STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Twin Oaks Vocational Academy II

Twin Oaks Juvenile Development, Inc.

(Contract Provider)

29841 Liberty wilderness Road

Sumatra, Florida 32335

Review Date(s): May 14-17, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Warren Garrison, Office of Program Accountability, Lead Reviewer (Standard 1 & 2)
Sherrell Cummings, DJJ Detention Services, Government Operations Consultant (Standard 5)
Katherine Gomez, Office of the Secretary, Director of Human Trafficking Intervention (Standard 2)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 4)
Sarah Hollar, Office of Programming and Technical Assistance, Government Operations Consultant II (SPEP)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Twin Oaks Vocational Academy II
Provider Name: Twin Oaks Juvenile Development, Inc.
Location: Liberty County / Circuit 2
Review Date(s): May 14-17, 2019

MQI Program Code: 1427
Contract Number: R2105
Number of Beds: 12
Lead Reviewer Code: 122

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
1 # Case Managers

1 # Clinical Staff
1 # Food Service Personnel
1 # Healthcare Staff
1 # Maintenance Personnel
2 # Program Supervisors

3 # Staff
3 # Youth
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☐ Affidavit of Good Moral Character
☒ CCC Reports
☐ Confinement Reports
☒ Continuity of Operation Plan
☒ Contract Monitoring Reports
☒ Contract Scope of Services
☐ Egress Plans
☒ Escape Notification/Logs
☐ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☐ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
3 # Health Records
3 # MH/SA Records
4 # Personnel Records
12 # Training Records/CORE
3 # Youth Records (Closed)
6 # Youth Records (Open)
_____ # Other: _____

Observations During Review

☒ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☐ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☐ Security Video Tapes
☒ Sick Call
☐ Social Skill Modeling by Staff
☐ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☐ Treatment Team Meetings
☒ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

* 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	Non-Applicable
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	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	Limited
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Satisfactory
3.12	* Suicide Precaution Observation Logs	Satisfactory
3.13	* Suicide Prevention Training	Satisfactory
3.14	* Mental Health Crisis Intervention Services	Satisfactory
3.15	* Crisis Assessments	Satisfactory
3.16	* Emergency Mental Health and Substance Abuse Services	Satisfactory
3.17	* Baker and Marchman Acts	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

Twin Oaks Vocational Academy II is a twelve-bed program, for ten to thirteen year old males, located in Hosford, Florida. The program is operated by Twin Oaks Juvenile Development, INC. through a contract with the Department. With the trajectory of minimizing risk to reoffend, the integral service goals are encompassed with, but not limited to, the following: intensive mental health treatment, mental health overlay services, a full continuum of care, comprehensive medical, mental health and substance abuse treatment which includes individual, group, and family counseling, parenting skills, and evidence-based and promising practices such as Impact of Crime (IOC) and Thinking for a change (T4C).

Pivotal to the program functionality are the staffing positions making up the administration. Administrative positions include the program director, the operations supervisor, the administrative assistant, the training coordinator, and the behavior specialist. The program utilizes a behavior specialist, as the position plays a quintessential role in the behavior management system at the program. The program has one behavior specialist and four behavior technicians. Case management staff are essential to assessing the youths' individual needs. Having an astute gauge of the youth needs consequential to administering assessments, together the youth and case mangers map out a trajectory for completing the program. Case management is replete with three staff at the program. Education is comprised of one lead teacher and five teachers. The program also has both a transition specialist and recreational therapist.

Medical services are provided by a psychiatrist, medical doctor, three registered nurses (RN), and one licensed practical nurse. Two RNs are part-time staff. The program also utilizes the Liberty County Health Department for medical services. Youth are provided comprehensive medical service treatment.

Care and custody services are provided twenty-four hours a day, seven days a week. The program utilizes seven team leaders, four night counselors, two night shift supervisors, and two day shift supervisors. Shifts are schism between night and day shifts, twelve hours each shift. Youth occupy the program's two sleeping quarters, the cafeteria, two class rooms, a testing center (room), a medical building, and designated outdoor areas for recreation. The program does not utilize any cameras. The program is surrounded by the Apalachicola National Forest with no fencing. The Apalachicola Forrest Youth Camp (AFYC) prepares all the meals for the program. At the time of the annual compliance review, the program had no vacant positions.

Strengths and Innovative Approaches

The program has a hog pen for raising pigs, a gated in garden on approximately one acre, a new aquaponics system, and two ponds.

Standard 1: Management Accountability

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

The program had nine staff who required an initial background screening. The program utilizes the Agency for Health Care Administration (AHCA) Clearinghouse for background screening. None of the staff were hired prior to receiving an eligible background screening result. Each background screening report was found in the staff's personnel record and the staff were included on the program's Clearinghouse employment roster. Each record contained a pre-employment assessment tool administered to direct care applicants with each staff receiving a passing score. The program did not have any volunteers, mentors, or interns who assisted or interacted with the youth on an intermitted basis for more than ten hours a month.

The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit (BSU) prior to January 02, 2019.

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

The program did not have any staff, volunteers, or interns who required a five-year background rescreening during the annual compliance review period. The program has a written policy and procedures regarding the completion of background rescreenings for staff, volunteers, mentors, and interns who have been with the program for five years. Rescreenings are completed prior to their five year anniversary date.

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.

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

A review of three staff records found each maintained signed code of conduct forms clearly communicating expectations for ethical and professional behavior. All youth and staff are required to report all cases, even suspicion of abuse according to the program's policy. Staff are to refrain from using threats, abuse, and profanity. Youth are never denied a call to the Florida Abuse Hotline. The program has not had any instances of abuse during the annual compliance review period. The Florida Abuse Hotline and CCC contact numbers were posted in both dorm rooms.

When youth request to make a call to the Florida Abuse Hotline, both the supervisor and program director are notified and a response is not needed for the call to be made. The supervisor will make the call for the youth and then allow the youth to report the alleged abuse incident. The program director reported staff are terminated immediately for all allegations of abuse. The program reports youth and staff are made aware of their right to report abuse during orientation and pre-service and in-service training.

Two of the three interviewed youth reported they feel safe at the program; the remaining youth said they do not because they were around too many other youth. Each of the three youth reported staff are respectful. Two of them said staff use curse words occasionally.

1.04 Management Response to Allegations (Critical)	Non-Applicable

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 had no instances of physical, psychological, or emotional abuse in the program during the annual compliance review period; therefore, this indicator rates as non-applicable.

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

A review of all five Central Communications Center (CCC) reports for the last six months revealed the program's incident reporting procedures were consistent with the Department's requirements, as each of the incidents were reported to the CCC within the required two-hour timeframe. A review of the program's internal incidents and grievances found there were no additional incidents which were required to be reported to CCC. Each incident was documented in the facility logbook. The program has not experienced an increase in CCC reports since the last annual compliance review.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
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 had one incident requiring the use of Protective Action Response (PAR) techniques. A review of the program's Department-approved PAR plan determined the program followed proper protocol during the PAR incident. The PAR report was completed by the end of the staff's workday and included statements from all of the staff involved. The report included a review by a PAR certified instructor/supervisory staff and the Post-PAR interview was conducted with the youth within the required timeframe. The PAR incident report was reviewed by an administrator, within seventy-two hours of the incident. The program's PAR rate during the annual compliance review period was 0.73, which is below the statewide residential PAR rate of 1.51. The program director reported each PAR is monitored within twenty four hours of incident by the staff involved, the program director, the assistant program director, the supervisor on-duty, and the PAR training officer.

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

A review of seven staff training records found each of the staff completed the required 120 hours of pre-service training within 180 days of hire. Each staff completed training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, child abuse reporting, emergency procedures, suicide prevention, and Prison Rape Elimination Act (PREA). Each of the trainings were documented in the Department's Learning Management System (SkillPro). A list of pre-service training was submitted to the Office of Staff Development and Training on April 10, 2019 and approved on April 23, 2019.

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

A review of five staff training records determined each of the staff completed all required in-service training hours. One of the staff training records reviewed was a supervisory staff. As a part of the in-service training requirements, the supervisor completed eight hours of training in management, leadership, personal accountability, employee relations, and fiscal. Each training was documented in the Department's Learning Management System (SkillPro). The annual in-service training calendar provided by the program included all in-service training and was submitted to the Office of Staff Development and Training on April 10, 2019 and approved on April 10, 2019.

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

The program's grievance process includes three phases. There is an informal, formal, and appeal phase. The informal phase includes both the youth and staff followed by the formal phase to include the youth and supervisor. The appeal phase includes the youth and program director to resolve any outstanding issues. Procedurally, attempts are made by the staff and youth to resolve an issue. A written response from the supervisor is required.

Three interviewed staff and three interviewed youth reported they understood the program's grievance procedures. Each were well versed in the grievance procedures. The program director explained the youth transmit their grievances to direct care staff and then to the supervisor and program director, if needed.

All grievances are maintained in the program's grievance binder. The program has not any instances of grievances submitted since the last annual compliance review.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance

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

Two staff are trained to deliver the program's delinquency intervention model. Each youth at the program participates in Impact of Crime (IOC) and Life Skills Training (LST). Both curriculums are evidence-based. Each facilitator completed all required training for IOC and LST. The program reported youth are matched to staff and are mindful of any staff history with youth in a further attempt to ensure appropriate service delivery. The staff facilitators work in accordance with the program's contract and guidelines. A review of group sign-in sheets validated both courses were provided weekly on Tuesdays and Thursdays. A review of youth records found each of the youth were participating in IOC and each of their performance plans included IOC as a goal. The program offers an array of structured, planned programming, and activities for at least sixty percent of the day, as indicated on the program activity schedule. Three youth were interviewed and each reported they participate in IOC and LST.

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

The program activity schedule includes and Life Skills Training (LST). LST is provided twice a week for one hour each session, on Tuesdays and Thursdays. The program utilizes one facilitator for LST, who is a therapist at the program. A review of training records determined the facilitator completed training in the respective curriculum. A review of three youth records found each of the youth were participating in groups, as outlined in their treatment plans. Sign-in sheets mirror the program's activity schedule. The program director reported LST has group meetings on-site every week by the mental health staff.

Three interviewed youth indicated they have patriciate in LST while at the program and were able to describe new skills or behaviors they have been taught.

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

The program utilizes the Impact of Crime (IOC) curriculum to provide restorative justice awareness to the youth. The curriculum allows for youth to have an opportunity to feel what it is like to be the victim of a crime and learn to empathize with victims. Community service projects are utilized as well.

IOC is held twice a week for one hour, as evidenced by a review of sign-in sheets and the activity schedule. A review of staff training records indicated one staff is trained to facilitate IOC. Observations of an IOC group provided insight on how the groups are conducted, as the youth were able to describe what the victim's experience. The program director reported youth can

earn sixty community service hours. Three interviewed youth reported they can demonstrate the skills they learned while in group.

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

The program provides gender-specific programing twice a week to all the youth at the program. During orientation, the nurse provides hygiene and male self-examination education. The registered nurse is trained to provide the services to the youth. The Liberty County Health Department offers male sexually transmitted disease screenings, education, and counselling. Boys and Girls Club provided gender-specific education and topics to the youth at the program. A review of sign-in sheets found groups were delivered, as listed on the activity schedule.

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 utilizes both an internal alert system and the Department's Juvenile Justice Information System (JJIS). The program's written policy and procedures delineate how alerts are identified, documented, updated, and communicated to staff. Procedurally, the program's mental health clinical staff, medical staff, or program director can downgrade alerts.

Three internal alerts were reviewed and were found to be consistent with the JJIS alerts. None of the alerts required a youth's status to be downgraded. The program director reported the program's alert process begins at intake for the youth as the program reviews each preexisting alert. The program director reported the program has a proclivity to review the youth's alerts, as youth often have prior alerts from detention centers or assessment centers. The program also utilizes an alert list available to each staff. Alerts are also discussed during shift change. In the kitchen, dietary alerts are maintained.

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

The program maintains a separate individual case management record and an individual healthcare record for each youth. Records are clearly labeled "confidential." The file tab for each record included the youth's name, Department identification number, date of birth, county

of residence, and committing offence. The healthcare records include the youth's medical, mental health, and substance abuse information. The sections are labeled as legal information, demographic and chronological information, correspondence, home visits, prescreening administration, orientation, admission classification, letters of consent, assessments, and miscellaneous. Records are secured in a locked file cabinet also labeled "confidential," located in a locked room case management room.

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

The program's formal process for youth input occurs quarterly. The program utilizes the Boys and Girls Club and advisory board meetings to host the discussions. Based on a review of sign-in sheets, the program held meetings for youth input quarterly. Sign-in sheets highlighted the youths' names and dates the meetings were conducted. Documentation also included what the youth wanted to discuss and the staff's response.

Three interviewed youth reported meetings are held at the program to allow the youth to provide input.

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

The program has a policy and procedures to establish and maintain an advisory board. Procedures require a session of citizens of the local community, judiciary, school board members, law enforcement, local business, victims, parents/guardians, and the clergy. The board is to serve as program advocates. The program director ensures the involvement of the advisory board.

The program maintains documentation for all advisory board meetings. The meetings were held quarterly as required. Approximately eight to ten board members attended each meeting. Attendee members included all appropriate members of the community. The program maintains a roster for all attendees. The roster included the names, titles, and contact information for all attendees. A review of the detailed minutes from the advisory board meetings found documentation of each meeting, participants, and a review of ideas. The program provides lunch from their dietary department.

The program director reported members of the community discuss quality of life services. A board member was not available for interview during the annual compliance review week.

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

The program has a policy and procedures regarding facility integration and stability. The policy establishes a system for staff to be involved in communicating issues, staff evaluations, and staff retention. Staff communication is accomplished during meetings, conference calls, utilizing the internal alert system, and shift reports. Recruitment and retention includes utilizing a TRENDSTAT process and quality improvement initiative. Recruitment efforts are used through

One Stop Career Center, job fairs, and local advertisements. The program director reported the program meets on quarterly basis. Sign-in sheets clearly captured the dates and times of the meetings.

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

The program has a policy and procedures which delineates the staff's performance process. The program's policy ensures a system for effective communication, annual evaluation, and staff retention. The objective is to inform management and the staff of their job performance.

A review of three direct care personnel records found each record included a staff performance review form. The form included a rating scale and overall rating scale, job knowledge, quality of work, ability, initiative, flexibility, professionalism, compliance, training, documentation/reporting, and leadership. Each staff had an annual evaluation. Each evaluation was signed and maintained in the staff record.

Position descriptions included a position summary, essential functions, working conditions, physical requirements, and acknowledgement. The program director reported each staff receives an evaluation and the evaluations are maintained in the staff's records.

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.	

Three individual youth records were reviewed for initial contacts to parents/guardians and legal stakeholders. In each of the records, there was documentation showing the contacts, verbal and in writing, were made on the date of admission, followed by mailed documents on the date of admission. Notification was made to the parents/guardians, as well as the committing courts, juvenile probation officers, and post-residential services counselor, if applicable.

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.	

Three individual youth records were reviewed for orientation processes and procedures. In all cases, documentation indicated orientation was completed on each youth's admission date. The orientation included all elements of the Department's policy. Youth were also given a handbook with relevant information. Case management records included an initialed checklist to ensure all portions of the orientation process were addressed correctly. Three interviewed youth reported they participated in the program's orientation within twenty-four hours of admission.

2.03 Written Consent of Youth Eighteen Years or Older	Non-Applicable
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 not had any youth eighteen years of age or older during this annual compliance review period; therefore, this indicator rates as non-applicable.

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

The program's policy and procedures, in accordance with Florida Administrative Code, clearly delineates the classification process and includes a classification system. Three individual youth case management records were reviewed. In all three records, youth were classified on their date of admission. The program completed an admission classification form for each youth which addressed all required elements. The program director was interviewed and stated the dorms are divided based on youth size, maturity level, history of violence, and current behavior. The program considered each youth's Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment and placed each youth accordingly. The program conducted reassessments when necessary.

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

The program has a written policy and procedures to address the identification of gang members and notification to law enforcement of potential gang members. Local law enforcement is notified by letter from the program's gang coordinator when a youth is admitted to the program with an alert in the Department's Juvenile Justice Information System (JJIS) and/or the youth was identified as having gang involvement during the admission process. An assessment is completed on each youth during admission to the program. Three individual youth management records were reviewed and found one youth was previously identified as a gang member. Three individual youth management records were reviewed and none were identified as potential gang members. The program has not had any youth identified with gang association during the annual compliance review period.

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

The program has a written policy and procedures addressing gang intervention. If a youth is identified as a gang member or a suspected gang member, the youth will participate in Impact of Crime (IOC) groups and participate in additional activities related specifically to gang activities prior to release from. Three individual youth management records were reviewed and

none were identified as potential gang members. The program has not had any youth identified with gang association during the annual compliance review period.

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

Three individual youth case management records were reviewed for Residential Positive Achievement Change Tool (R-PACT) assessments. In all three records, the R-PACT was completed within thirty days of the youth's admission to the program. Each R-PACT was maintained on the Department's Juvenile Justice Information System (JJIS). In addition, the program completed the Residential Assessment of Youth (RAY), the Department's new assessment instrument, for youth immediately following the statewide deployment of the RAY assessment. Each youth required a reassessment which was completed within the ninety-day time frame, as required.

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

Three individual youth case management records were reviewed for the completion of a Youth Needs Assessment Summary (YNAS). In each record, a YNAS was completed within thirty days of the youth's admission to the program. Each of the three YNASs were maintained in the Department's Juvenile Justice Information System (JJIS).

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

Three individual youth management records were reviewed for development of performance plans. Treatment team members participated in the development of initial treatment plans. The plan stipulated goals for each of the youth and staff and specified target dates for completion.

Each plan was measurable, individualized, and based on the priority of needs derived from the initial assessment as it included all the appropriate risk factors. The treatment team leader, youth, administrative representative, direct care staff, treatment staff, medical staff, and education staff all participated in the development of initial treatment plans. All performance plans were developed within thirty days and after the completion of the Residential Positive Achievement Change Tool (R-PACT) and the Youth Needs Assessment Summary (YNAS). Performance plans were mailed to parents/guardians and juvenile probation officers (JPO).

Three youth were interviewed. One of the three reported they did not participate in the development of their performance plan. The remaining two reported they did. Each of the three youth reported they have a copy of their performance plan.

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

Three individual case management records were reviewed for revisions to performance plans. Each record indicated the performance plan revisions were completed in the when applicable and were updated to reflect the youth's progress toward goal completion and newly acquired 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.*	

Three individual youth management records were reviewed for performance summaries and transmittals. All records included performance summaries completed during the required time frame and included pertinent information about the youth's status and progress within the program. Each performance summary included the youth's status on each goal, overall treatment progress, academic status, grades, credits earned in the program, performance and behavior in school, youth's overall behavior, level of motivation and readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Each summary included comments prior to signing the performance summary, the youth was provided a copy of the performance summary, and the original performance summary was found in each case management record. Summaries were transmitted to all required parties.

Three closed youth records were reviewed. The written notification of the youth's planned release included written notification to the youth's parent/guardian of the planned release and an Exit Residential Positive Achievement Change Tool (R-PACT).

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.	

Three individual youth management records were reviewed for parental involvement in case management services. Staff contacted each parent/guardian at admission by phone and by mail to advise them of the youth's arrival to the program and to request input in the youth's case management plan. Case managers mailed copies of performance plans for parent/guardian review and requested signatures from the parents/guardians. Three treatment team meetings were observed during the annual compliance review; the parent/guardian was called by telephone and participated in the treatment team meetings.

Three youth were interviewed and reported their parents/guardians were invited to participate in case management services by telephone.

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.	

Three individual youth management records were reviewed for the composition of treatment teams. Prior to each youth's admission to the program, key staff meet in person to plan for initial treatment and academic needs in person. Treatment team members were identified during this process. During orientation to the program, the youth is introduced to treatment team members. Treatment team members included the youth, an administration representative, a living unit representative, educational staff, treatment staff, facility gang prevention specialist (where applicable), and case management staff. Reviewed documentation indicated parents/guardians and juvenile probation officers (JPO) were invited to participate in treatment team meetings.

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

Three performance plans were reviewed for the incorporation of academic, vocational, and treatment plans. In each record, the performance plan included all necessary components. Each of the academic and education plan was incorporated into their performance plans academic progress monitoring plan. None of the plans included specific Agency for Persons with Disabilities (APD) or Department of Children and Families (DCF) plans, as none of the youth had current involvement with those agencies.

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

Three individual youth management records were reviewed for documentation of treatment team meetings. All records documented formal and informal treatment team meetings and included all relevant parties. None of the youth treatment team packets indicated the youth had behaviors resulting in physical interventions. All parties were invited to attend and to provide input. Three treatment team meetings were observed during the annual compliance review; the parent/guardian was called by telephone and participated in the treatment team meetings. The youth were invited to provide input as well and were given the opportunity to demonstrate the skills they have acquired in the program.

Three youth were interviewed and reported they were provided the opportunity during treatment team meetings to demonstrate what they had learned in the program.

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

The program offers Type 2 educational programming. Type 2 programming includes personal accountability skills and behaviors which lead to appropriate work habits, as well as exposing youth to a broad scope of career choices. Programming also addresses communication, interpersonal, and decision-making skills. The youth at the program are not age appropriate for any of the additional vocational and carpentry services offered. However, three closed youth case management records contained documentation of the youth receiving Career Shines. Career Shines help the youth plan for their education. The youth also receive the Department's common assessment once they enter the program and before the youth are released. The assessment focusses on Math & Reading. Classes are between 8:15 a.m. and 2:45 p.m. An interview with the program director revealed the program offers welding and carpentry courses to age appropriate youth in the program and the younger youth are serviced through educational planning by utilizing the Department's common assessment.

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 provided the daily school schedule, the school year calendar for the program, and the schedule for the school district for review. The youth at the program participate in educational programs 250 days a year, with 300 minutes of instruction each week. Three youth records were reviewed, and each youth received course credit for completion of course work. A review of the logbook, compared with the program's activity schedule, documented minimal interference, as little movement occurred during the educational instruction time.

The lead teacher reported each youth's educational needs are assessed upon arrival. The youth and teacher map out an educational plan which includes an exit plan from the program.

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

Three closed youth case management records were reviewed. The three records had an individual education transition plan developed based on the youth's post-release goals. Each of the three closed case management records reflected the required participants involved in the development of the education transition plan. In all three closed records reviewed, a transition plan was developed with the required participants. All three closed case management records documented education transition plans included services and interventions based on the youth's assessed educational needs and post-release education plans. The education transition plans included the recommended educational placement for post-release based on youth's individual needs and performance. All three plans also addressed the specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services.

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

Three individual youth management records were reviewed for transition planning activities. The program has a written policy and procedures which addresses transition planning activities. Two of the records were for youth who were actively in the transition phase of the program. Transition planning meetings were held at least sixty-days prior to the targeted release date for the youth. Treatment team members participated in the transition planning meetings, which were separate from biweekly treatment team meetings. Input was also solicited from parents/guardians and juvenile probation officers. Documentation of team members participating included the youth, treatment team leader, program director, and other team members within the program. Documentation also revealed the team members reviewed transition activities and made revisions, if necessary, as part of the transition conference.

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.	

Three closed case management records were reviewed for exit portfolios. All three closed records contained evidence showing the exit portfolio was discussed and initiated during the transition conference. Each closed record contained a copy of the youth's transition plan, and a calendar with all dates/times/locations of follow-up appointments in the community. All three closed case management records had documentation the youth's exit portfolio was verified at the exit conference and the exit portfolio was completed and given to the youth upon completion of the program. The portfolio information was forwarded to the juvenile probation officer (JPO). The program's practice coincides with the contract, as all requirements were met.

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.	

Three closed case management records were reviewed for exit portfolios. An exit conference was conducted for each of the youth subsequent the juvenile probation officer (JPO) being notified of the youth's projected release date. Each of the JPOs were notified within fourteen

days of the youth’s projected release date. The exit conference was conducted within the required time frames and included all required parties. The treatment team leaders invited all required participants and encouraged them to attend by mailed letters. The exit conferences were separate from the transition and Community Re-Entry Team meetings. Each record documented the date of admission and date of termination matched the dates in the Department’s Juvenile Justice Information System (JJIS).

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 written policy and procedures ensuring there are mental health professionals available to provide services to youth in the program. The mental health professionals in the program are providing oversight, intervention treatments, and counseling services. The program has a licensed psychiatrist, who serves as the designated mental health clinician authority (DMHCA). A copy of the DMHCA's license and service agreement was reviewed and was found to be clear and current. A review of the sign-in sheets confirmed the DMHCA is on-site weekly on Sundays. According to the program director, the DMHCA is on-site for a minimum of two hours each visit. The program has a licensed mental health counselor (LMHC) serves as the clinical director. The LMHC represents the DMHCA during treatment team meetings.

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 one licensed mental health counselor (LMHC), who serves as the clinical director. A review of the program's contract found staffing was in accordance with contract and Rule 63N-1, F.A.C. The license of the clinical director was reviewed and was found to be clear and active.

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

The program has a written policy and procedures ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. The clinical director supervises four non-licensed clinical staff. Education records for each non-licensed staff member was reviewed and reflected appropriate degrees were obtained. Two of the three non-

licensed staff members hold master's degrees in areas of counseling, social work, or psychology, while the third staff member holds a bachelor's degree in the field of counseling and has the required clinical experience. All of the non-licensed staff received the required training. There was documentation of each non-licensed mental health and substance abuse clinical staff receiving at least one hour a week of on-site face-to-face direct supervision by the licensed clinical director.

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

The program has a written policy and procedures to ensure the mental health and substance abuse needs of youth are identified through a comprehensive screening process which ensure referrals are made when a youth has a mental health or substance abuse need. Three youth records were reviewed and determined each of the youth record contained a Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). Each of the MAYSI-2 assessments were completed in a confidential manner on the youth's day of admission, by trained staff and subsequently reviewed by the clinical director. There was also documentation in all of the records indicating the electronic commitment packet was reviewed. It is the program's practice to complete a new Assessment of Suicide Risk (ASR) on each youth. No additional assessments were needed for the youth reviewed; however, the program has a referral process in place if the MAYSI-2 generate any hits. According to the program director interview, the MAYSI-2 and the ASR are the used to identify youth at risk of mental health and substance abuse problems and suicide.

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

The program has a written policy and procedures to ensure youth identified by screening, staff observation, or behavior after admission as in need of further evaluation are referred for a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation. Reviewed documentation confirmed the program's practice is to complete a comprehensive mental health evaluation and substance abuse evaluation for each youth admitted to the program. A review of three open youth mental health and substance abuse records revealed the clinical director completed or approved a new mental health evaluation and substance abuse assessments on each youth within twenty four hours of the youth admission to the program. Each of the evaluations documented all of the required elements. The substance abuse assessments were completed under the program's licensure; Chapter 397.

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

The program has a written policy and procedures to ensure treatment planning 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. Three youth mental health records were reviewed for mental health and substance abuse treatment. Each youth was assigned to a multidisciplinary treatment team. Each multidisciplinary treatment team was comprised of all the required parties. Documentation showed all of the required parties participating in both mental health and substance abuse treatment for each youth. Each youth record contained an Authority for Evaluation and Treatment (AET) and substance abuse treatment Substance Abuse Consent and Release form. Three youth receiving mental health and substance abuse treatment were all observed to have a mental health and/or substance abuse related diagnosis. Notes concerning each youth were observed to be documented on the Counseling/Therapy Progress Note form. A review of group therapy sign-in sheets reflected groups are limited to ten or fewer youth for mental health treatment groups. A review of sign-in sheets for substance abuse groups reflected groups are limited to fifteen or fewer youth at a time. Each youth reviewed were receiving the services as outlined in their individual treatment plan. Three interviewed staff reported they are not responsible for facilitating mental health and substance abuse groups.

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

The program has a written policy and procedures to ensure youth determined to have a serious mental disorder or substance abuse impairment and receive mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. Three youth mental health records were reviewed for an initial mental health and substance abuse treatment plan. Each of the three youth records had an initial treatment plan developed on the day of admission and contained the all of the required elements of the Department's Initial Mental Health/Substance Abuse Treatment Plan sample form . All three initial treatment plans were developed by the clinical director. All three of initial treatment plans were also signed by the treatment team members, who participated in the development of the plans.

The individualized treatment plans were documented on a form containing all elements of the Individualized Mental Health/Substance Abuse Treatment Plan form. Each of the three individualized treatment plans were completed and signed by all of the required parties within thirty days of admission. The program also mailed the individualized plan to the parents/guardians for signature. Documentation reflected all three youth were participating in services, as outlined in the individualized treatment plan. Each youth record contained documentation showing treatment teams were held monthly since admission to the program.

Three closed records were reviewed for discharge summaries. All three discharge summaries reflected the youth participated in mental health and substance abuse treatment while in the program. Documentation also revealed the discharge plan was discussed with the youth, parent/guardian, and juvenile probation officer (JPO) during the exit conference for all three youth reviewed and each party was provided a copy.

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

The program has a written policy and procedures to ensure specialized treatment services are provided to youth in the program. Delineated in amendment two and four of the contract, the program provides transitional planning in a residential setting and in-home counseling through home visits. In the residential setting, the program utilizes two case managers and a master's-level counselor to develop and coordinate transition services. A review of three youth records revealed the youth received mental health counseling and an individualized treatment plan. The three youth were also interviewed, and each reported they receive intensive mental health and substance abuse specialized treatment. The plan addresses the youth's strength and weaknesses, family communication, conflict resolution, and problem solving. Most of the services were provided through Life Skills Training (LST) and Thinking for a Change (T4C) curriculums, as staff training records and sign-in sheets verified the services were delivered appropriately. Each of the youth selected also received mental health overlay services, as documented in their individual youth records. Each record had documentation of the case mangers tracking the youth's progress and addressing day-to-day needs of the youth while at the program. Furthermore, as outlined in the contract, the three youth records had documentation of the case managers assisting in the development, attending, and participating in the Community Action Teams.

An additional eight closed records were reviewed to verify the program delivers care through home visits. An even number was selected based on available sample sizes. To document the occurrence of home visits, the program created a ninety-day post-commitment discharge form. The form allows the master's-level counselor to record the youth's name, the juvenile probation officer's (JPO) name, and other demographic information concerning the youth. Also, listed on the forms are the therapeutic sessions, and post-commitment interventions utilized. Each of the eight youth had a completed form. The form had notes from the counselor, as the sessions were recorded to document the post-commitment interventions. Interventions included telephonic conversations between the counselor, youth, and parent/guardian, and they discussed the youth's overall adjustments to being back in community, Department of Transportation (DOT) earnings, and progress on post-commitment probation. Documentation revealed only one of the eight youth actually received a home visit by the counsellor.

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

The program has a written policy and procedures to ensure psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling is 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. Reviewed documentation revealed the programs psychiatrist is on-site weekly to provide psychiatric evaluation, psychiatric consultation, and medication management services.

One of the three youth records reviewed were applicable for entering the program on psychotropic medications. Additional records were requested; however, there were no additional applicable records available. The initial psychiatric diagnostic interview was conducted within fourteen days and contained all of the required elements, as required by the Department. The initial diagnostic psychiatric interview was completed on the Clinical Psychotropic Progress Note (CPPN) and included all three pages. The psychiatric evaluations included mental health history, mental status examination, Diagnostic Statistical Manual – V (DSM-V) diagnosis, treatment recommendations, and any medications prescribed. There was documentation of monthly medication monitoring by the psychiatrist. A review of the collaborative practice protocol with advance registered nurse practitioner (ARNP) revealed the ARNP is utilized when the psychiatrist is unavailable as the psychiatrist was available for each of the three youth records reviewed.

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 policy and procedures regarding suicide prevention. The program's suicide response plan was observed to be reviewed annually. The program's plan detailed suicide prevention procedures, and included all required elements outlined in Florida Administrative Code 63N-1. The plan outlined the identification and assessment of youth at risk of suicide through the screening or alert process and any time subsequently, as well as suicide precautions and the levels of supervision. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and to recognize verbal and behavioral cues. The plan included the referral process, communication, notification, documentation, immediate staff response, and review process. According to the program director, the program conducts mock suicide drills monthly, medical drills monthly, and all staff have been trained in cardiopulmonary resuscitation (CPR) and first aid.

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

The program has a written policy and procedures to ensure all youth are screened for suicide risk factors. None of the three youth records reviewed were applicable for this indicator; however, the program was able to provide one additional applicable youth record for review. According to the documentation provided, the staff completed the Assessment of Suicide Risk (ASR),and placed the youth on precautionary observation (PO) subsequent information provided by the youth. Suicide precaution observation logs were completed as required. Reviewed alert indicated they was entered into the Department's Juvenile Justice Information System (JJIS) at the time the youth was placed on PO and removed when placed on standard supervision. A review of the program logbooks verified the information was documented to include the beginning and ending times the youth was placed on PO. Documentation reviewed showed there was not lapse in supervision, the youth received the required intervention service, a conference between the program director and the licensed mental health professionals was conducted, and a follow-up ASR prior to being placed back on standard supervision.

The program maintains a suicide prevention kit (SPK) in each living unit and each vehicle. The SPKs were observed to be secured. Observations during the annual compliance review week confirmed each SPK contained the knife-for-life, wire cutters, and needle nose pliers. The program has an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. The process includes an administrative review of the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services. According to three staff interviewed, if a youth expresses suicidal thoughts, they are responsible for notifying mental health staff, searching the youth's room for sharps, maintaining sight and sound observations, placing the youth in a locked room, and document supervision. They also reported the suicide response kits were located in the dorms and one also indicated in medical.

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

The program has a written policy and procedures ensuring youth who are placed on suicide precautions are placed on precautionary observation. Three records were reviewed for suicide precaution observation logs, none of which were applicable for suicide services. The program

was able to provide one additional applicable record for review. The suicide precaution observation logs were maintained for the duration of the youth's placement on suicide precautions. The appropriate level of supervision was documented, all observations of the youth's behavior was documented in real time, and did not exceed thirty minutes, and warning signs were reported to mental health clinician staff and was documented on the suicide precaution observation logs. The suicide precaution observation logs were reviewed and signed by the shift supervisor and licensed mental health counselor (LMHC) and all supervision, supervisory reviews, response to warning signs, and documents of safe housing requirements were met.

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 and procedures ensuring all staff who work with youth are to be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. A review of mock suicide drills confirmed drills were conducted quarterly as required on each shift, since the last annual compliance review. All staff with direct contact with youth, on a day-to-day basis, participated in at least one quarterly mock suicide drill semi-annually. Mock drills included the use of cardiopulmonary resuscitation (CPR) and/or lifesaving measurers. Seven pre-service and five in-service staff training records were reviewed, and found all of the staff completed the required six hours of web-based and instructor-led suicide prevention training, in addition to receiving quarterly CPR and first aid training.

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

The program has a written policy and procedures to ensure they are responding to youth in crisis in the least restrictive means possible while protecting the safety of the youth and others in the program. A review of the program's Mental Health Crisis Intervention Services Plan validated the plan contains all the required elements. The Mental Health Crisis Intervention Services Plan was observed to be reviewed and signed annually. The plan outlines the procedures to follow to ensure staff and administration are notified in the event a youth experiences an acute non-suicidal psychological crisis, procedures for immediate staff response, referral procedures for youth and staff, lines of communication, supervision levels, documentation requirements.

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

The program has a written policy and procedures to ensure a crisis assessment is completed on each youth demonstrating acute psychological distress. One of three youth records reviewed were applicable for a crisis assessment. The program was not able to provide any additional records for review. In the one youth record reviewed, a crisis assessment was completed on the youth the same date the youth demonstrated acute psychological distress.

The assessment contained the date, time, and reason for the assessment and documented all of the required elements, as outlined by the Department. The licensed mental health clinical staff completed the crisis assessments and provided the description of the crisis and action taken for treatment and follow-up services, the youth's symptoms or behaviors, relevant medical or mental health history, and current behavioral observation. The program director notifies the supervisor on-duty who is responsible for documenting the crisis on the shift pass-on report. There were no alerts which were required to be entered into the Department's Juvenile Justice Information System. The youth was evaluated and determined to no longer be a risk to himself or others.

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

The program has a written policy and procedures to ensure youth who are determined to be in imminent danger to themselves or others due to mental health and substance abuse emergencies receive emergency care. The program has a written emergency mental health and substance abuse plan. This plan includes all of the required elements as outlined by the Department. The emergency mental health and substance abuse plan is reviewed and signed by the licensed mental health counselor (LMHC) and program director annually.

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

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

Standard 4: Health Services

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

The designated health authority (DHA) is a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA's license is clear and active and will expire on January 31, 2020. The DHA's specialty training is in internal medicine. The DHA is on-site once a week, which was verified by reviewing the program's sign-in sheets and medical calendar. The DHA is available to communicate with medical staff regarding youth medical needs, and electronic availability twenty-four hours a day, seven days a week, as needed. The DHA treats all referrals, conducts youth physicals, provides follow-up on chronic conditions, acute medical concerns, emergency care, and coordination of off-site care. When the DHA is on leave, the program utilizes the psychiatrist. The program has a licensed psychiatrist who is on-site once a week and available for emergency services twenty-four hours a day, seven days a week. The psychiatrist has a clear and active license. Review of the program's sign-in sheets and medical calendar revealed the psychiatrist covered for the DHA twice in April 2019. The DHA oversees the medical department standards in accordance with Department requirements. The DHA oversees all health services performed by the medical staff. In addition to the DHA, the medical staff consist of a registered nurse (RN) as the director of nurses, another part-time RN, and two license practical nurses (LPN).

When the DHA was asked to describe his role at the program, he indicated he reviews policy and procedures annually and as-needed, performs comprehensive physical assessments, and conducts periodic evaluations. The DHA reported chronic clinic initial paperwork is completed at the time of the youth's admission. The DHA reviews all youth lab and x-rays results and signs off on the documentation. The DHA reports he is on-call twenty-four hours, seven days a week, to the nurses or staff on-site as needed, to perform any task needed for youth.

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 a written policy and procedures for all health-related procedures and protocols utilized. A review of all Facility Operating Procedures (FOP) and health services protocols are completed annually and signed, with date, by the designated health authority (DHA) and program director (PD). Documentation shows the DHA and nursing staff reviewed, signed, and dated a cover page for the FOPs, treatment protocols, and other procedures. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies and procedures. This was confirmed by the new employment of the director of nurses. Approval of treatment protocols or standing procedures are written and authorized only by the DHA.

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

A review of three youth records found copies of three completed Authority for Evaluation and Treatment (AET) forms signed and dated by each youth's parent/guardian. All copies of the AET had "copy" written legibly on the documents. All AETs were found in the youth records and are valid until the youth's eighteenth birthday. None of the youth were over the age of eighteen or in the care of the Department of Children and Families (DCF).

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

All three youth records reviewed had completed parental notifications. According to the director of nurses, the program has a parental notification packet which is sent to all parents/guardians of youth when admitted to the program. The packet consists of notification of over-the-counter medications and vaccinations/immunizations not covered under the Authority for Evaluation and Treatment (AET). Parental notification of significant changes to existing medication, discontinuation of medication prescribed prior to entering custody of the Department, and changes in condition/medication for youth with chronic conditions. Any off-site emergency care, hospitalizations, surgeries/invasive procedures, non-routine dental procedures, and whenever and youth is taken off-site for medication treatment. All youth records included off-site visits for testing and two records had changes to medications while at the program. Appropriate parental notifications were included for all required new events.

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

All three reviewed youth records contained documentation the youth had been prescribed psychotropic medications with notations made showing parent/guardian consent was obtained. Two youth records were of youth not taking medication when entering the program and one youth was admitted with prescribed medications, which were not changed. One record had a written notification to the parent/guardian when the youth was prescribed medication. The parent/guardian letter did not document the inclusion of the Clinical Psychotropic Progress Notes (CPPN), page three. An interview with the director of nurses and the program director, confirmed a copy of page three of the CPPN is sent out in all instances of a change in medication. The director of nurses suggested page three was missing because they parent/guardian did not return a signed copy. All three youth records documented verbal notifications and parental consents were witnessed by another nurse. The other two youth records had page three of the CPPN copied and attached to the written parental notification with a certified receipt.

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

Three individual health care records (IHCR) were completed and documented all vaccinations were verified within thirty days of admission. None of the youth had exemptions for religious beliefs. Each of the Authority for Evaluation of Treatment (AET) form had documentation where parents/guardians signed for consent for immunizations. Nursing staff stated immunization records are obtained through the Florida Shots website. None of the youth records indicated the youth needed any vaccinations. If needed, vaccinations are done by the local health department and reviewed the same day of admission by nursing staff.

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

All three youth records reviewed had completed Facility Entry Physical Health Screening (FEPHS) forms. Two of the FEPHS forms were completed by the licensed practical nurse (LPN) and one was complete by a registered nurse (RN). All screenings were complete on the youth's date of admission. The form was inclusive of the title of the person completing the screening.

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

The program has a process in place for medical alert notifications. Youth alerts are located in a binder available to all staff. None of the three youth had been identified with any chronic conditions while they have been at the program. Two youth did not have prescribed medications when entering the program and were initially given the medical grade of one, which was changed to five when they were prescribed psychotropic medications. One youth record included a youth entering the program with psychotropic medications with a medical grade five. One of the three youth records reviewed was for a youth with food allergies which was listed on the internal alerts. All three youth had "psych meds" listed on the internal alerts. Medication interactions and side effects were found on the Medication Administration Record (MAR) in each of the three youth records reviewed. A review of the medical alerts matched the information which was documented within the youth records. All required alerts were required were noted, updated, and verified by the nursing staff.

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

All three youth received an orientation to healthcare services upon admission to the program. All three youth records had documentation of an acknowledgement form signed by the youth. The orientation included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effect monitoring, the right to refuse care and

how it is documented, what to do in the case of sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers. A review of the program's written policy and procedures outlines the program's health care services rendered to youth.

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

None of the three reviewed youth records contained any documentation showing the youth had been identified as having a chronic condition; however, two additional applicable records were provided for review. Upon admission, the nurse notifies the designated health authority (DHA) by telephone, advising of the youth's chronic condition. One youth record documented the DHA's referral by phone and fax in the nurse notes. The other youth was not identified with a chronic condition until the doctor completed the comprehensive physical assessment.

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

The program has a written policy and procedures for healthcare admission screenings and rescreenings. None of the three reviewed youth records contained a healthcare admission rescreening and the program did not have any youth who had left the program and received a rescreening.

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

All three reviewed youth records had Health Related History (HRH) forms which were each completed on the day of entering the program, complying with the required seven days of admission. The HRH forms were completed by a licensed practical nurse or registered nurse. All of the HRH forms had signatures and dates where the designated health authority reviewed the HRH form. The HRH forms were completed prior to, or at the same time as, the comprehensive physical assessment. The program used the Department's form to document this information.

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

All three youth records reviewed had completed comprehensive physical assessments (CPA), as required. All three records had sections of the CPA marked with an 'O.' All three youth refused the genital exam, which was marked. However, two CPA forms had "refused" next to the mark and one form just showed the mark. All assessments were signed and dated by the medical doctor. All three of the youth's Problem Lists were updated with current information. All three CPAs were inclusive of the youth's medical grade, body mass index, and Tanner Stage information. All three CPA forms included the youth's medical grade at the time of admission.

The CPA was completed in accordance with the Department's Health Service Manual requirements.

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

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

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

All three reviewed youth records contained completed tuberculosis (TB) screenings documented on the Facility Entry Physical Health Screening (FEPHS) forms. All youth results were also documented on the Comprehensive Physical Assessment (CPA) form. None of the youth tested positive for Tuberculosis and/or needed further evaluation. All TB screenings were completed within seventy-two hours of each youth's admission. Documentation on the Infectious and Communicable Disease forms and CPAs included the Tuberculosis testing dates and results.

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

A review of three individual healthcare records (IHCR) were reviewed and were clinically screened and evaluated for sexually transmitted infections (STIs). None of the youth screened reported being sexually active, but one youth agreed to STI testing. The other two records documented refusal to Human Immunodeficiency Virus (HIV) testing. The one record documented the designated health authority (DHA) referral and order for STI and HIV testing.

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

The program utilizes the Liberty County Health Department for youth who consent to sexually transmitted infection (STI) and/or human immunodeficiency virus (HIV) testing. The health department is 500/501 certified and provides the pre and post-test counseling to the youth. A copy of the certification was provided. Three youth records were reviewed and all three youth were offered counseling, testing, and treatment for HIV upon admission to the program. One youth consented and the other two youth refused, which was noted on all STI screening forms. Documentation was reviewed of the youth's off-site visit to the Liberty County Health Department. The HIV results are given directly to the youth from the Liberty County Health Department. It was noted on the youth's off-site medical form, results were normal. Three youth were interviewed and reported they can ask for an HIV/AIDS test.

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

None of the three reviewed youth records included a youth with three or more similar sick call complaints within a two-week period. In the three records reviewed, none of the sick calls were for severe pain staff was unfamiliar. One of the youth records included one sick call request form filed with the progress notes. No additional files with sick calls were available.

Sick call hours are held seven days a week from 3:00 p.m.-5:00 p.m. and are conducted by the nursing staff. The program does not have a computerized system to document medical information. All sick call requests are filed in each youth's healthcare record. Three youth were interviewed and asked how quickly they saw a nurse once making a sick call request. Two reported within one day and one stated he has not made a sick call.

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

One of the three reviewed youth records had documentation of completed a sick call requests. The sick call was completed by the licensed practical nurse (LPN) and reviewed by a registered nurse (RN). Sick calls are documented in accordance with the Health Services Rule, which consists of a check of vital signs, treatment, education, and follow-up plans, if needed. The one sick call reviewed included the youth's signature documenting when the youth was seen and noted in the progress notes, and on the sick call index.

The youth have access to sick call forms, which are in the dining hall, medical, and classrooms. Staff turn the youth's sick call request into the nurse and nurse will evaluate the youth during the designated sick call time. Sick calls are conducted Monday through Sunday from 3:00 p.m. to 5:00 p.m. The medical department allows the youth privacy during sick call encounters. Medical has an exam table and equipment used to perform sick call duties. The program's sick call process was observed during this annual compliance review. Staff escorted the youth to the medical department and remained within sight and sound of the youth. The youth provided verbal and written consent for the process to be viewed for this annual compliance review. The RN identified herself and the youth explained his reason for being there. No other youth were present during this examination. The youth was asked to sign they were seen.

Three staff were asked who conducts sick calls and all three staff reported the nurse. One staff reported the supervisor. Three youth were interviewed and all three reported they could see a dentist and a doctor, if needed.

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

The program's policy, procedures, and practice confirms the program does not use restricted housing; therefore, this indicator is rates as non-applicable.

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

Two of the three reviewed youth records indicated the youth received episodic/first aid care while at the program. All three records had documentation of the date/time of the episodic care, nature of complaint, findings of person rendering care, and treatment rendered. One of the two youth required a referral for off-site care. Both youth received education/instructions and plans for follow-up care. Both records documented the name of the staff providing care to the youth and what licensed healthcare staff completed the evaluation. The on-site licensed healthcare staff documented the subject, objective, assessment, and plan (SOAP) elements on the form in both records. The medical department maintains an episodic log documenting all instance of first aid and/or emergency care.

The program has eighteen first aid kits with approved contents. First aid kits are located on the dorms, medical department, administrative building, and vehicles. When the clinical manager was asked the process for monitoring the first aid kits. Her system is to maintain the expiration dates on all the items in the first aid kit in a book and seal the kit. If the seal is broken, inventory will be completed immediately on the kit, if the seal is not, monthly inventory is completed and maintained by the nurse.

Three staff were interviewed and all three staff reported they are allowed to call 911 for medical emergencies.

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

The program has a process in place to address emergency care which includes mock medical drills to be conducted quarterly on each shift. The program had supporting documentation of quarterly drills being completed and staff who participated. The program had a list of emergency contact numbers, poison control, and staff phone numbers posted in the nurse's office to be used in the event an emergency occurs. None of the youth records required any auto injections or parenteral medications. A review of staff training records found the staff completed the basic cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED) trainings. The program has one AED, which is located in the medical building outside the door. The AED procedures are located inside the AED box. The nursing staff completes AED checks monthly. The AED battery expires May 2022, and pad expires May 2021. The AED date of last battery change was May 2018, and date of last pad change was May 2019.

4.23 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.	

All three reviewed youth records included off-site care. All three youth received electrocardiogram (EKG) testing and one youth required off-site first aid or emergency care. Parental notifications and a Summary of Off-Site Care forms were reviewed in all three youth

records. Discharge documents were in the individual healthcare records (IHCR) and were reviewed by the designated health authority (DHA) in all instances. One record required follow-up referrals, which were tracked, and timely follow-up care was completed as instructed.

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

None of the three reviewed youth records contained documentation showing the youth were identified with a chronic condition. A request for additional records revealed only two youth were applicable. One youth was identified on the Facility Entry Physical Health Screening (FEPHS) form as possessing a chronic condition, while the other youth was identified after admission. Both youth were classified with the appropriate medical grade and received periodic evaluations no greater than three-month intervals. These evaluations were tracked, documented, and maintained in the individual healthcare records (IHCR). Periodic evaluations were conducted prior to renewal of any of the prescription medications expiring. All three youth were placed on the chronic illness list. One youth record contained a specialized treatment plan. An interview with the licensed practical nurse (LPN) revealed the youth was seen every month by the psychiatrist, which was documented in the progress notes and did not require a formal specialized treatment plan. On-site evaluations were documented in the IHCR, as well as in the progress notes. The treatment orders were written so they are clearly distinguishable for clinical staff. None of the youth received an off-site evaluation, had a lapse in care, or missed periodic evaluation. The Department's Problem List was updated in accordance with the Health Services Rule 63-M for both records reviewed.

The program director reported each youth receives health education during orientation and health care staff review important medical issues during the youth's intake.

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

One of the three reviewed youth records indicated the youth was admitted to the program on prescribed medications. One additional youth record was provided for review. The nurse reviewed and verified medications at the time of admission. The designated health authority (DHA) was notified and the DHA notification was documented on the nurse's admission notes. The DHA resumed the specified medications in both records reviewed. Both youth were admitted when a nurse was on-duty. The program has a facility operating policy in place developed by the DHA for non-healthcare staff to follow if a nurse is not on-duty. It was previously reported youth are not admitted when a nurse is not on-duty. Youth are only admitted during weekdays and in the mornings, when medical staff are available and on-site.

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

Three youth healthcare records were reviewed. All three youth were prescribed medications, which included current and valid orders. None of the youth had taken any over-the-counter

(OTC) medications was not listed on the authority of evaluation and treatment (AET). One of the three youth had current medications, which were continued.

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

All medication was observed being stored in the secured medical department, which is not accessible to youth. All non-controlled medication is stored in a separate, secure, locked area, while narcotic and other controlled medications are stored behind two locks. Refrigerated medications are stored in a separate location from food storage. The refrigerator located in the medical department is for medical use only. Oral medications are stored separately from topical medications. All syringes and sharps are secured. The medication cart was clean and organized with items stocked separately from youth specific medications. A local pharmacist comes to the program on the first of every month to collect expired medications and destroys them off-site.

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

The program provided documentation all over-the-counter (OTC) medications are inventoried at least weekly, per Rule 63M-2.026(a). A perpetual inventory with running balances is maintained on all controlled medication with a shift-to-shift inventory requiring two staff signatures. Syringes and sharps are counted whenever used and weekly, using a perpetual inventory. An inventory log was reviewed for the past six months, which revealed this process was being conducted as required. The clinical manager reported if a discrepancy occurs, they will conduct a new count. The program has a protocol in place for disposal of narcotics and other controlled substances, through the pharmacist. Inventory of three random youth medications, three random over-the-counter (OTC) medications, and three sharps was observed being completed by the licensed practical nurse. The nurse completed a medication count then verified the number matched the ending inventory numbers was observed. All counts and inventories matched. Sharps are disposed of in a biohazard container. The program has a contract with a local lab for disposal of syringes.

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

All controlled medication is administered by either the registered nurse (RN) or licensed practical nurse (LPN) at this program. A count was observed being conducted by the LPN on three random controlled medication and all medication matched the ending inventory numbers during this annual compliance review. The controlled medication was stored behind two locks in a cart in the secured medical department, where no youth have access. Annual compliance review team observed counts from psychotropic, controlled substance, topical, and over-the-counter medications with all counts matching the ending inventory numbers.

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

Three youth medication administration records (MAR) were reviewed. All three included the required elements of youth name, date of birth, allergies, precautions, medical grade, medical alerts and a picture of the youth in all three records. The Medication Administration Record (MAR) clearly indicated the stop and start dates of medications. If a youth refuses medication, refusal is clearly marked on the MAR, as well as a refusal form. Nursing staff document weekly side effect, as required. A review of the facility entry nurse admission notes indicates whether a youth was admitted with a medication. There was no lapse in medication administration. Progress notes were reviewed to determine medication was reviewed and compared with the orders within the MAR.

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

None of the three reviewed youth records required any parenteral medications. In the event a youth is admitted to the program with a parenteral medication, the licensed nurse will administer the medication. Medication pass was observed with the licensed practical nurse (LPN) in a clean and organized work space, and with the nurse in complete control of the medication containers and cart during this annual review compliance. Three staff were interviewed and all three staff reported the nurse provides medication to youth. Three youth were interviewed and reported the nurse gives medication.

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

None of the three reviewed youth records indicated any medication was administered by a non-licensed healthcare staff. The clinical manger provided a copy of the individuals at the program who have been trained in medication administration but stated it rarely occurs. This is only allowed to take place when medical staff are not on site, and with self-administration of oral, topical, or inhaled prescribed medication. Observation of medication administration by a non-healthcare staff did not occur during this annual compliance review.

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

One of the three youth reviewed records indicated the youth was admitted to the program while taking psychotropic medications. The nursing staff notified the psychiatrist and designated

health authority (DHA). Two records reviewed were of youth placed on psychotropic medication after being admitted to the program. The nurses note and progress notes both had documentation of the youth being evaluated by the psychiatrist. Two of the records reviewed received an initial diagnostic psychiatric interview within fourteen days of the youth's admission. One record was late and was done within a month from the youth's admission. Medication monitoring was completed by the psychiatrist, as required. The results from the psychiatrist evaluation determined the psychotropic medication was needed. All three pages from the Clinical Psychotropic Progress Notes (CPPN) were completed and signed, by the psychiatrist as required. The CPPN also included prescribed psychotropic medications, side effects, the youth's adherence to the medication regimen, height, weight, blood pressure, laboratory findings, signature of the psychiatrist, date of signature, and documentation of monitoring Tardive Dyskinesia. The program has no standing orders, emergency treatment orders, or PRN orders for psychotropic medication.

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

The program has a written policy and procedure for infection control which includes prevention, containment, treatment, and reporting requirements related to infectious diseases. The programs' infection control procedure includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, as well as hepatitis A, B, and C, and HIV infectious diseases caused by blood-borne pathogens. The procedure also includes other outbreaks of epidemics caused by any other infectious agent, outbreak of lice and/or scabies, methicillin-resistant staphylococcus aureus, food-borne illnesses, bio-terrorist agents, chemical exposures, hepatitis B immunization for staff, and protective equipment available to staff. The program had no instances where the local county health department, should have been notified. This information is updated as necessary and reviewed on an annual basis. The program has not had any incidents where the local health department or Central Communications Center (CCC) were required to be notified of an infectious disease at the program.

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

A review of three individual health care records (IHCR) was completed and all three indicated the youth received training in prevention of communicable disease and blood-borne pathogens. This documentation is on the health education record form in the IHCR. A review of seven pre-service and seven in-service staff training records indicated all staff completed the training per Center for Disease Control guidelines.

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

The program's exposure control plan is written in accordance with Occupational Safety Health Administration (OSHA) standards. The program's exposure control plan is located in the administrative building, which is available to all staff. The exposure plan is reviewed and signed annually by the administration or the program. Risk assessment and methods of compliance, as well as a comprehensive process is in place for needle stick post-exposure evaluation are included in the plan. The program director has established a separate file for youth and employees who have experienced a program/occupational exposure. This file is confidentially maintained for a ten-year period.

The program had no instances where the local county health department, should have been notified. The program did not have any instances involving the quarantine or hospitalization of at least ten percent of the total population of youth or staff.

The program director reported the exposure control plan is located in the building utilized for medical services and it's reviewed annually.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures which address youth supervision. According to the policy, staff-to-youth ratios are one-to-eight during day time activities, as well as when the youth are asleep. During the annual compliance review, observations of youth during daily activities to include school, recreation, meals, breaks and movement from one activity to another, found supervision was conducted, as required, with no exceptions noted. There is a daily schedule posted in the program’s two sleeping quarters, the cafeteria, two class rooms, and a testing center (room). When asked, staff were able to identify and provide the number of youth under their supervision.

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

During the annual compliance review, observations of the behavior management system (BMS) included daily youth and staff interactions. All interactions were appropriate and within the guidelines of the BMS. The BMS contained all of the required information including opportunities for positive reinforcement, opportunity for staff and youth to discuss impact of behavior on others, positive and negative consequences, and discussion of alternative behaviors.

Three interviewed youth revealed staff are consistent in their use of rewards and they can receive rewards such as snacks and off-site trips. Three interviewed staff reported they received training in the BMS and training records validated specific BMS training. Each staff reported items cannot be taken away. The BMS is outlined in the Student Handbook and staff are provided with training to utilize the system daily. Orientation includes training on the BMS when youth arrive at the program.

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 policy and procedures outlining the behavior management system (BMS). A review of three case management records revealed each youth's orientation included a review of the program's BMS. A review of the BMS revealed there is a process wherein staff and youth discuss sanctions imposed, consequences, and alternative acceptable behaviors. The BMS is not used to increase the youth's length of stay nor are the youth's basic rights. Program staff, case managers, and therapists are responsible for the implementation of the BMS. Three youth interviews stated youth are not allowed to punish other youth.

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

The program does not utilize cameras therefore video documentation was not available for review. A random selection of four days of ten-minute check sheets revealed the following: each dorm's visual check sheet was reviewed and documented by staff all visual checks were performed within the ten-minute requirement with no exceptions. Checks were documented in real time, to included staff signatures. Three staff interviews revealed room checks were conducted every ten minutes when youth are sleeping or in their rooms.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program has a policy and procedures which indicates the primary function of direct care staff is to provide supervision of youth. A review of the facility logbook determined counts, both formal and informal, were conducted and documented within the logbook. The documentation included the number of youth, the time the count was conducted, the type of count, and staff initials. Three staff interviews revealed formal counts are conducted every hour as this was observed during the review. All movement was observed to stop during counts. Staff were actively seen conducting counts during the formal head counts after being prompted via the two-way radio utilize and maintain on each staff's hip. Three interviewed staff were able to explain the process if a formal head count cannot be reconciled. Those staff reported they immediately stop all movement and a recount is conducted. The supervisor is notified, and search of the facility is conducted.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

The program maintains one master logbook, utilized by the supervisors and located in the operations supervisor's office. The program's logbook was found to be bound with numbered pages. The log book was not falling apart nor had any missing pages. Entries were made with ink and there were no white-out areas observed. All entries included the date and time of the event, with staff initials confirming the entry. None of the logbook entries were obliterated or removed; errors were struck through with a single line and initialed by the staff correcting the error. The program maintains a chronological record of events, incidents, and activities in the master control logbook. Observation of the Logbook determined the program documented all calls to the Central Communications Center (CCC).

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

The program has a policy and procedures in place to govern the control and use of keys. The procedures include a system of key assignment and usage, to include restricted keys. Each day of the review, as the annual compliance review team members entered the program, the times were recorded by utilizing a vistor self-logging book. As the personal keys were taken away, secured, and locked in a box mounted to the wall, the program issued a number for the location of the personal keys. Procedurally, staff have written responsibilities regarding key assignments; however, master control maintains and distributes keys by inventorying and tracking all keys. Youth do not have access to the key storage area. Staff assigned keys are inventoried by each shift to ensure accuracy. All keys were maintained on rings and matched on a key inventory form. Restricted keys are documented as permanent and restricted. All program staff are responsible for reporting missing keys to master control and the assistant facility director immediately. When keys are missing or lost, the program is placed on red alert, youth movement is confined, an immediate search is conducted, youth are searched, and locks will be changed in the event a key is permanently lost. Three staff were randomly selected and none of the staff had their personal keys in their possession.

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

The program has a written policy and procedures to address contraband introduction into the facility. The program's policy delineates what is considered contraband. The program prohibits personal cell phones, equipment, and electronic devices. The youth handbook outlines a list of items considered to be contraband. The program conducts weekly searches of the living units. A

review of the program's search report revealed room searches are conducted every day on each shift.

Each room search log includes the staff conducting the room search, the shift it was conducted on, dorm, and if contraband was discovered. A review of the program's logbook validated no contraband was discovered. A review of the logbook found searches were documented. The program director revealed when contraband is discovered it is turned over to the assistant director who disposes of it.

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.	

Youth were observed during the annual compliance review being searched before and after groups and all movement from one location of the program to the next. For example, the direct care staff of the same gender would complete a youth search if the youth was changing location from the cafeteria to the classroom. Staff were not observed using unnecessary force or rhetoric defacing the youth's dignity or respect. Searches and full body visual searches were conducted based on the Protection Action Response (PAR) training manual. Observations of searches were conducted each day during the annual compliance review. Three interviewed staff and youth determined searches are conducted before every youth movement and before and after visitation.

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

The program utilizes two vans for the transportation of youth. Proper maintenance was documented and maintained for all vehicles, including annual safety inspections. The program utilizes a certified car mechanic to conduct vehicle inspections. All vehicles were equipped with an appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. The program director reported company cell phones are provided during each transport. According to three staff and three youth interviews, all staff and youth wear seatbelts and both youth and staff understood seatbelts are always to be worn during transportation.

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

During the annual compliance review, a transport was observed and both the youth and the two staff wore seatbelts and the vehicle was inspected prior to use. The appropriate ratios were maintained, as there were two staff, both being the same gender as the youth and two youth. Drivers had a valid driver's licenses. Youth are prohibited from driving vehicles and staff were observed supervising the youth at all times while in the vehicle. All personal vehicles were locked securely. Doors on the transport vehicle could not be opened from inside the vehicle. Three interviewed staff reported they are not allowed to use personal vehicles for transport. Staff further indicated they are issued cell phones during transports.

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

The program has a policy and procedures which outlines weekly safety and security audits. The policy indicates who is responsible for conducting the weekly audits and met the requirements of Florida Administrative Code 63E-7.013. Weekly safety and security audit documents for the past six months were reviewed and were found to meet all requirements. All areas of the program are reviewed during the weekly audit.

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

The program maintains a written policy and procedures to addresses the issuance, inventory, and control of all tools. The procedures outline the process for missing and/or lost tools. There were no reports of missing or lost tools during the review process. All tools are marked and stored on a shadow board. A review of inventory revealed staff conducts a daily inventory of all tools with sharp edges and a monthly inventory of all other tools.. Kitchen tools were limited because the program does not prepare meals on-site. All staff were found to have completed training for the intended and safe use of tools. Tools are maintained in four areas of the program. All tools were accounted for and youth do not handle tools or are allowed in the area where tools are stored.

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

The program has a policy and procedures which address youth handling tools and the supervision by staff. Youth do not handle tools at the program. The program procedures address youth tool handling with assessing their risk. None of the youth at the program utilizes any tools Risk assessments only allow youth to handle mops, brooms, and scrub brushes. Three interviewed staff reported youth only use mops and brooms. Three interviewed youth reported only using scrub brushes, mops, and brooms.

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

The program has a policy and procedures which provides contractors with a notice of tool/equipment instructions prior to any work occurring and restricting only the tools deemed necessary. Vender agreement forms for the past six months were reviewed and found all tools were checked upon arrival and again at departure. A review of the project invoices submitted to the program by the vendor matched the sign-in sheets of the outside contractors.

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 conducts practice drills on an annually and monthly basis. There was documentation indicating fire drills were conducted monthly. The program experienced a natural disaster and had to conduct an actual safety and evacuation. Documentation was consistent with safety and evacuation standards.

The documentation of drills included the type of drill, date and time of the drill, participants, brief scenario, and findings/recommendations. The program director revealed fire drills are conducted monthly and drills, such as weather, bomb threat, and escape drills are conducted at least annually. Three youth were interviewed and each stated they participated in fire and safety 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 review of the Continuity of Operations Plan (COOP) found the plan was reviewed, approved, and signed by the regional director on February 28, 2019. The plan addresses alternative housing plans, older plans, and the plan. The COOP is maintained in the administrative building and is readily available to staff. The plan contained all the required elements.

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.	

All flammable, poisonous, and toxic materials are stored securely in the administrative building, inaccessible to youth. The actual flammable, poisonous, and toxic items and materials at the program are all accounted for. A review of the Safety Data Sheets (SDS) determined there is an SDS for all materials. The storage area restricts access to only appropriate staff. A review of the

facility's operating procedures determined the program utilizes SDS to capture the storage and inventory.

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 policy and procedures which prohibits youth from handling flammable, poisonous, and toxic items and/or materials. All items are strictly maintained in the secure administrative building and are inaccessible to youth. There were no containers of paint/toxic chemicals located on the facilities ground during the annual compliance review. No youth were observed handling chemicals. Three interviewed youth revealed they are prohibited from handling any chemicals.

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

The program's operations supervisor is primarily responsible for the disposal of hazardous waste. The local solid waste authority is utilized for the disposal of all waste produced by the kitchen and medical. The operating procedures also include disposal of hazardous items and toxic substances in accordance with Occupational Safety and Health Administration (OSHA). The program did not have any instances appropriate for the disposal of flammable, toxic, caustic, and poisonous items as indicated on the program disposal log.

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

The program maintains an activity schedule which documents supervised and structured indoor and outdoor recreation leisure activities for the youth. Activity schedules were posted throughout the facility. The program employs a recreational therapist, who meets all requirements, as outlined in the contract. The therapist holds a bachelor's degree in a related field. The recreational therapist is responsible for developing activities and an activity schedule for the youth. Recreational therapy is included in each youth's performance plan, as required. Three interviewed youth reported they are provided at least one hour daily of physical and leisure activities. These activities include basketball, exercise, and running. A review of the logbook determined the activities are provided as outlined on the program's activity schedule

5.22 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Satisfactory Compliance

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

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

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

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

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

The program has a policy in place regarding participation in water-related activities. The program’s water safety plan addresses safety, emergency procedures, and the rules to be followed during water-related activities. The program utilizes two lifeguards. Both life guards are certified, consistent with the American Red Cross. Each youth must take a swim test before participating in water-related programming to determine the risk lever for each youth. A review of the swim test for thirty-nine youth found four were not successful during the test. The program advised those four youth did not participate in any water activities until they passed the swim test. The remaining youth were successful. Youth were given the opportunity to retake the swim test every thirty days. Three youth were interviewed and each youth stated they have taken a swim test and participated in water activities.

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures related to visitation, youth correspondence (mail), and use of telephone. During the tour, the visitation schedule was observed posted in areas accessible to youth and staff. The program provides alternative visiting arrangements,

when deemed necessary. All youth are given the opportunity to speak with family by phone and correspondence. Three youth interviews determined all youth are given the opportunity to contact their families.

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

The program does not participate in the use of a controlled observation room; therefore, this indicator is rated non-applicable.

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

The program does not participate in the use of a controlled observation room; therefore, this indicator is rated non-applicable.

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

The program does not participate in the use of a controlled observation room; therefore, this indicator is rated non-applicable.

Program Name: Twin Oaks Vocational Academy II
Provider Name: Twin Oaks Juvenile Development, Inc.
Location: Liberty County / Circuit
Review Date(s): May 14-17, 2019

MQI Program Code: 1427
Contract Number: R2105
Number of Beds: 12
Lead Reviewer Code: 122

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.08 Specialized Treatment Services*	