCR. All applicable records contained a sealed envelope, which contained the youth's HIV testing results, and the envelope was marked confidential. A review of the program's internal medical alerts and Department's Juvenile Justice Information System (JJIS) alerts revealed there were no alerts related to a youth's HIV status.

An interview with the HSA indicated the youth are asked upon admission if they would like to receive an HIV test. If the youth answers yes, then the designated vendor comes to the program and provides testing and pre/post counseling. The nurse further indicated the HIV consents and

risk assessments are located within each youth's IHCR and the youth's pre- and post-test is documented within their IHCR. The HSA reported the program maintains an HIV tracker which indicates if the youth agreed or did not agree to testing, and the date the youth received the pre- and post-testing. All seven interviewed youth indicated they could request an HIV test.

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

The program has a policy and procedures in place to ensure a Sick Call system is in place to respond to the complaints of youth illness or injury of a non-emergent nature. The policy indicates sick call care, including dental complaints shall be available to all youth. Sick call care shall be provided by licensed health care professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program has postings of the sick call hours in each of the program dormitories, in administration, on the medication pass through door in the cafeteria, and on the medical examination clinic door. The program has Sick Call forms available on each of the six dormitories and in the cafeteria. The locked sick call box is in the cafeteria and is checked several times a day by nursing staff. The program completes sick call three times a day, seven days a week, and has nursing staff on-site twenty-four hours a day, seven days a week. There is never an instance where a sick call or medication is given to a youth by a non-licensed individual. Sick call is always conducted by a registered nurse (RN) because the program is only contracted to hire RNs. Sick call is conducted daily from 8:00 a.m. to 10:00 a.m.; 1:00 p.m. to 3:00 p.m.; and again from 5:00 p.m. to 7:00 p.m.

A review of seven youth Individual Healthcare Records (IHCR) revealed four youth submitted one sick call request. None of the youth presented with similar sick call complaints three or more times within a two-week period. All four Sick Call Request forms were filed in the progress note section of each youth's Individual Healthcare Record (IHCR) in reverse chronological order. There were no sick call complaints of any severe pain with which nursing staff were unfamiliar. All four Sick Call forms were documented in accordance with the Department's Rule 63M-2 and contained the youth's vital signs, treatment, education and any follow-up plans. All four sick calls were documented on the youths' Sick Call Index in their IHCR and on the program's Sick Call Referral Log. During the annual compliance review, a sick call was observed after the youth and RN granted permission for the review team member to be present. The youth was escorted to the medical clinic by a direct care staff, who sat in the hallway with the clinic door cracked for security reasons; however, the youth's confidentiality was maintained during the entire sick call. The RN identified themselves to the youth, the youth sat on the examination table and reviewed the Sick Call Request form with the nurse. The RN discussed the youth's symptoms and took the youth's vitals. The youth's parent/guardian was contacted during the sick call and the parent/guardian granted approval for the required treatment. The youth then received the treatment as indicated by the nursing protocols. The youth reviewed and signed the Sick Call form prior to exiting the medical clinic.

Seven youth were interviewed and six indicated they could see the nurse within one day of submitting in a Sick Call Request. One youth indicated they could see the RN immediately. Seven staff were interviewed and all indicated nursing staff conduct sick call. An interview with

the health services administrator (HSA) indicated sick calls are conducted in the privacy of the medical clinic, which includes a medical examination table. The HSA confirmed in the interview sick call is conducted three times a day, seven days a week at the times listed above.

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 comprehensive process for the provision of episodic and first aid care. The program has a registered nurse (RN) on-site twenty-four hours a day, seven days a week, and there was no evidence of non-healthcare staff providing first aid/or episodic care to the youth. A review of seven youth Individual Healthcare Records confirmed four were applicable for episodic care, first aid, and emergency care. There were thirteen instances of episodic care reviewed in the four applicable records. Nursing staff document each event in the nursing chronological progress notes and label it, as an episodic incident. Each episodic incident was documented in problem-oriented narrative charting indicating the subjective, objective, assessment and plan (SOAP) format. All thirteen instances of episodic care were listed on the program's Episodic Care Log. Three of the episodic incidents resulted in the youth being transported to the local hospital for emergency care upon orders from the designated health authority (DHA). The DHA also conducted an evaluation of each youth the next time they were on-site, after the youth returned from the hospital, to follow-up on the youth's care.

The program has written policy and procedures for the provision of emergency medical care, including emergency dental treatment. The DHA is available by telephone twenty-four hours a day, seven days a week for consultation. Postings were found throughout the facility informing staff of their right and responsibility to call 9-1-1. A review of fourteen non-healthcare staff and seven nursing staff training records contained documentation of current first aid, epinephrine auto-injector, basic cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) certifications. The program had listings of emergency telephone numbers to include the Poison Control Center number in the medical clinic and master control; and was inaccessible to youth. Interviews with seven staff indicated they all knew they have permission to call 9-1-1 if a youth or staff has a medical emergency.

The program has a total of five first aid kits which were located in master control, alpha dormitory, bravo dormitory, charlie dormitory, and another one located in master control to be used for transportation. The program has four suicide response kits which were located in master control, alpha dormitory, bravo dormitory, and charlie dormitory. Documentation reviewed supported the nursing staff conduct weekly reviews of the first aid kits and monthly checks of the suicide response kits. A review of three first aid kits, which included the first aid kit used for transport, were observed to be fully stocked with all content approved by the DHA. The program has four AEDs, which are located in the administrative building, alpha dormitory, bravo dormitory, and charlie dormitory. The AED procedures are located within each AED box and in the medical clinic. The master control AED battery expires in August 2023 and was last changed on August 21, 2019. The pads expire in September 2020 and there was no notation of when they were last changed. The alpha dormitory AED battery expires on February 8, 2021 and was last changed on August 8, 2017. The pads expire in July 2021 and were last changed on June 26, 2019. The bravo dormitory AED battery expires on February 8, 2021 and was last changed on August 8, 2017. The pads expire in July 2021 and were last changed on June 27, 2019. The charlie dormitory AED battery expires on February 8, 2021 and was last changed on August 8, 2017. The pads expire in July 2021 and were last changed on June 26, 2019.

Reviewed documentation confirmed the nursing staff conducted monthly testing of the AED for the entire annual compliance review period.

The program is required to conduct monthly medical drills on all three shifts with CPR/AED being practiced at least quarterly. A review of the medical drills for the last year indicated drills were not conducted on the second shift in November 2018, first shift in December 2018, and second shift in February 2019; however, all other monthly medical drills were completed as indicated by the program's policy. The medical drills further indicated the program staff demonstrated CPR and the use of the AED at least quarterly for each shift while conducting the medical drills.

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 in place outlining the program's procedures for off-site care and referrals. Seven youth Individual Healthcare Records (IHCR) were reviewed and all were applicable for off-site care. Six of the seven IHCRs were applicable for parental notification and all contained parental notification. The seventh record was not applicable for parental notifications due to the youth being eighteen years of age when they required off-site care. All seven records had the Department's Summary of Off-Site Care form used and each were filed in the youth's IHCR. All Summary of Off-Site Care forms were reviewed and signed by the designated health authority (DHA). Six applicable records required follow-up testing, referrals, or appointments, and there was documentation in each record the youth received the necessary follow-up care.

An interview with the health services administrator (HSA) indicated the program tracks all youth off-site first aid or emergency care by documenting the incidents on the program's episodic care log, the internal nursing outlook calendar, and daily shift log. The HSA indicated all off-site care information is provided to the DHA on their next site visit. An interview with the DHA indicated the nursing staff places all off-site care findings, instructions and information in a folder and they review the information the next time they are on-site.

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 in place for youth with chronic medical condition(s), which indicates youth shall have treatment plans/physical progress notes which specify a youth's course of therapy, identifies the role of qualified health professionals in carrying it out, and is updated as needed. The policy further indicates youth with a chronic condition, communicable disease, receiving prescription medications including psychotropic medications, or are being treated for tuberculosis shall receive a periodic evaluation from the physician every sixty days.

A review of seven youth Individual Healthcare Records (IHCR) revealed two youth had a chronic medical condition identified at admission and required placement on the program's chronic condition list. Another youth was found to have a chronic medical condition after being

in the program for a short period of time and upon examination by the designated health authority (DHA). A fourth youth was placed on the chronic condition list for being identified as having a chronic condition upon admission and for being on psychotropic medications. The three remaining youth were on the chronic conditions list due to being on psychotropic medications. A review of the program's chronic condition list revealed all youth were appropriately placed on the list and their corresponding medical conditions and/or medication regiment was properly listed. All four youth identified with a chronic medical condition were seen by the DHA every sixty days for a periodic evaluation. The four youth who were on the chronic conditions list due to being on psychotropic medications received monthly medication monitoring by the psychiatrist. All documentation for the periodic evaluations and medication monitoring evaluations were found in each youth's IHCR. All applicable youth records contained specialized treatment plans for the youth based on their chronic condition. None of the youth were applicable for anti-tuberculosis medications. According to the interview with the health services administrator (HSA), all youth who require periodic evaluations are placed on the program's medical tracker to ensure the youth receive periodic evaluations every two months.

Five of the seven reviewed records reflected a periodic evaluation, or a medication management evaluation was conducted prior to the renewal of any prescription medication. All treatment orders were written clearly and were distinguishable for clinical staff to interpret. None of the periodic evaluations were conducted off-site. A review of all applicable records revealed there were no lapses in care or missing periodic evaluations. A review of seven youth IHCRs revealed all youth's problem list accurately reflected each youth's physical health, dental health and mental health. An interview with the DHA revealed all youth with a chronic condition are evaluated every two months and youth with chronic conditions are placed on the program's periodic evaluation tracker. An informal interview was conducted with the HSA, which indicated the healthcare staff reviews important youth medical issues with facility administration during the daily morning management meetings, which occur every Monday through Friday morning at 10:00 a.m.

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 in place to ensure youth receive all prescription medication(s) as prescribed by a physician. The policy indicates medical staff shall verify any medications arriving with a newly admitted youth. The program's policy also indicates only medications from a licensed pharmacy, with a current, patient-specific label intact on the original medication container may be accepted into the program. The policy further indicated verification of the actual medication contents is not required if the youth has been transferred directly from the Department and the medications have been under the Department's controls the entire time. A review of seven youth individual healthcare records (IHCR) revealed four youth entered the program with currently prescribed medication. The four applicable youth who entered the program with medications entered the program from a Department of Juvenile Justice (DJJ) detention center and verification was noted on the Department's Medication, Receipt, Transfer and Disposition form. Each youth's nursing progress note indicated staff verified the youth's medication with the parent/guardian upon the youth's admission. All applicable records reflected the designated health authority (DHA) was notified when the youth entered the program with prescribed medications. All youth records reflected the DHA advised the program to continue all medications until the youth were seen in person for their initial medical evaluation. Three of the

four youth entered the program with psychotropic medications, and the program's assigned psychiatrist was also notified of the youth's admission and each youth's prescribed psychotropic medications. Each youth's nursing progress note indicated the psychiatrist continued all medications until the youth were seen in person for their initial psychiatric evaluation. An interview with the health services administrator (HSA) indicated the program has twenty-four hour nursing and only licensed medical staff verify the youth's medications with the records sent from the DJJ detention center, and with the parent/guardian during the initial medical intake. The program did not have any instances of restricted housing; however, the program's policy indicates youth in restricted housing will be given their medications as ordered by the physician.

Five of the seven reviewed records reflected the youth received over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment form and they were administered in accordance with the approved nursing protocols. None of the youth's parents/guardians prohibited the administration of OTC medications. All seven reviewed youth IHCRs contained one or more Medication Administration Record (MAR) form. Four of the seven records were youth who arrived at the program on medications and all applicable records contained an initial MAR which matched the medication the youth was receiving upon their arrival. All MAR forms contained the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, side-effects, and medical alerts. A photograph of each youth is maintained in the current medication administration book, along with the current MAR. Each MAR indicated the youth received medication as ordered and clearly indicated when medication started and stopped. Each time a medication was administered the staff initialed the medication entry. A review of the MARs indicated nursing staff documented weekly side-effect monitoring for all medications administered. There were no lapses or errors in medication administration in the any of the reviewed youth records. All refusals were marked with the letter 'R' on the MARs and had a corresponding signed refusal form in the nursing progress notes. An interview with the HSA indicated the program uses pre-printed pharmacy MARs provided by their contracted pharmacy.

Observations of the medication administration office indicated the office was neat, clean and organized and locked upon entry. The medical cart where all medications were stored was neat, clean, organized, and locked. The program stores oral medication separately than injectable and topical medications. The program stores narcotics and other controlled medications in a lockable drawer within the locked medical cart. All other medications are stored in the medication cart, which is secured, locked, and inaccessible to the youth. The program has a process in place for the destruction of expired and/or discontinued medications. Unused non-controlled medications which are within the expiration date are returned to their contracted pharmacy by the pharmacy consultant, who comes to the program monthly, and the program is given credit for the unused medications. The program maintains documentation to support the medications were returned to the pharmacy. If the unused non-controlled medications are expired the program destroys the medications by using a medication jar. Two nurses verify the medication and then place the unused medication in the jar and when the jar is filled it is disposed of in the trash. All unused controlled medications are destroyed with the pharmacist and two nurses. The destruction of all medications is documented on the program's Disposal of Medication Logs. A review of the logs indicated all medications were destroyed in compliance with the program's policy and procedures.
The annual compliance review team member was able to observe a medication pass. Each youth was brought to the medication pass door in the cafeteria by a direct care staff. When each youth came to the door the nurse verified the Six Rights of Medication Delivery. The nurse also asked each youth about their allergies and side-effects of the medications they were receiving. Interviews with seven youth indicated six youth receive medications from the nurse. The

remaining youth indicated they did not take medication but knew the nurse gave the youth in the program their medications. An interview with seven staff indicated the youth receive their medications from the nursing staff.

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 in place for the storage of medications, and sharps. The program's policy indicates the program shall ensure all chemical products, medications, medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Observations of medications indicated they were stored in two locations within in the program. The youth's medications and over-the-counter (OTC) medications are in a locked medical cart maintained in the medication administration room. There is a second medication cart maintained in the medical clinic, which holds OTC medications. Both carts were locked when observed and have separate storage areas for different forms of medication. The cart within the medication administration room has an area where youth's medications are stored and has an additional lockable drawer, with a different key, which is used for controlled substances. The program contracts with a pharmacy, who is responsible for filling medication requests. An interview with the health services administrator (HSA) indicated the program has a quarantine area for the disposal of medications and documents such in the quarantine log. All medications are destroyed monthly using the disposal system provided by the pharmacy. The HSA further indicated all controlled substances are destroyed by the pharmacy consultant, a nurse, and a witness.

Observations confirmed all medication and sharps were securely stored in locked cabinets in the medical clinic. Syringes and sharps were counted using a perpetual inventory. The inventories are verified on a weekly basis, and the reviewer was able to observe the weekly counts were conducted for the entire annual compliance review period. Opened OTC medications were inventoried using a perpetual inventory and verified weekly, and the review team member was provided with documentation to support the nursing staff conducted the weekly counts for the entire annual compliance review period. The program also conducts shift-to-shift counts of controlled medications and the review team member was able to observe a shift-to-shift count of controlled medication; which was conducted in accordance with the program's policy. The program maintains all controlled medication counts within the youth's Individual Healthcare Record or in the current monthly Medication Administration Record (MAR) book. The program has a policy and procedures for detecting and responding to inventory discrepancies. A review of the Department's MAR and documentation confirm the program maintained perpetual daily inventories for all prescription medications. During the review, an inventory of three sharps, three medications, and three OTC medications were conducted and all were found to be accurate. An interview with the HSA confirmed the secure storage and routine inventory of medications listed above.

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

The program has an exposure control plan and a policy and procedures in place for the control of infectious and communicable diseases. A review of documentation indicated both the facility administrator (FA) and the designated health authority (DHA) conducted an annual review of the exposure control plan and policies on June 18, 2019. An interview with the FA indicated the exposure control and infection control plan is kept with the facility operating procedures binder which is located in the FAs office and in the medical clinic. The programs' infection control procedures included prevention, containment, treatment, and reporting requirements, as required by the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The infection control procedures addressed all required types and categories of diseases outlined in the Department's Rule 63M-2. There were no instances in which the local county health department, CDC, or the Central Communications Center required notification of an infectious disease.

The program's exposure control plan is located within the medical clinic and the FAs office and is accessible to all staff. The programs' exposure control plan includes risk assessment, methods of compliance, and contains all requirements of OSHA federal regulations. The policy included a comprehensive process for needle stick post-exposure evaluations. The program has not had any youth or employees who have experienced a facility/occupational exposure during the annual compliance review period. There were no instances involving quarantining or hospitalization of at least ten percent of the program's total population or staff during the annual compliance review period. A review of fourteen staff training records indicated all received annual training in infection control and site-specific exposure control plan. All staff are offered Hepatitis B immunizations at the cost of the program.

Seven reviewed youth Individual Healthcare Records contained evidence of training in infection control, hand washing techniques, universal precautions, prevention of communicable diseases, and vaccinations within seven days of their admission. An interview with the health services administrator (HSA) confirmed the program has an exposure control plan and infection control policy. The HSA also indicated the corporate trainer provides training on the program's exposure control plan during pre-service training. The HSA further indicated the program's nursing staff provides training on the site-specific infection control and exposure control plan to the staff at the program twice a year. The HSA also confirmed the youth are provided infection control training during their initial medical screening and the nursing staff also provide monthly groups on health education topics.

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, the indicator rates as non-applicable.

Standard 5: Safety and Security

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

The program has a written policy and procedures establishing how they 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. Reviewer also observed two staff members sitting with youth during a musical presentation and not posted in positions for proper supervision of all youth. Informal interviews with two staff found they were aware of the number of youth under their supervision immediately without having to stop and count. Formal interviews were conducted with seven staff. Each staff consistently indicated all movement would stop and a recount would immediately take place if the youth count is not correct. One staff indicated they would lock all youth down, behind their individual dorm if the count was still incorrect to conduct an emergency count. The staff to youth ratio indicated in the provider contract is one staff to seven youth. Observations during the annual compliance review found this ratio was maintained during all daily activities, such as education, meals, breaks and recreation with staff implementation of the behavior management system (BMS

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

The program has a written policy and procedure which define the program's behavior management system (BMS). This policy indicates the program shall have a "Positive Performance System" (PPS) designed to foster compliance with the program rules and teach youth alternative pro-social methods of dealing with problems utilizing both rewards and a system of progressive discipline. A review of seven youth case management records reflected each youth had the PPS explained to them during their program orientation. This was validated through the presence of a signed acknowledgement form in each of the records which indicated they received a copy of the resident handbook. A review of the resident handbook found all areas of the PPS are included. This includes the program's point system, expectations for each level, the interventions which shall be used to address unhealthy behaviors, the consequences and process to address the unhealthy behaviors, and the means youth can advance and earn more privileges through the PPS. An interview with the facility administrator (FA) and a unit manager found the program tracks all behaviors for each youth on a daily point card which corresponds to their current level. Observations of program postings and interviews with youth confirmed the program offers numerous incentives for the youth. Their point totals are tracked daily using a character point card for each youth. All of this information is tallied each week and is used for the canteen and to measure each youth's behavioral progress. All points have to be

earned by youth for each time period of the day and are never taken away from youth after being earned, according to the policy and observed practice.

Interviews with seven staff found they were knowledgeable regarding the PPS. All seven staff indicated the PPS includes a point system and a level system. Six indicated the rewards and consequences are given at a four to one ratio, the PPS information is posted throughout the program, and the PPS information is included in the youth handbook which is reviewed in their orientation. Two of the staff also indicated their points factor into moving through the level system and are used to earn incentives. Interviews with seven youth found all were able to explain the level system and what needs to be done to move forward between each level and towards transition. Six of the seven youth were able to explain the consequences which can be received for negative behaviors. The youth indicated staff will give verbal prompts three times when they are off track. If they refuse to stop, the youth indicated they may receive a special treatment team depending on the nature of their violation. At the special treatment team, they youth may receive a level freeze. This could lead to the loss of incentives or can keep them from moving to the next level. The interviewed youth indicated they receive many different types of rewards. These include going to the canteen each week, snacks, movies, attendance at special events held at the program, and the ability to be a part of the program's youth advisory board. An interview with the FA indicated they track the progress of each youth in the PPS through a point tracking system. Supervisory staff can use this, in addition to observations, to monitor how staff are implementing the PPS daily. This topic is also covered during morning management meetings. Special treatment teams which are set for the youth are also reviewed at the same time.

A review of staff training records found all seven new staff received training on the program's BMS during their orientation training. A review of seven staff in-service training records confirmed the staff also received refresher training each year on the PPS.

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

The program has a written policy and procedure which define the program's behavior management system, which is called their positive performance system (PPS). This system tracks infractions made by youth on their daily character point cards. The PPS is inclusive of a point card and a level system. The point cards and level system give youth an opportunity to gain rewards or privileges as they progress through treatment and advance further in the level system. The PPS does not include the use of room restriction or controlled observation. The program maintains a character point card for each youth where they can earn points for specific activities each day for positive completion of hygiene, meals, groups, recreation, and school. The point cards are updated throughout each day and reflect what program activities the youth positively participated in or completed. The youth can request to see their point card anytime

throughout the day to see how they are progressing. The youth can use the points they earn to purchase items from the canteen once a week.

The program has a youth advisory board which provides the youth with the opportunity to suggest what types of rewards and incentives they can receive through the PPS. A daily community meeting is held in each dorm after school where youth can share any ideas or concerns. Seven youth were interviewed about the PPS. Three youth reported the PPS is very good, one stated it was good, two stated it was fair, and one indicated it was poor. All seven youth stated they are never allowed to punish other youth. Each of the youth indicated staff are fair and consistent in the use of rewards. Youth indicated everyone is given the same thing if it is earned. No concerns were shared regarding staff consistency by the interviewed youth. Seven staff were interviewed about the PPS. All seven of the staff indicated they are provided feedback informally throughout each day, as needed, and during shift briefings. An interview with the facility administrator reflected the supervisory staff conduct fidelity checks on the youth's character point cards. Any concerns are addressed with staff immediately, and this is included in the semi-annual evaluations for all staff. One respondent to the staff interviews was a supervisor. They were able to confirm the process of fidelity checks

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

The program has a written policy and procedures which ensures an effective means for population counts and youth supervision to determine and accurately document the total number youth and their whereabouts at all times. Once the program has lights out and youth are sleeping in their dorms, the policy requires master control to initiate room checks at intervals not to exceed ten minutes. Program practice is for master control to notify staff on the living units to conduct checks every six minutes using the radio system. They maintain a log of when they radio to all the dorms to conduct their checks. The intervals documented between checks was reflected at six-minute intervals. Individual staff are positioned in each dorm. When the check is called they are required to walk down the hallway, stopping to check each room to see the skin or a body part of each youth prior to moving on to the next room. They then record these checks on the visual check sheet with the time of the check and their initials.

A review of the visual check sheets confirmed checks were being completed every six minutes as required by the written documentation. The program indicated their digital video record system (DVR) maintains thirty-days of information. Six different days were randomly selected for review of the six youth dorm areas. The program reported they have 140 cameras on their campus, and forty of them are not working. The facility administrator indicated the problem has to do with some of the equipment. He reported the needed parts must come from China, and the current tariff situation has caused issues in the provider being able to secure the needed components. An interview with the master control worker indicated the system gets too hot, so they have to keep certain cameras off to keep things from overloading or causing the system to shut down.
July 17, 2019 Charlie South – could not review this time because of an issue with cameras. The staff in master control indicated this has been one of their trouble areas with their cameras, as they constantly jump, and will not record consistently. July 19, 2019 Charlie North – 1:00 a.m.-

2:00 a.m. All checks were completed, with one exception. Staff appeared to have missed a documented check between 1:22 a.m. and 1:34 a.m. The video review results were as follows: July 28, 2019 Alpha South – 1:43 a.m.-2:43 a.m. There were no checks completed between 1:50 a.m. and 2:25 a.m. by staff, as documented on the visual check sheet. The program's initial thought was a supervisor had missed a check, but it was later discovered the time on the video is approximately fifty minutes behind real time. All of the above concerns were reported to the assistant facility administrator (AFA). The July 28, 2019, concerns were reported to the Department's Central Communications Center and call was accepted. There were no concerns or deficiencies seen on the other four reviewed nights.

Interviews with seven staff found six knew the program conducted checks on youth every six minutes while they were sleeping. The other staff member indicated they did not know how often this should be completed. An interview with the AFA reflected they conduct checks on the visual room checks at least weekly.

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

The program has a policy and procedures regarding census counts and tracking of youth. The program keeps a running census count on a whiteboard in master control. This shows the current count in-house, and which youth are out of the program. This information is also maintained in the master control logbook. The policy requires them to conduct at least six formal counts within each twenty-four hour period. The policy indicates these will be done at 5:30 a.m., 8:30 a.m., 12:00 p.m., 5:30 p.m., 9:30 p.m., and 1:00 a.m. A review of logbook documentation confirmed formal counts are being conducted at these times on each reviewed day. The program is required to ensure all youth are accounted for at all times through a system of physically counting youth at various times through the day. Florida Administrative Code 63E-7.107(b) requires the following: "Each program shall ensure staff conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during any emergency, escape incident, or riot". While occasional informal counts and weekly emergency counts were observed, the program was not conducting beginning shift counts or counts after each outdoor activity. This was validated through a review of the master control logbook and shift report documentation for the previous six months. While the scheduled 5:30 a.m. formal headcount satisfies the end shift count requirement for their third shift. None of their other standard counts meet these needs. The reviewed logbook documentation found the youth going outside for recreation on a regular basis. No evidence of formal or informal headcounts

being conducted after each outdoor activity, as required. During the logbook review, there was very little evidence reflecting the occasional informal count being conducted. After the program was informed of their random counts being conducted infrequently, this practice was changed, and informal counts were being called almost every hour for the final day of the annual compliance review.

Observations also validated staff requesting authorization to master control prior to movement from one location to another. During the annual compliance review, a review team member heard a count which was found to be incorrect by master control. All movement was stopped, and a recount was conducted immediately. This count came in accurate, and the program returned to their daily schedule. Informal interviews with staff during the annual compliance review found they were aware of how many youth were with them without having to stop and count the youth before answering. Seven staff were interviewed regarding when youth counts are conducted. Five of the staff were aware of the program's written policy. Two of these staff reported information which was consistent with the six formal counts listed in the policy, another two indicated two formal counts are done each shift, and the other respondent said counts are done every three hours. One of the remaining two staff said counts are done every time they conducted movement, and the other indicated a formal count is done at the beginning of each shift, and then master control will conduct four more formal counts during each shift. As indicated previously, reviewed documentation did not support the response from the last staff. The respondents were also asked what would happen if a count was incorrect. Each indicated all movement would stop and they would immediately conduct a recount if the count is not correct. One respondent indicated they would lock all youth down in their dorm rooms if the count was still incorrect, all youth would be locked down to conduct an emergency 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 has a written policy and procedures regarding logbooks and shift reports. The program has a master control logbook, which is maintained by a master control worker. A review was conducted on the master control logbooks from the past six months. The logbooks contained a chronological record of events, incidents, and activities occurring in the program. Each logbook was bound with numbered pages, and contained entries regarding admissions and releases, emergencies, security risks, incidents, transports, and staff assignments. Florida Administrative Code 63E-7.107(15)(a)4 requires the entries reflecting, "Population counts at the beginning and end of each shift and any other population counts conducted during a shift." The review of the master control logbook for the past six months reflected physical counts consistently being conducted at 5:30 a.m., 8:30 a.m., 12:00 p.m., 5:30 p.m., 9:30 p.m., and 1:00 a.m., which meets the expectations of their policy. While the scheduled 5:30 a.m. formal headcount satisfies the end shift count requirement for their third shift. None of their other standard counts meet these needs. Reviewed documentation was able to confirm the program is documenting all physical counts which are conducted in the logbook.

The program does document sharing of the recorded census count from one shift to another, but no physical head count is completed at this time. Each logbook entry included the date and time of the event, names of staff and youth involved, a brief description of the event with the name and signature of the person making the entry, and the date and time of the entry. There

were no entries obliterated or removed, and any errors were struck through with a single line and initialed by the person correcting the error. All applicable incidents for calls placed to the Department's Central Communications Center and/or the Florida Abuse Hotline were documented in the logbook. The program completes a shift report to share important information with oncoming staff regarding the previous shift. Prior to staff reporting to their assigned living unit, a shift briefing is held in the conference room to review any important information from the previous shift, and any information which staff need to be aware of. A review of the shift reports for the previous six months found they contain youth census information from the beginning and end of the previous shift, status of absent staff, intakes/releases, staff assignments, youth alert information, and other important incidents which occurred during the previous shift. The shift report was then signed by all staff present in the shift briefing. A copy of each shift report is maintained in the sub control/conference room area in each of the three buildings which house youth for at least forty-eight hours

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

The program has a written policy and procedures for the control and accountability of all keys in the facility. The program has a policy in place to govern the control and use of keys including key assignment and usage, inventory and tracking, secure storage, procedures for missing or lost keys, and reporting and replacement of damaged keys. All the program's active keys are housed in two locking cabinets in the master control area. Neither of these cabinets were found locked during the first three days of the annual compliance review. This was observed by at least two team members on at least seven different occasions. They also have two smaller locking cabinets, one of which houses the emergency keys, and the other houses the emergency access keys for the other two programs operated by the same provider in another location . Observations during the annual compliance review found the keys for the emergency cabinet in the lock for the cabinet, which provided no security for this cabinet. The keys in this cabinet would allow access to any area of the program, as well as egress from multiple points in the program. When a review team member asked about the emergency access keys, a master control worker just opened the door, which was not locked. The failure of the program to secure all the key cabinets was an even greater concern since the door to master control was found unlocked on at least three different occasions during the annual compliance review.

Interviews with a master control operator confirmed their knowledge of the procedures for addressing missing or lost keys, and the reporting and replacement of damaged keys. When a key is broken, a work order is submitted. This is then addressed by the physical plant manager. An interview with the physical plant manager, who is responsible for addressing broken keys, and a review of work order documentation confirmed this practice. The physical plant manager maintains a locked key cabinet in his locked shed, which contains backup and master keys in the event the program needs to replace a damaged key. There were no reported incidents of lost keys or staff leaving the building with access keys to the program during the annual compliance review period. Observations of all facility keys found most of the key rings had a

tamper proof mechanism designed to inhibit the removal of keys. During the annual compliance review, random checks of three staff found each was carrying only facility keys on their person always, and youth did not have access to handle facility keys. The program was able to provide an inventory which reflected all their key rings, which reflected the number of keys and type of keys on each ring. Six sets of keys were compared to the provided inventory for accuracy, and a deficiency was found for each inspected key ring. They are as follows: Ring 140 (Inventory indicates the ring has six keys; the metal chit on the ring indicates seven keys are on the ring; The ring has nine keys), Ring 003 (Inventory and chit indicate twenty keys; the ring has twenty-two keys), Ring 139 (Inventory and metal chit indicate there are nine keys; the ring has eleven keys), Ring 14 (Ring and inventory both reflect eleven keys; the ring has two additional rings attached. One with five keys, and one with four keys. Any of these keys were easily removeable. The extra rings are not soldered, and none of these keys are on the inventory.), Ring 017 (This ring was not on the provided inventory), and Ring 31 (Inventory indicates the ring has three keys; inspected ring has four keys).

Visitors keys are taken and placed on a numbered board to the left of the two large keys boxes for staff keys on numbered hooks. Each visitor is given the number of the hook which their keys were placed on, and this information is recorded on the visitor sign-in log. Interviews were conducted with seven staff to determine their knowledge regarding the key control system. All seven staff indicated staff's personal keys are given to master control upon entry, their personal keys are securely stored, personal keys of visitors are given to master control upon entry, daily tracking is kept using a key log, program keys are assigned to staff, and an inventory of keys is maintained by the program. All seven respondents also indicated youth are not given access to the program keys. Six of the interviewed staff were able to explain the procedures which would be followed in the event of a lost key, while one staff member indicated they were not familiar with the procedures which would be followed.

5.08 Contraband Procedure	**Limited 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 written policy and procedures to prevent the introduction of contraband into the program. The program's policy defines certain items and materials to be considered contraband when found in the possession of a youth, and what actions will be taken in the event items are found in a youth's possession. The policy also indicates those same items are

prohibited for staff to have within the program. Each youth is oriented on the all items considered to be contraband on the day of admission. They sign an acknowledgement form reflecting this review, which is filed in their case management record. The program policy and contraband list reviewed with youth were found to include all items required by Florida Administrative Code 63E-7.107 (9)(b). There was documentation to support the program conducted and documented searches of the youth, physical plant, and common areas, daily; however, they could not provide documentation to reflect regular room searches on their dorms, except for Alpha South. The program provided all room search documentation for previous six months.

The program policy is for each youth room to be searched weekly, at a minimum. The reviewed documentation reflected common area searches of each dorm daily on the overnight shift, and the Alpha South dorm. They could only provide documentation to reflect sporadic room searches on the remaining five dorms. The reviewed documentation indicated room checks were not completed during the following periods: July 2019 (No room check documentation for Bravo East or Bravo West. They provided special treatment team documentation which reflected checks were likely conducted on the other dorms.), June 2019 (No room checks documented on Alpha North for the month; room check documentation missing for two of four weeks in Bravo East, Bravo West, and Charlie South; room check documentation missing for three weeks of the month on Charlie South.), and May 2019 (There was no documentation for any room checks on Bravo West, Charlie North, or Charlie South dorms during the month; room check documentation missing for at least two weeks on Alpha North and Bravo East dorms). When presented with information regarding the missing room check documentation, the program indicated their recreation specialist may have thrown the great majority of this documentation away after reviewing it to see if youth needed to be set for a special treatment team due to having contraband. The available logs validated each dorm was searched, whether or not unauthorized items were found and what the found items were.

A review of visitation documentation for the previous six months reflected all visitors are searched prior to entering the program for visitation. The policy requires each youth to have a full body visual search following each visitation. Youth search forms were found in the weekly visitation documentation for each youth for the past six months. Informal interviews with staff indicated they will notify an administrator if any illegal contraband is found. An interview with the facility administrator revealed the contraband items will be preserved as evidence pending a possible criminal investigation. Illegal items will be provided to law enforcement, if required. Any item deemed non-threatening will be maintained by the facility administrator.

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

The program has a written policy and procedures regarding searches of youth. The policy requires youth to be searched by male staff prior to movement from one area to another. The program also conducts full body visual searches on youth at the time of their admission to the program, when visitation is completed, and when there is a reasonable suspicion a youth is concealing contraband. These searches are required to be conducted by two male staff. Observations during the annual compliance review confirmed youth were searched before movement from one program area to another. Each observation found staff making the youth aware of the search, and the searches were done as required by policy and with respect for the youth. Reviewed documentation confirmed the completion of full body visual searches, when

required. No full body visual searches were observed during the annual compliance review. Informal interviews were conducted with three male staff. They were able to explain the process for how they complete the searches during the intake process and following visitation. There was documentation in the reviewed youth records and visitation documentation to support searches and full body visual searches were conducted consistently. All seven interviewed staff reported youth are searched prior to each movement. One of the staff indicated searches occur when returning from off campus trips, such as a medical appointment. All seven interviewed youth reported searches are conducted when returning from off campus, when items are missing, and after visitation. Six of the seven youth also indicated searches are completed after outdoor activities and after meals. Four of the respondents indicated they would be searched after a work detail.

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

The program has a written policy and procedures in place to address vehicles and maintenance. The program has one van which is used to transport youth. A random inspection during the annual compliance review found this van to be locked. Observations found the van had a security cage which had been installed, and the door could not be opened from the inside by youth. The van was equipped with a fire extinguisher, which was inspected by a fire safety company within the past year. An inspection of the van was conducted by a review team member. The van had a tool which was an emergency seatbelt cutter and a window punch. The program also has a first aid kit for the van, which is kept in master control, and is to be checked out for each transport, so the items inside the kits are not subjected to the extreme heat while the van is not in use. The program conducted an annual vehicle inspection the week prior to the annual compliance review. No concerns were identified on this inspection. A review team member was able to observe a transport upon arrival to the program. This observation found two staff preparing one youth for transport to educational testing. Both staff and the youth were wearing their seatbelts. An informal interview with a transporter indicated both staff and youth wear their seatbelts during all transports. Interviews with a transporter and a master control operator indicated they have a cellular phone which is available for transporting staff.

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

The program has a written policy and procedures for the transportation of youth. A transport was observed by a member of the annual compliance review team. There were two staff present for one youth. Staff were observed assisting the youth in putting their seatbelt on for the trip to educational testing. Their policy indicates they will maintain a ratio of at least 1:5 while transporting youth. An interview with a transporter revealed the program will always have two staff present during transports. The program maintains an approved driver list which is maintained by the program's human resources specialist. A check of each transporter's drivers

license is conducted monthly, and the transporter is certified on the approved driver list. Observations and an interview with a transporter confirmed they are provided with a cellular phone for use during transports. Observations during the annual compliance review found program vehicles were locked when not in use. Perimeter checks include a check of the security of all vehicles, program and personal, in the parking lot, which no concerns or issues were found by the reviewer. Interviews with seven staff indicated they are not allowed to use their personal vehicles to transport youth. Each of the respondents also indicated the program provides a cellular phone for each transport.

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

The program has a policy and procedures in place to address weekly safety and security audits. The reviewed documentation found the program's assistant facility administrator completed the Facility Security Audit and Safety Inspection weekly. This document includes checks of program areas including: surveillance, communication equipment, doors, metal detectors, mechanical restraints, sally port, transportation vehicles, youth rooms, classrooms, kitchen/dining area, grounds inspection, exterior structures, perimeter, chemical storage, and tool and sensitive item control. Weekly safety inspections are maintained in a binder, which contained Facility Security Audit and Safety Inspection for the past six months. Documentation included comments on concerns and information relating to corrective action which was needed for any identified problems. An interview with the facility administrator revealed all physical plant concerns are tracked by the management team and are addressed in their meetings. All safety and/or security issues pending repairs are tracked by the management team. They also were able to provide documentation reflecting they have been working to address their current camera concerns. In addition to the weekly inspection, the program has the supervisor on shift complete an inspection sheet to look for potential concerns on each shift. If any concerns are found, this information is provided to and addressed by the management team.

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

The program has a written policy and procedures which address tool inventory and management. The program's tool management procedures include tool identification, inventory procedures, training, and oversight. The program maintains Class A tools in their maintenance shed, which is not accessible to youth. All tools were marked with easily identifiable numbers, which clearly matched the numbers on the tool inventory. The tools are also maintained on a shadow pegboard which also allows easy identification if any tools are missing. Random checks of tools were completed, and all were found on the program inventory. A daily check of all tools is completed by the physical plant manager each day they work. When a tool is used, it is checked out on the log in the tool area and checked back in at the end of the day, or when the project is completed. The program maintains a binder containing all monthly inventory sheets, which document verification each tool in the storage shed. A review of seven case management records confirmed each youth was trained on the safe use of Class B tools as part of the intake process. The review of seven pre-service staff training files also reflected each staff being trained on the safe use of tools. Seven interviewed staff indicated youth are allowed to use mops and brooms. Four of the respondents indicated they may use a scrub brush, and two said they may use a dustpan. Seven youth were interviewed, and six of the youth indicated they

have used a Class B tool. All six indicated they have used a mop or broom, two said they have used a scrub brush, and one said they have handled a paint brush.

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

The program has a written policy and procedures regarding youth tool handling and supervision. A review of seven staff training records documented receipt of tool safety training during pre-service training. Seven case management records were reviewed; the youth orientation packets confirmed youth were trained on the usage of Class B tools. Before a youth is permitted access to a Class B tool, a risk-assessment is completed to determine the youth's level of risk to harm self or others. The program also completes a monthly risk assessment to determine if youth are still eligible for the use of Class B tools. No youth is ever allowed to use any tool without direct supervision of a staff member. A review of the risk assessment binder found these are completed on each youth, and are updated monthly, as required by program policy. The program was also able to provide risk assessments which were completed by a contracted program when each youth was accepted to their program. Seven interviewed staff indicated youth can use mops and brooms. Four of the respondents indicated they may use a scrub brush, and two said they may use a dustpan. Seven youth were interviewed, and six of the youth indicated they have used a Cass B tool. All six indicated they have used a mop or broom, two said they have used a scrub brush, and one said they have handled a paint brush.

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

The program maintains a written policy and procedures for how they will manage and supervise outside contractors. The policy requires a physical plant staff to maintain constant supervision of all outside contractors while they are on-site. Youth are not allowed access to the area where outside contractors are working. Any areas the outside contractor worked in are searched after the work is complete. The program maintains a binder which contains the signed checklists of expectations to be followed by each contractor, which are filled out whenever a contractor comes on-site to complete a work project. The reverse of each form has information which reflects the inventory of the tools which are brought into the secure area. It also reflects a second inventory which is conducted when they leave the program to ensure no tools are left behind. They do not keep a separate sign-in log for the contractors to track all who comes on-site. The program was able to provide nine invoices for randomly selected vendors from the past six months. This review found the binder was missing signed forms for five of the dates on which services were conducted by outside contractors. For the other four instances, there was evidence each contractor signed the written notification and guidelines for outside contractors, in addition to filling out the tool inventory list which documents what items and/or tools were brought on-site. The vendor and supervising staff each initialed when the tools came in and left.

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

The program has a policy and procedures in place addressing fire, safety, and evacuation drills. The policy requires drills to be conducted every month and on every shift. An interview with the facility administrator confirmed fire drills are conducted monthly on each shift, and other emergency drills are conducted at least once a quarter. A review of the program's drill documentation found the program completed fire drills monthly on each shift during the past six months. The review of drill documentation also found the program has completed an emergency drill each of the past six months. These drills addressed weather situations (including a hurricane drill), escape, gang concerns, program disturbances, and a bomb threat. Seven youth were interviewed, and each stated they have been instructed on what to do in case of a fire. Six of the youth reported fire drills occur at least once a month, and one indicated he did not know since he arrived twenty days ago. Seven staff were interviewed regarding the types of drills they have participated in during the past twelve months. Five indicated they had participated in, escape, and fire drills, four indicated they participated in a bomb threat drill, three indicated they participated in a chemical spill or hostage drill, one indicated they had participated in a flood drill, and one staff said they did not participate in any drills during the past six months. Staff also reported participation in medical and suicide drills.

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

The program has a written policy and procedures which details all aspects of the Continuity of Operations Plan (COOP). The program's COOP was reviewed and approved by the Department on March 7, 2019. An interview with the facility administrator, as well as observations made during the annual compliance review, confirmed the program maintains a copy of the COOP in master control. The COOP addresses alternative housing plans, vendor contact list, emergency staff contact numbers, and county cooperation checklist. The program provided documentation reflecting COOP drills were conducted every month, which included scenarios such as weather, safety, escape, and disaster. The drills were documented in the logbooks and on facility emergency drill forms. A review of the program's COOP drills indicated the drill forms includes a synopsis of the drill, the date, the time, what type of drill was being conducted, any deficiencies identified, any corrective action needed, and the staff involved.

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

The program has a written policy and procedures to address the storage and inventory of poisonous, flammable, and toxic items. An inspection of the area where the chemicals are stored found all materials were in a locked cabinet in the kitchen and in a locked flammables locker in the maintenance shed. There were Safety Data Sheets (SDS) in each area for all chemicals maintained. The inventories for chemicals in each area were found to be accurate. Youth do not have access to either of these restricted areas. They also maintain a small supply of cleaning chemicals in a storage closet near the dining area. This closet contains cleaning carts for each of the six units. A small supply of cleaning chemicals is maintained on each cart for use on the dorms. These are replenished as needed for use when cleaning is completed each day. There was a clipboard which had an inventory of the chemicals present, and a daily sign-out and sign-in for each cart. No discrepancies were noted in this area during observation by a review team member. No chemicals are stored on the youth dorms.

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

The program has a written policy and procedures which prohibits youth from having access and using any flammable, poisonous and/or toxic materials. The program maintains strict control of these items. Youth are restricted from the areas where flammable, poisonous, and toxic materials items are stored. Observations made during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. The ongoing perpetual inventory for these cleaning items matched the quantity of each remaining item. Youth do not participate in the disposal and/or clean-up of any harmful or toxic materials. The program has a system in which the daily cleaning supplies are prepared, maintained, and distributed to each dorm after school. Once the cleaning has been completed, these cleaning carts are returned to the storage closet for replenishment, when needed. This process is tracked on logs which reflect the chemicals being picked up for use, and their return once the cleaning has been done. Interviews with seven youth revealed two have participated in a work project. These respondents indicated they helped paint over graffiti using a paint brush or roller under staff supervision. One youth also indicated he was given an alcohol pad by medical to rub on a wound once. None of the seven youth indicated they have ever handled any chemicals while in the program. The program employs staff whose primary role is to complete housekeeping work in the program.

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

The program has written policy and procedures for the disposal of flammable, toxic, caustic, and poisonous materials. These types of hazardous materials are to be disposed according to Occupational Safety and Health Administration (OSHA) requirements. An interview with the facility administrator revealed these materials would be taken to the Hillsborough County dump on their quarterly amnesty day. The physical plant manager indicated the program has not had to dispose of any chemicals during this annual compliance review period.

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

The program has policy and procedures to address visitation, telephone access, and correspondence. An approved visitation and telephone call list are developed upon a youth's admission throughout their orientation process. Feedback and input for this list are obtained from the youth's juvenile probation officer and parent/guardian. A copy of this list is maintained in each's youth's case management record and in the visitation binder, which is kept in master control. Visitation is held every Saturday and Sunday from 2:00 p.m. to 4:00 p.m. Information regarding visitation is mailed to each youth's parent/guardian upon the youth's admission to the program. Visitation is usually held in the dining hall. A review of documentation confirmed visitation was conducted each week. A review of telephone logs confirmed youth were receiving telephone calls on a weekly basis, which were facilitated by the case management staff. This was verified through documentation seen on each youth's monthly call logs, which are maintained in each youth's case management record. The program maintains a log of all mail which is received. An interview with the lead case manager revealed they log, open, and inspect all mail without the youth present. They indicated they will then provide the mail to the youth. This process does not comply with Florida Administrative Code 63E1.107(2)(d), which requires, "During the search of incoming or outgoing mail, the youth receiving or sending the mail shall be present or, if the program conducts mail searches at a central location, a youth representative shall be present to witness the process". All seven of the interviewed youth indicated they have been given the opportunity to communicate with family members by mail, telephone, or at visitation.

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

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures on safety plans and has established safety plans for all youth as required by the July 1, 2019 mandate. The safety plans include warning signs, youth's baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Seven youth case management records were reviewed, and all youth were admitted prior to the mandate for safety plans, therefore, they were not required to be completed within fourteen days of admission; however, each of these youths had a safety plan created within thirty days of the new requirement. An additional three records were reviewed who were admitted after July 1, 2019. One youth's safety plan was completed sixteen days late, and the other two were completed within the fourteen-day timeframe. Due to the mandate going into effect on July 1, 2019, none of these recent youth admissions were applicable for the completion of an updated safety plans. The safety plans have been prepared by the youth, parent/guardian, clinical staff, direct care staff, case manager, education, and an administrative representative. Interviews were conducted with seven youth, and six of the reported they were involved in the development of their safety plan. The other youth said he was not. All seven interviewed staff indicated the safety plans are maintained in each sub control/conference room area on the youth dorms for review.