STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Twin Oaks Vocational Academy II

Twin Oaks Juvenile Development, Inc.
(Contract Provider)
29841 Liberty Wilderness Road
Sumatra, Florida 32335

Review Date(s): February 18-21, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Jill Foy, Office of Program Accountability, Lead Reviewer (Standard 1)
Derrick Henderson, DJJ Probation, Circuit 14, Senior Juvenile Probation Officer (Standard 2)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 4)
Ken Phillips, Office of Program Accountability, Regional Monitor (Standard 3)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Twin Oaks Vocational Academy II
Provider Name: Twin Oaks Juvenile Development, Inc.
Location: Liberty County / Circuit 2
Review Date(s): February 18-21, 2020

MQI Program Code: 1427
Contract Number: R2105
Number of Beds: 12
Lead Reviewer Code: 168

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

Overall Rating Summary

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

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
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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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 Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Satisfactory
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Satisfactory

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Program Overview

The Twin Oaks Vocational Academy II is a twelve-bed program, for ten to thirteen-year-old males, located in Sumatra, Florida. The program is operated by Twin Oaks Juvenile Development Inc, through a contract with the Department. The program provides mental health overlay services (MHOS), transitional planning, in-home counseling services, and education services. In addition, the program fosters each youth by providing Impact of Crime (IOC), Life Skills Training (LST), and gender-specific programming. Additional treatment services provided includes individual, family, and group therapy, social and life skills trainings, restorative justice programming, and recreational therapy. Program administration is comprised of a program director and assistant program director. Case management services are provided by two case managers and one transition specialist. Mental health staff at the program includes one designated mental health clinical authority (DMHCA) who is a licensed psychiatrist, a clinical director who is a licensed mental health counselor (LMHC) who carries a caseload of twelve youth, and one clinical coordinator. Medical services are offered 7:00 a.m. to 7:00 p.m. and are provided by one medical doctor who serves as the designated health authority (DHA), one full time registered nurse (RN), one part-time RN, and two full-time licensed practical nurses (LPN). Educational services are provided by the Liberty County School Board. The layout of the program includes: four total buildings; one houses the cafeteria and education classrooms, one houses the clinical coordinator offices, administration offices, and case management offices, one houses medical, and one youth living unit. The program does not have security cameras providing coverage. At the time of the annual compliance review, the program director reported no current vacancies.

Strengths and Innovative Approaches

Youth are currently involved in two major projects: aquaponics and a butterfly garden. A combination of agriculture and hydroponics. Youth have been involved in building the pond and the aquaponics physical structure. The youth participate daily by feeding the fish food such as worms and crickets found in the surrounding area. Youth harvest the vegetables and sell them for three-dollar donations which goes towards buying supplies and fish food to keep the vegetables healthy. To date, the youth have proudly worked hard and have seen the fish thrive and fertilize food products such as swiss chard, lettuce, kale, collards, tomatoes, and sage. The goal is for the youth to have fun while becoming self-sustaining. Additionally, youth have begun the process to build a butterfly garden. Youth have constructed the physical structure and planted yarrow, roses, strawberries, amaryllis, and lilies.

Standard 1: Management Accountability

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

The program has a written policy and procedures in place to ensure all prospective employees, contracted staff, and volunteers complete a background screening. Fifteen employees required a background screening since the last annual compliance review. Documentation reflected all fifteen employees received a background screening in which their criminal history was reviewed prior to their date of hire. None of the fifteen employees required an exemption and one record indicated a break in service. All fifteen employees required a pre-employment assessment (Diana screening) and each of the employees received a passing score. There have been no new contracted staff hired since the last annual compliance review. The program submitted the Annual Affidavit of Compliance for Level 2 Screening Standards on January 2, 2020. Education staff are employed through the provider. Documentation was present in each of the personnel records reflecting the hiring authority reviewed Central Communication Center (CCC) involvement history, Staff Verification System (SVS), and Florida Department of Law Enforcement Automatic Training Management System prior to the date of hire.

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

The program has a written policy and procedures in place requiring staff members who have been employed with the program for five years to complete a five-year background re-screening prior to the anniversary of their date of hire. Three employees were eligible for a five-year re-screening since the previous annual compliance review. Documentation reflected all three employees had a re-screening completed and submitted more than ten business days prior to their anniversary date of hire.

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

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

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

The program has a written policy and procedures in place ensuring the program will provide an environment in which youth, staff, and others will feel safe, secure, and never threatened by any form of abuse or harassment. The program has not had any allegations of physical, psychological, or emotional abuse since the previous annual compliance review. Staff adhere to a code of conduct. Staff sign and date the program's code of conduct which was observed in personnel records. Telephone numbers for the Florida Abuse Hotline and Central Communications Center (CCC) were observed posted throughout the program. All youth are oriented on the procedures of how to access the Florida Abuse Hotline. Each of the three reviewed pre-service training records reflected staff received training on child abuse reporting. The program director reported a Trauma Responsive and Caring Environment (TRACE) self-assessment was completed in 2018 and a new TRACE self-assessment will be completed prior to July 1, 2020. According to the written policy and procedures, youth will have immediate, unhindered access to contact abuse. The first person to witness or obtain knowledge of child abuse will report the abuse as soon as possible without jeopardizing the safety and security of youth in their custody. The shift supervisor will be notified immediately of any youth request to call the Florida Abuse Hotline. Youth will be provided telephone access in order to place the call upon their request. Three of three staff members interviewed were familiar with abuse reporting procedures. All three staff members reported never observing a co-worker tell a youth they cannot call abuse and all three staff reported they have never heard a co-worker using threats or profanity towards a youth. Two of three interviewed youth reported they have never needed to call the Florida Abuse Hotline but could request to, if necessary. One youth reported he wanted to call when he first arrived at the program but changed his mind. This youth was asked by the interviewer if he needed to make a call about anything at this time, in which the youth responded "no." Additionally, all three youth reported they feel safe at the program and none have heard staff cursing at youth. Two of three youth reported staff are respectful when speaking to them; one reported staff are sometimes respectful. According to the program

director, all staff must adhere to a code of conduct which forbids them from using physical abuse, profanity, threats, or intimidation. The program director added, in the event of an allegation of abuse, the staff member will be removed from youth contact and pending the outcome of an internal investigation, the staff my face suspension or possible termination. The program director was able to explain the program's incident reporting process.

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 has not had any instances of physical, psychological, or emotional abuse since the last annual compliance review; therefore, this indicator is rated as "non-applicable."

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

The program has a written policy and procedures outlining the requirements for incident reporting. The program has had five incidents reported to the Central Communications Center (CCC) in the previous six months. All five incidents were reviewed. All five CCC reports reflected the incidents were reported within the required two-hour timeframe and were observed documented in the program's logbook. There were no internal incidents/grievances which should have been reported to CCC. The program director was able to explain the program's incident reporting process.

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 has not used physical interventions or mechanical restraints during the scope of the annual compliance review; therefore, this indicator rates as "non-applicable."

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

Three personnel records were reviewed for completion of pre-service training. Three of three staff reviewed completed over 120 hours of training within their initial 180 days of employment, as required. Training documentation was observed within the Department's Learning Management System (SkillPro). Each of the staff completed the required training prior to having any contact with youth to include: cardiopulmonary resuscitation (CPR), first aid, automated

external defibrillator (AED), Protective Action Response (PAR), ethics, suicide prevention, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA). Additionally, two of three staff completed active shooter training. Contractually required trainings were completed and included the following: homicidal risk, emotional behavioral development of adolescent youth, gender-specific programming, and trauma-informed care. All instructors were qualified to deliver training. All pre-service training was observed documented in SkillPro. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training on April 10, 2019 and the training plan was signed on May 10, 2019.

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

Three personnel records were reviewed for the completion of in-service training. Documentation reflected all three staff completed well over the required twenty-four hours of annual in-service training to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) update, ethics, and suicide prevention. One staff member reviewed was applicable for annual supervisory in-service training. The one applicable supervisory staff completed the required training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal training. The program employs four nurses, all of whom have a current certification in CPR with AED. All training was documented in the Department's Learning Management System (SkillPro). All instructors were qualified to deliver training provided. The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training on April 10, 2019 and the training plan was signed on May 10, 2019. The program has an annual in-service calendar, which is updated as changes occur.

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

The program has a written policy and procedures which outline the program's grievance process. A total of six staff records were reviewed for grievance training (three in-service and three pre-service), all of which the completion of training was observed. The program's grievance process includes three phases: informal, formal, and appeal. Upon admission to the program, the youth is oriented to the grievance process. Grievances forms were observed available to youth throughout the program. The first step in the program's grievance process is personal contact. The youth is responsible for making contact with the person involved and talk about the matter in a calm and polite way. If the matter cannot be informally solved, the process moves to the formal phase. During the formal phase, the youth completes a grievance form and submits it to the supervisor on-duty. The supervisor has forty-eight hours to address the matter and provide written feedback. If the youth accepts the decision, the youth will sign the form. If

the youth does not accept the decision, the grievance proceeds to the third phase. During the third phase, the program director reviews the grievance and findings from the supervisor and makes a final determination in the matter. There have been no grievances filed since the last annual compliance review. The program utilizes Request to Speak to Staff forms when youth have an immediate need to speak to staff. These forms were also observed available to the youth throughout the program. Three of three youth interviewed were familiar with the grievance process and could ask for help completing the form. Three of three staff members interviewed were familiar with the program's grievance process. The program director was able to explain the program's grievance process.

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

The program's contract of required services relating to delinquency interventions includes Impact of Crime (IOC) and Life Skills Training (LST). One staff is designated to provide interventions for this program. Documentation was available for review which reflected the staff completed training for both IOC and LST. The staff member providing interventions to the youth has a master's-level education in counseling. Education and work experience are considered by the program director when determining staff delivery of intervention services. The program's interventions address the delinquency intervention strategy utilized. The daily activity schedule reflected the program is providing structured, planned programming or activities at least sixty percent of the youth's awake hours. Group sign-in sheets were available for review and reflected groups were delivered as indicated on the group schedule. Each of the three reviewed youth records reflected the youth received or are currently participating in IOC and LST. All three youth have been involved in a delinquency intervention addressing a priority need. All three youth's performance plans included a delinquency intervention. The program director reported delinquency interventions are facilitated by the program's clinical coordinator in which all youth receive IOC and LST.

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

The program provides life and social skills intervention services. Life skill groups address socials skills interventions to include: communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking including problem solving and decision making. The program provides Life Skills Training (LST) for all youth in the program. A review of the activity schedule and sign-in sheets reflected groups were held, as required. A review of three youth records indicated each of the youth were participating in life skills group. All three interviewed youth reported they participate in groups. All three youth could describe something they have learned from group.

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.	

According to the program's contract, the Impact of Crime (IOC) curriculum is used to provide restorative justice awareness to youth. In addition, all youth participate in community projects. Youth thirteen years old are also eligible to participate in the Department of Transportation work program. The IOC curriculum is designed to assist youth to accepting responsibility for the harm they have caused others by their past criminal actions, challenge them to recognize and modify their irresponsible thinking, and teach youth about their impact of crime on their victims, families, and communities. Training documentation reflected the facilitator for this group completed the required training. The program's activity schedule reflects restorative justice groups and activities were held, as scheduled. Youth were observed working on a community service project during the annual compliance review. Each of the three reviewed youth records contained documentation of participation in restorative justice activities. According to the program director, community service projects are regularly scheduled events, as well as guest speakers from the community.

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

The program designs its services based on the common characteristics of its primary target population. Youth receive gender-specific programming through participating in Boy & Girls club gender-specific education topics and health education. Sign-in sheets for participation in the Boys & Girls Club gender specific-programming was available for review. Youth receive gender-specific healthcare education upon admission to the program. In addition, a representative from the Liberty County Health Department also comes out to the program to speak on topics to the youth at the program. The program director reported needs of the target population are addressed as follows: empowering youth to reach their potential, promoting effective communication and listening techniques, developing relationships of interdependence, promoting cultural diversity education, promoting self-respect, changing attitudes which prevent or discourage male offenders from recognizing their potential, and helping youth prepare for challenges they may face if they have a child or are preparing to have a child.

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

The program has a written policy and procedures in place to ensure the communication of medical, mental health, and security alerts and concerns of the youth are disseminated throughout the program. According to the written policy and procedures, a copy of the program's internal alerts is maintained in the shift supervisor's office and medical office and a copy of food allergies is kept separately in the kitchen. Copies of the alerts were observed during the annual compliance review in the locations described in the written policy and procedures. The program's practice is to have the off-going shift supervisor brief the on-coming shift about the day's events on the Daily Shift Report in which alerts are included. Staff sign the shift report, as acknowledgement of the briefing. In addition, the internal alert roster is updated as needed by the nurse on duty. Three youth were reviewed for alerts. Alerts were verified and updated by appropriate program staff upon the youth's admission to the program. The program's internal alerts were observed to be consistent with the Department's Juvenile Justice Information System (JJIS). Alerts were observed to be entered, closed, and/or updated by appropriate personnel. All three interviewed staff reported alerts are discussed daily during shift briefings. The program director reported any safety/security, medical and/or mental health conditions, along with special instructions shall be communicated through the program's internal alert system to all staff. The program director added important medical issues are reviewed through treatment team and the chronic clinic.

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 separates youth records into three separates records: individual healthcare record, individual mental health record, and an individual management record. The file tab on the individual management record contained the following information: youth's name, Department identification number, date of birth, county of residence, and committing offense. The individual management record contained the following sections: legal information, demographic and chronological information, correspondence, case management and treatment team activities, and a miscellaneous section. All youth records observed during the annual compliance review were labeled "confidential." The program stores youth records in secure cabinets marked "confidential" and youth do not have access to these areas.

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

The program solicits constructive input from the youth through the use of the Youth Advisory Board and Town Hall meetings. The program's Youth Advisory Board consists of two youth and several key staff members. The Youth Advisory Board conducts formal meetings on a quarterly basis. Agendas and meeting minutes were available for review and reflected quarterly meetings were held, as required. The program also holds informal Town Hall meetings on a monthly basis, in which all youth participate in an open discussion with the program director in the cafeteria. Request to Speak to Staff forms are available to youth and were observed throughout the program. In addition, the program has youth complete Quality of Life surveys prior to release from the program and ninety-days post-release from the program. A sample of these surveys was available for review. Three interviewed youth reported they ask staff for what they need, they request stuff in group, and they meet and talk about stuff in the chow hall. The program director reported the Youth Advisory Board is utilized for youth to provide input and youth have unimpeded access to the program director. The program director added, Trendstat and treatment teams are used to solicit input on systemic issues impacting the residential community.

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

The program has a Community Advisory Board which meets quarterly. The Community Advisory Board binder, which contained sign-in sheets, meeting minutes, agendas, and correspondence (letters) was available for review. Documentation reflected the meetings were held quarterly, as required. The program director solicits involvement from law enforcement, judiciary staff, community and business partners, school board or district, faith community, and victim services. The program's current Community Advisory Board contains a representative from each area, including a victim and parent/guardian of former youth in the program. The only member not represented on the board is a member of judiciary staff, in which documentation (letters) requesting involvement from judiciary staff was available for review. A board member was available for interview and confirmed their membership and meeting frequency. The program director reported the Community Advisory Board meetings are held quarterly and members are actively recruited from all required areas.

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

The program has a written policy and procedures relating to program planning. The program is in the process of completing a Trauma Responsive and Care Environment (TRACE) self-assessment in which surveys will be sent out to both youth and staff. The last TRACE self-assessment was completed in 2018 and the next TRACE self-assessment will be completed prior to July 1, 2020. Additionally, the program sends out Quality of Life Surveys to both youth and parents/guardians prior to a youth's release and ninety-days post-release. The program's most recent Comprehensive Accountability Report (CAR) was available for review. The program utilizes the monthly Trendstat reports to monitor positive and negative trends within the

program. When any negative trends are identified, targeted strategies are developed, implemented, and tracked to ensure improved effectiveness. Employee retention levels are consistently reviewed as a part of the program's Trendstat process and is an objective tracked as a part of the program's CAR initiative. To minimize turnover and improve morale, the program awards staff for employee of the quarter and employee of the year. This includes a plaque, gift card, personalized cup, and a designated parking spot. The provider also offers a competitive benefits package. The program conducts monthly "all staff" meetings in which agendas and sign-in sheets were available for review. In addition, supervisors meet weekly and corporate management meetings are held weekly. Three staff were interviewed in regards to the frequency of staff meetings, staff responses included: meetings are held daily (briefings), weekly (supervisor), and monthly. Staff were able to explain topics discussed in meetings and reported Quality Improvement results were discussed with them. One of three staff reported communication amongst staff at the program was very good, another reported it was good, and the third staff reported communication was fair. All three staff reported they can give feedback or input about the program at any time. The program director reported the CAR is reviewed annually with the management team. Additionally, the program director reported staff communication is accomplished through meetings, alerts, shift reports, memorandums, and other postings.

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

The program has a written policy and procedures in place relating to staff performance evaluations. A sample position description was available for review. The sample position description reflected performance standards were clearly identified. Three staff records were reviewed for completion of annual performance evaluations. Documentation reflected employee evaluations reflected performance evaluations were completed on an annual basis. A review of the contract reflected all key positions are currently maintained and performed as outlined in the contract. All three interviewed staff reported they receive performance evaluations annually. The program director reported staff received an annual evaluation which is completed by their supervisor and reviewed by human resources and the program director.

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

The program's activity schedule reflects a range of supervised and structured activities during the week and weekend. The program's contract reflects an agreement with the Boys and Girls Club to provide a variety of activities such as gender-specific programming, recreation, and off-campus activities. A review of the logbook reflected recreation and leisure activities were held in accordance with the daily activity schedule. All outdoor recreation activities are weather dependent and youth alerts are reviewed prior to activities to reduce the possibility of heat stress, dehydration, and other issues related to extreme outdoor temperatures. Recreation was observed during the annual compliance review and was held as indicated on the activity schedule. Youth have a choice of recreation and leisure activities and are encouraged to explore their interests. Recreation activities promote social and cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program's current recreational therapist has a bachelor of science degree in recreation management, which meets the program's contractual requirements. Therapeutic activities were

observed to be incorporated into youth's individualized performance plans. The program utilizes the Youth Advisory Board, Town Hall meetings, and Request to Speak to Staff forms to promote constructive input by youth. Three youth interviewed they participate in the following activities for more than one hour a day: basketball, football, kickball, dodge ball, and fishing. Three staff members reported youth participate in the following activities for one hour a day: basketball, football, soccer, kickball, Boys & Girls Club, Physical Education, and exercise.

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 case management records were reviewed for initial contact with parent/guardian, and notification to the committing court. Documentation in all three records reflected the parent/guardian was notified of the youth's admission to the program within twenty-four hours of arriving. The case management staff sent correspondence to parent/guardian, committing courts, juvenile probation officers, and the post-residential services counselors, if applicable, on the date of admission.

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

A review of three youth case management records reflected there was clear documentation to support the youth were all oriented to the program within twenty-four hours of admission. The program's orientation included the following: services available, posted schedule, expectations and responsibility, the behavior management system, medical/mental health access, grievance procedures, access to the Florida Abuse Hotline or Central Communications Center (CCC) for those youth over eighteen years of age, items considered contraband, treatment team, living unit and room assignment, dress code, emergency procedures and drills, facility layout and restricted areas, the process developing the performance plan, visitation, mail, telephone privileges, community access, assignment to a living unit and room, treatment team, and length of stay along with the expectation for successful discharge. Observations were made of the orientation process during the annual compliance review. The case manager assigned was observed discussing all elements as outlined in the program's written policy and procedures. Three youth were interviewed, and all stated they were provided an 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 only accepts youth ages ten to thirteen; 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 which may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program utilizes a classification system to promote safety and security and effective delivery of treatment services in accordance with the Florida Administrative Code. The program uses a classification form detailing factors such as the youth's physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and identified risk factors. The program utilizes an efficient internal alert system documenting any medical, mental health, security risks, or special needs identified during the initial classification process or identified throughout the youth's stay at the program. Three case management records were reviewed for youth classification. All three youth were classified on their date of admission. A new Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) was completed for each youth prior to their room assignment. An interview with the program director indicated at the time of admittance, prior to youth being assessed or reassessed, the following factors are considered prior to being allowed to participate in off campus activities: physical health status, cognitive performance, age, and prior victimization, which is considered when assigning a youth to a living unit and/or sleeping room.

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 which address gang identification, notification to law enforcement, and prevention and intervention activities. The program has zero tolerance for gang related behavior. Three youth case management records were reviewed. All three youth received a gang assessment upon admission. One of the three youth was found to have gang involvement. Two youth were not applicable and there were no other youth in the program at the time of the annual compliance review who had gang involvement. Observations made during the annual compliance review included all youth living and program areas. There was no evidence of gang graffiti or youth wearing gang clothing during these observations made. The program has designated the assistant program director as the gang liaison. The program's policy indicates the youth's assigned case manager will report any gang-related information to the Florida Department of Law Enforcement (FDLE) and to the program director. Documentation in the applicable youth's record reflected notification was made to local law enforcement, youth's home county law enforcement, and an update was added to the youth's gang alert. The program shares youth gang status with the education staff and post-residential providers, if applicable.

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 outlining gang intervention strategies. The program utilizes the Impact of Crime Curriculum (IOC) as their gang intervention strategy. Three youth case management records were reviewed. All three youth received a gang assessment upon admission. One of the three youth was found to have gang involvement. The youth identified had a gang alert and was participating in IOC, as reflected on his performance plan.

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

Three youth case management records were reviewed for Residential Assessment for Youth (RAY) initial assessments and re-assessments. Documentation in each of the three reviewed records reflected a RAY was completed for each youth within thirty days of admission to the program and were maintained in the Department's Juvenile Justice Information System (JJIS). Each youth required a reassessment which was completed within the ninety-day time frame, as required. Updates and reassessments were completed for each youth as deemed necessary by the treatment team to effectively manage the youth's case. All reassessment documentation was found in all three records.

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

A review of three case management records was conducted for completion of the Youth Needs Assessment Summary (YNAS). Documentation in all three records reflected a YNAS was completed for each youth within thirty days of admission to the program. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and in the case management records.

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.*	

A review of three case management records was conducted for performance plan development and transmittal. All the records had an initial performance plan developed within thirty days of admission to the program. There is documentation each member of the team was present during the development of the Initial Performance Plan for each youth. Each of the three interviewed youth reported they participated in the development of their Initial Performance Plan. All three performance plans were individualized and prioritized needs reflecting the risk and protective factors identified during the initial assessment process. The performance plan targeted measurable outcomes decreasing criminogenic risk factors and promoting strengths, skills, and supports reduce the likelihood of the youth reoffending. Each of the plans reviewed targeted the top three criminogenic needs and addressed transition activities for the last sixty days of the youth's stay. Each performance plan covered staff and youth responsibilities. Also, the plans had target dates for completion of goals prior to release of the program. All three youth stated they knew their performance plan goals. Each performance plan was signed by the youth, treatment team leader, parent/guardian, and appropriate treatment team members, indicating acknowledgement of its contents and associated responsibilities. Documentation in all three records reflected a copy of the performance plans were sent to the committing court, parent/guardian, and juvenile probation officer (JPO) within ten business days of the plans being completed. The original performance plans were observed in all three case management records. All three interviewed youth also reported they received a copy of their performance plan.

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

The program has a written policy and procedures in place regarding revisions to a youth's performance plan. The program's multidisciplinary treatment team revise a youth's performance plan any time a new need is discovered based upon the Residential Assessment for Youth (RAY) reassessment results, when the youth has demonstrated progress or lack of progress towards completing a goal, and/or when newly acquired information is revealed. Three case management records were reviewed for revisions to performance plans. All three records indicated the performance plans were completed 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 youth case management records were reviewed for performance summaries and transmittals. Summaries for each youth were completed every ninety-days following the signing of the performance plan. The records included documentation indicating the youth's status on each performance plan goal and overall treatment progress. All three records included progress updates which included academic status, behavior, level of motivation and readiness to change, interaction with peers and staff, overall adjustment to the program, significant positive and negative events, and justification for release (if applicable). In all three records reviewed, youth could read and add comments prior to signing the summaries. All three records included the original summary, and indicated the youth received copies of their summaries. In all three youth records reviewed, the performance summaries were signed by all required parties. Copies of summaries were sent to the committing court, the assigned juvenile probation officer (JPO), youth, and parent/guardian. None of the records required a summary to be sent to a Department of Children and Families caseworker.

Three closed records were reviewed for release summary contents. In all three closed records, an original summary, along with justification for release and the pre-release notification, were sent to the JPO at least forty-five days prior to the youth's planned release. Signed copies of the summaries were retained in each of the records reviewed. The exit Residential Assessment for Youth (RAY) was included in each closed record. None of the records required victim notification for youth who were determined to be required for Sexually Violent Predator Program.

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

The program provides opportunities for the youths' parent/guardian to participate in the treatment and case management services provided. The program has an assessment process for the parent/guardian to complete. Parents/guardians are asked to complete surveys, which the results are shared with administration and submitted to the corporate office for compilation in a quarterly report. Observations of a treatment team meeting and performance planning process were made during the annual compliance review. The youth's parent/guardian was contacted by phone during team meetings observed. Prior to formal treatment team meetings and transitional conferences, parents/guardians are given advanced notice of meeting dates and times. Parents/guardians can participate by telephone, if unable to visit in person. A review of the provider's contractual agreement found evidence performance expectations were being met related to parent/guardian involvement. The program director was interviewed and stated upon entrance to the program, the case manager contacts the parent/guardian through an

introductory letter, as well as a phone call to advise them of the process their child will be going through while in the program. Parents/guardians are informed of the treatment team schedule and visitation times and the program invites them to be actively involved in the process. Three youth were interviewed and each reported their parents/guardians 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.	

The program holds regularly scheduled treatment team meetings to discuss each youth's progress regarding their performance and treatment plan. A review of three youth case management records reflected documentation, as well as direct observations of treatment team meetings were conducted. The assigned case manager serves as the treatment team leader. Other members include the following: youth, administrative representative, recreational therapist, living unit representative, therapist, educational staff, and nurse. The youth's parent/guardian and juvenile probation officer (JPO) are invited to attend by telephone if they are unable to in person. The program's gang prevention specialist and transitional staff person will attend, if applicable for the youth.

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 youth case management records were reviewed for incorporation of other plans into the performance plan. All three youth records included a performance plan which referenced the youth's academic plans. All three records also referenced the youth's mental health and/or substance abuse treatment plans. Recreational therapeutic activities were also incorporated into the plans observed. None of the reviewed records were applicable for requiring a case plan through the Department of Children and Families and/or Agency for Persons with Disabilities.

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

The program has a written policy and procedures in place regarding formal and informal treatment team meeting reviews. The policy clearly states the formal treatment team meetings occur every thirty days, while informal treatment team meetings occur on a bi-weekly basis with the youth and case manager. Three case management records were reviewed to ensure formal and informal reviews were completed within the required timeframes, and necessary documentation was captured in the case management records. The informal performance reviews were documented in the case management records to include the youth's name, date of review, meeting attendees, pertinent information from the treatment team, a brief overview of

the youth's progress as it relates to treatment, and Residential Assessment for Youth (RAY) reassessment results.

A review of three youth case management records confirmed treatment team formal reviews were conducted at least every thirty days. Formal treatment team meetings were documented in the case management record and included the youth's name, date of review, meeting attendees, comments from treatment team members, a summary of the youth's progress in the program, and any performance plan revisions. A review of all three plans documented correct anticipated release dates and updates, at least every ninety days, as confirmed in the Department's Juvenile Justice Information System (JJIS). All three interviewed youth stated they were provided an opportunity, during treatment team meetings, to demonstrate skills learned in the program. There was documentation in all three records indicating the youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged to participate in the treatment team meetings. All interviewed youth stated they could demonstrate skills learned in program. During the annual compliance review, there were three treatment team meetings observed and at the meetings, the following individuals were present or participated by telephone: JPO, representative from administration, parent/guardian, medical, school, recreational therapist, mental health therapist, and direct care staff. The educational representative discussed progress on each youth's performance plan, positive and negative behaviors, and the youth were able to discuss and demonstrate skills acquired in the program. All team members actively participated in the treatment planning process.

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

The program offers Type 2 educational programming which includes Type 1 (personal accountability skills and behaviors leading to appropriate work habits for employment and living standards) program content. Youth are administered the My Career Shines assessment and the Department's common assessment upon admission to the program. Youth in the program are ten to thirteen years of age and are not age appropriate for vocational services offered on-site. Due to being under the age of fifteen, none of the youth in the program have employability as one of their goals upon completion of the program. All three reviewed closed records indicated the youth were administered the My Career Shines assessment and the Department's common assessment. In addition, although not required for youth of this age, two of the three youth had completed a resume. The program is currently exploring a hydroponics class for this age group.

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 integrates education instruction into their daily schedule. The activity schedule reflects youth attend school Monday through Friday from 8:00 a.m. to 2:45 p.m. Youth participate in 240 of 250 days of instruction. Ten days are utilized for teacher planning or training. A review of the logbook reflected minimal interference of educational instruction, as well as the bell schedule consistently being followed, as required. Each of the three interviewed youth reported there is no interference with educational instruction. An interview with the lead teacher confirmed the education schedule as reflected on the activity schedule.

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

Three closed youth records were reviewed for education transition plans. Documentation reflected all key personnel were involved in the development of the education transition plans. Each education transition plan addressed services and interventions based on post-release education needs, recommendations for educational placement based on the youth's needs, and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. None of the youth were age appropriate for employability as a goal.

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 closed records were reviewed for transition planning. Documentation in each of the three records reflected a transition conference was held sixty days prior to the youth's release from the program. Documentation further reflected the youth, juvenile probation officer (JPO), case manager/treatment team leader, parent/guardian, program director, and education staff participated in the transition conferences. During the transition conferences, participants reviewed transition activities on youth's performance plan, revised performance plans if necessary, identified additional transition activities, if needed, identified target completion dates, identified persons responsible for completion, as well as signatures and dates were obtained to acknowledge transition goals and accountability for completion. Each youth's JPO participated in the transition conference; therefore, a copy of the plan was not sent electronically. All three records reflected documentation indicating a Community Re-Entry Team (CRT) meeting was held prior to each youth's release from the program. Documentation further reflected the youth, case manager/treatment team leader, parent/guardian, and JPO participated in this meeting.

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 youth records were reviewed for an exit portfolio. All three records contained an exit portfolio which included documentation reflecting it was discussed at each youth's exit conference. Each exit portfolio contained all required age appropriate documents for youth under fifteen years of age. Documentation reflected correspondence for all three youth in which the parent/guardian and juvenile probation officer (JPO) received the exit portfolio. Documentation further reflected the program is meeting its contractual requirements, as well as administrative rule requirements.

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 an exit conference. Documentation indicated exit conferences were conducted at least fourteen days prior to the youth's release and after the youth's juvenile probation officer (JPO) was notified of the release. In addition, documentation included the date, signature and summary pending transition goals, and the status of transition activities established at the transition conference. The date of admission and termination documented in each record matched the dates in the Department's Juvenile Justice Information System (JJIS). All three records reflected the required attendees were present for the exit conference: program director or designee, parent/guardian, treatment team leader, education representative, JPO, and therapist. Each record indicated the exit conference was separate from the transition and Community Re-Entry Team (CRT) meetings.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed psychiatrist who serves as the designated mental health clinical authority (DMHCA). The DHMCA has a contractual agreement which requires him to be on-site at least one day a week for two to three hours. The DMHCA is a board licensed psychiatrist, licensed under Chapter 459 with a clear and active license. The DMHCA's license expires January 31, 2022. The program's clinical director is responsible for providing direct supervision of the case management and therapeutic department. The clinical director is licensed and serves as the licensed mental health counselor (LMHC) and is responsible for coordinating and verifying the implementation of necessary and appropriate mental health and substance abuse services in the program. The DMHCA was interviewed and stated he is on-site once weekly and meets with staff available on-site and accepts reports verbally or by email through nursing staff members. In addition, the DMHCA stated he reviews protocols as directed by the program director, and approves them if current, as well as approves any changes when necessary.

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

The program has a clinical director who is licensed and serves as the licensed mental health counselor (LMHC) and is responsible for coordinating and verifying the implementation of necessary and appropriate mental health and substance abuse services in the program. The LMHC has a clear and active license, with an expiration date of March 31, 2021. The program's clinical director is responsible for providing direct supervision of the case management and therapeutic department. Licensed mental health and substance abuse clinical staffing is in accordance with the current contract and Florida Administrative Rule. The program also has a part-time clinical psychologist who is on-call and available Monday through Friday. The psychologist serves as the back-up for the clinical director.

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 licensed mental health counselor (LMHC) provides direct supervision for non-licensed staff, to include the clinical coordinator and two case managers. Non-licensed mental health and substance abuse clinical staffing and training is in accordance with the provider's contractual agreement. Direct supervision is conducted weekly by the LMHC for the non-licensed staff for at least one hour of face-to-face supervision. A review of the direct supervision was completed for the scope of the annual compliance review to confirm the practice. Direct supervision notes were documented on the Department's Mental Health and Substance Abuse form (MHSA 019). A review of all therapeutic and case management staff training records confirmed each non-licensed clinical staff completed all required specific training. The program's clinical coordinator is primarily responsible for providing substance abuse services for applicable youth. The clinical coordinator holds a master's degree in addiction counseling. The program also holds a Chapter 397, which expires July 6, 2020. A review of pre-service training for non-licensed clinical staff found evidence each had fifty-two hours of pre-service training in areas of basic counseling skills, group therapy, treatment model and program philosophy, therapeutic milieu, behavior management, client rights, crisis intervention, and adolescent development. All non-licensed staff received the required training. Training was documented on the Department's Mental Health and Substance Abuse form (MHSA 022).

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.	

Three mental health records were reviewed for mental health and substance abuse admission screening. All three youth screenings were completed by the assigned case manager. The date and time of the initial screening matched the youth's date of admission. Available information was reviewed to include the commitment packet, reports and records for existing documentation of mental health or substance abuse issues. A Massachusetts Youth Screening Instrument - II (MAYSI-II) was completed for all three youth by the case manager, who received training for administering the MAYSI-II, according to training records reviewed. The clinical screening process captures the youths' mental health and substance abuse history, recent history of victimization, current medical status, behavioral observations, findings/recommendations, and disposition. The MAYSI-II was administered on the day of admission in a confidential manner. All screenings were completed in the Department's Juvenile Justice Information System (JJIS). Each MAYSI-II was completed in full and indicated further assessment was required. None of the youth required a suicide referral, although according to the licensed mental health counselor (LMHC), the program's practice is to complete an Assessment of Suicide Risk (ASR) for every youth as part of the initial assessment and admission process. Two ASRs were completed by the clinical coordinator and one was completed by the licensed mental health counselor. A review of training documentation found the clinical coordinator completed all required training to complete ASRs. None of the three assessments indicated the need for a crisis intervention or emergency services. Each youth was referred for, and received, a comprehensive evaluation.

The reason for referral was documented on the program's Referral for Mental Health Evaluation form. The program director is responsible for developing written policy and procedures for the implementation of a standardized admission/intake mental health and substance abuse screening process. A review of each youth's commitment information, including commitment packet, reports, and records for existing mental health and substance abuse information was completed according to the program's written policy and procedures. The program director was interviewed, and stated case managers conduct the MAYSI-IIs and referrals for any mental health and substance abuse issues and make referrals for service. If youth is suicidal, he will be given a suicide risk assessment.

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's licensed mental health counselor (LMHC) was interviewed and stated a new Bio-Psychosocial and Substance Abuse Evaluation is completed for each youth based on referrals done during the initial screening process by the case manager. All three reviewed youth records included referrals signed by the program director and LMHC. All three records contained a new mental health evaluation. Each evaluation was completed within thirty calendar days of admission by the LMHC. Each of the three records and evaluations found evidence relevant background information was included, as well as behavioral observations, mental status examinations, discussion of findings, diagnostic impressions, recommendations, and results from mental status examinations. Substance abuse assessments were completed for all three youth. All were completed by the LMHC. All three records contained evidence of youth consent for substance abuse services. Substance abuse evaluations were new and completed within thirty-days of admission. Each substance abuse assessment included the reason for assessment, relevant background information, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and other drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impressions including DSM diagnosis, and recommendations. Each of the three mental health and substance abuse assessments addressed the original referral reason. Each youth had a previous comprehensive evaluation attached alongside the current mental health and Bio-Psychosocial Evaluation. None of the three youth required an updated evaluation.

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.*	

Three youth records were reviewed for mental health and substance abuse treatment. All three youth were assigned to a treatment team upon arrival to the program. The multi-disciplinary treatment team is comprised of a youth, program administration, residential living unit representative, education, vocation, medical staff, and staff responsible for delinquency intervention and treatment services. A treatment team was observed during the annual

compliance review and found all required members were present, to include the assigned juvenile probation officer and parent/guardian, who participated by telephone. One of three records contained evidence indicating the youth was in need of, and receiving, substance abuse treatment services. The program's licensed mental health counselor (LMHC) stated the program currently has only one youth who meets this criterion. The youth receives services through individual therapeutic sessions as documented within the treatment plan. Weekly progress notes revealed the sessions were conducted, as required. Services were provided by the clinical coordinator who holds a master's degree in addiction counseling and is a non-licensed staff working under direct supervision of the LMHC. All three youth records reviewed had evidence the youth were receiving mental health treatment. Upon admission, program practice is to obtain an Authority for Evaluation and Treatment (AET) form and a Substance Abuse Consent and Release form for each youth. Each record contained an AET form. None of the youth were eighteen years of age or older. Youth diagnosis was captured within each youth record. Each youth record also contained a signed Substance Abuse Consent and Release form, which includes the youth's diagnosis (when applicable). The program utilizes a Weekly Summary form to document mental health and substance abuse treatment. The Weekly Summary form captures all information required within the Department's Mental Health and Substance Abuse form (form MHSA 018). Group therapy for the youth is limited to ten or fewer youth for mental health and substance abuse treatment. All three youth records had evidence the youth received individual counseling between the youth and a clinical staff. All three youth records reviewed indicated each youth received Life Skills Training. A review of the Department's Juvenile Justice Information System (JJIS) found evidence each youth has completed this group In addition, youth also receive the following groups: Team Building, Anger Management, and Decision-Making and Problem-Solving group. The program's clinical coordinator provides substance abuse treatment. The designated mental health clinical authority (DMHCA) was interviewed and stated the program provides intensive mental health and substance use services. The DMHCA stated he provides oversight of specialized services in the way of records review, staff reporting information, youth assessments, and follow-up. None of the three staff interviewed reported they are responsible for facilitating therapeutic groups. Three interviewed youth all reported they are participating in groups. The youth stated they discuss issues such as anger control and substance abuse.

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.*	

Three mental health records were reviewed for treatment planning. Each record included evidence the initial treatment plan was completed on the day of admission. None of the youth plans were required to be developed on an expedited basis. The initial mental health treatment plans were all completed on a form developed by the program which included all elements of the Department's Mental Health and Substance Abuse form (MHSA 015). One of three records required a substance abuse treatment plan in which the initial substance abuse plan was

developed and documented as required. Each initial mental health and substance abuse treatment plan was developed within seven days of the onset of treatment. One of three records was applicable for psychiatric services. For this record, the plan was developed within seven days of the initial psychiatric diagnostic interview. Initial treatment plans were all signed by the clinical coordinator. Each plan was reviewed and signed by the licensed mental health counselor (LMHC) within ten days of completion. The plans were also signed by treatment team members who participated in plan development. One of three plans was applicable for and included the youth's psychiatric needs, including medication and frequency of monitoring by the psychiatrist.

A review of the three records found each individualized treatment plan was developed for youth within thirty-days of admission. The plans were developed and documented on a form created by the program which contained all elements required in Mental Health Substance Abuse form 016 (MHSA 016). Each plan is signed by the clinical coordinator and reviewed and signed by the LMHC. Plans were all signed by treatment team members who participated in plan development. Only one of three plans had a parent/guardian signature indicating participation. The remaining two plans did not have parent/guardian signatures but did have documentation the plans were mailed to the parent/guardian. One of three records was applicable for the youth having psychotropic medication. For this youth, the individualized treatment plan included psychiatric services and medication and frequency of monitoring by the psychiatrist. The individualized treatment plan reviews were completed on a form which contained all elements on the Mental Health Substance Abuse form (MHSA 017). These reviews were completed every thirty-days, as required, following the development of the treatment plan. Each of the three records reviewed had documentation of prescribed services outlined within the treatment plans. The plans defined which groups the youth were required to attend, and the frequency. A review of progress notes revealed the groups were held, as required. Monthly treatment team meetings were also found documented within the youth records reviewed.

Three closed youth records were reviewed for discharge planning. All three youth closed records contained evidence of a discharge plan documented on the Mental Health and Substance Abuse Form (MHSA 011). None of the records reviewed were applicable for suicide risk notification. Discharge plans reviewed were discussed with the youth, parent/guardian, and assigned juvenile probation officer (JPO). A copy of the Mental Health/Substance Abuse Treatment Discharge Summary was documented as provided to the youth, JPO, and parent/guardian. This was documented on each youth's exit portfolio within the closed records.

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

The program director was interviewed and reported mental health overlay services (MHOS) are provided for youth. The program's licensed mental health counselor (LMHC) reported the program provides therapeutic services for youth seven days a week. Psychiatric services are provided weekly. Youth with co-occurring substance abuse disorders receive substance abuse services. The program's LMHC is a full-time employee on-site at least five days a week. The program has also arranged for a psychologist to provide services as needed and serve as the back-up for the LMHC. The LMHC reported the counselor caseloads do not exceed sixteen youth. In addition, the program's contractual agreement indicates the program will provide Continuous Case Services for twelve slots which provide transitional planning and in-home

counseling services for this population of youth. A review of three closed youth records was completed to confirm this practice. The program's clinical coordinator is primarily responsible for providing follow-up care for youth. The documentation reviewed was captured on the program's Ninety-Day Post-Commitment Discharge Form. The documentation included evidence of monthly telephone contact with the youth, as well as home visits completed by the clinical coordinator to each youth's home for follow-up continuous care services.

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

Three youth records were reviewed for psychiatric services. Upon entering the program, each of the three youth received a referral to see the psychiatrist, and had a psychiatric interview conducted. Evaluations were completed within fourteen days. Only one of the three youth reviewed entered the program already receiving psychotropic medication. The initial psychiatric interview conducted consisted of a review of each youth's medical and mental health history, mental status examination, treatment recommendations, medications (when applicable), and documentation of their diagnosis. One of three records reviewed were applicable for psychiatric services due to the need for psychiatric medication. For this record, the explanation for the need of medication was documented along with the frequency of medication monitoring and management. All three diagnostic interviews were documented on a form created by the program with all elements of the Department's Clinical Psychotropic Progress Note (CPPN). The form was clearly identified as the Initial Psychiatric Interview. The program attached page three of the Department's CPPN form to the documentation. Psychiatric evaluations were completed within thirty days of the referrals. For the one youth applicable for requiring and receiving psychotropic medication, there was evidence the youth was seen by the psychiatrist for a medication review every thirty-days, as required. Each of the reviews were completed on the Department's CPPN form. Documentation within this record also included evidence of the psychiatric medication regimen incorporated into the youth's mental health treatment plan.

The program has a written contractual agreement with the psychiatrist to be available for emergency consultation twenty-four hours a day, seven days a week. The psychiatrist is required to be on-site once each week for two to four hours. The agreement was signed by the psychiatrist, designated health authority (DHA), and program director. The program does not employ an advanced practice registered nurse (APRN), thus does not require a Collaborative Practice Protocol. Sign-in/out logs were reviewed for the previous six months for the psychiatrist. A review of the documentation found a period of four days where there was no signature from the psychiatrist. The psychiatrist, who serves as the designated mental health clinical authority (DMHCA), was interviewed and stated he is on-site weekly, and conducts initial assessments on youth and follow-up services if medically necessary. He stated he is responsible for providing medication management and monitoring youth who require medications. Upon assessments, he interviews youth, reviews the record, and obtains any staff report information available. If a youth is reporting sleep or concentration symptoms, he stated he will order a sleep study or Attention Deficit Hyperactivity Disorder symptom checklist and check for collaborative reports. The DMHCA reported having no concerns with healthcare at the program. He stated he meets with nursing and mental health staff before, during, and after

youth assessments, and follows-up to provide verbal reports and any related logs or checklists needed. He stated he is available twenty-four hours daily, seven days each week, and will call back for a consultation regarding any youth needs.

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

The program has a suicide prevention plan which outlines the process for identification and assessment of youth at risk of suicide. The plan lists the levels of supervision, a referral process, communication by staff, notification requirements, immediate staff response, and documentation of youth who are at risk of suicide. The plans also detailed a review process, to include suicidal attempts and a mortality review process. The plan was reviewed annually and signed by the licensed mental health counselor (LMHC) and program director. The program's training plan also found requirements for staff training related to suicide prevention. Three pre-service and three in-service staff training records were reviewed. All six staff records found evidence to indicate the staff received the required training for suicide precautions, which included four hours of instructor-led training, and two hours of training documented within the Department's Learning Management System (SkillPro). The program director was interviewed and stated the program conducts emergency response mental health drills in response to mock suicide attempts or incidents of serious self-inflicted injury. Drills are conducted to ensure staff can practice and become acclimated to experiencing stressful situations in a controlled environment. In addition, the program director stated each staff will be provided six hours annual training which includes two hours of SkillPro and four hours of webinar or instructor-led training.

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.*	

According to the licensed mental health coordinator (LMHC), all newly admitted youth have an Assessment of Suicide Risk (AR) completed. Three youth records were reviewed for suicide prevention services. All three youth had an ASR screening completed at the time of admission. Two of the assessments were completed by the clinical coordinator under the direct supervision of the licensed mental health director (LMHC), and one ASR was completed by the LMHC. A review of staff training records revealed the clinical coordinator had documentation of twenty completed hours for suicide risk screening. The ASRs were completed using the required form. The program director and LMHC reviewed and signed all ASRs within twenty-four hours of each youth's admission. Documentation of the actual date and time the clinician conferred with the program director and LMHC was recorded on the ASRs and entered in real time on the forms.

None of the youth reviewed were determined to be in crisis. Only one of the three youth entered the program with an open suicide alert. The program had no additional samples to provide for suicide prevention services implemented. For the one applicable youth, the youth arrived at the program on October 17, 2019, and had a previous suicide alert placed on him October 16, 2019 from detention. This youth was immediately assessed by the clinical coordinator and placed on standard supervision after admission. Precautionary observation was not required, as the youth remained with the clinical staff throughout the assessment process. An alert note was placed into the Department's Juvenile Justice Information System (JJIS) by the LMHC, moving the youth to standard supervision on the day of admission. The program does not utilize secure or controlled observation.

The program has a suicide response kit located in the youth living quarters. The kit was secured in a locked cabinet and contained a 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, and a mortality review for a completed suicide. The process is incorporated into the program's Crisis Intervention and Emergency Services Plan, which was observed signed by the LMHC and program director. The plan includes multi-disciplinary review of circumstances surrounding the event, facility procedures related to the incident, all relevant training received by staff involved, medical and mental health services, precipitating factors, and any recommendations made. Three interviewed staff reported in the event a youth expresses suicidal ideations, the staff is responsible for notification of the mental health staff, providing constant sight and sound supervision of the youth, and documenting the supervision as required. All three staff reported the suicide response kit was maintained in the youths' living area.

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.	

None of the three youth records reviewed were applicable for the usage of suicide prevention logs. The program had no additional records to provide to demonstrate suicide prevention logs for the population of youth reviewed. The program has a Suicide Prevention Plan which ensures the program follows a process to safely identify, assess, and protect youth with elevated risks of suicide in the least restrictive means possible, in accordance with Department policy and Rule. The program uses the Department's precautionary logs entitled Suicide Precaution and Close Supervision Logs (MHSA 006).

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.	

Three in-service and three pre-service training records were reviewed for suicide prevention training. All six staff records had the required four hours of webinar, or instructor-led training. All staff also had two hours of training through the Department's Learning Management System (SkillPro). All review of drill documentation found all reviewed direct care staff participated in quarterly drills, which included at least one mock drill incorporating the use of cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED). Sign-in sheets for staff

members were reviewed behind quarterly drills conducted. The licensed mental health counselor (LMHC), who serves as the clinical director was interviewed and stated it is the procedure of the program to review the drills with staff who were not present to afford them the opportunity to understand the process and review and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. Three interviewed staff reported they have participated in suicide and medical drills at the program.

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

The program has a written crisis intervention plan signed by the licensed mental health counselor (LMHC) and program director. The plan includes a notification and alert process, means of referral for youth, communication, supervision of youth, documentation, and a review process. The program utilizes the Department's Crisis Assessment form (MHSA 023). The program also has a written policy and procedures which includes the mental health and substance abuse Crisis Intervention and Emergency Services Plan.

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.	

A review of three youth records found none of the youth were applicable for requiring a crisis assessment. The program was unable to provide any additional record applicable to the crisis assessment process. In the event a crisis assessment is required, the licensed mental health counselor (LMHC) reported the assessment is conducted by the LMHC or the clinical coordinator, who works under the direct supervision of the LMHC.

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 which incorporates the Emergency Mental Health and Substance Abuse Services Plan. The plan includes immediate staff response, notification requirements, communication, supervision of youth, transportation services, documentation and training requirements, and a review process. The plan was signed annually by the program director and licensed mental health counselor. The plan was signed May 17, 2019.

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 reported having had no incidents of Baker or Marchman Acts during the annual compliance review period; therefore, this indicator will rate as non-applicable.

Standard 4: Health Services

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

The program's 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 January 31, 2022. The DHA's specialty training is in Family Practice and Internal Medicine (with experience with adolescents). The DHA is required to be on-site weekly, for two hours, which was confirmed through the DHA on-site sign-in sheets. A review of the program's weekly clinic logs reflected the DHA is on-site weekly, with two instances in which the program's psychiatrist covered twice. The DMHCA is licensed medical doctor who provided coverage in December 2019 and in February of 2020. 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. 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).

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 written policies and procedures for all health-related procedures and protocols utilized at the program. The designated health authority (DHA) and program director signs and dates all respective treatment protocols. Nursing staff reviews, signs, and dates a cover page on which all facility operating procedures (FOPs), treatment protocols, and other procedures are listed. An annual review of all FOPs and protocols is completed by the program. All newly employed healthcare personnel receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, given by a registered nurse. A copy of the healthcare staff orientation packet was provided by the program. Approval of treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. The review and development of FOPs or other protocols related to psychiatric services and psychotropic medication management is performed by the program's psychiatrist.

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

The program has a written policy and procedures to ensure the program provides informed consent to each youth admitted to the program and general parental authorization for healthcare is present and parent/guardians are notified of healthcare. 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. One youth record contained a court order for medical and

mental health treatment, as this youth was in the care of the Department of Children and Families (DCF) where the parental rights had been terminated. AETs are valid until the youth's eighteenth birthday. All copies of the AET had "copy" written legibly on the documents. Copies of parental notifications were maintained behind the AET in the IHCR. According to the nurse, the registered nurse (RN) or case manager will contact the youth's juvenile probation officer (JPO) in the event a new or current AET is needed.

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

All three youth records reviewed had completed parental notifications. Each of the records contained a parental notification packet which was 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 Healthcare Admission Screening and Rescreening Form (Facility Entry Physical Health Screening Form)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff.	

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

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.

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

All three youth received an orientation to healthcare services upon admission to the program. Three youth individual healthcare records (IHCRs) were reviewed for completion of orientation to healthcare services. Documentation in all three records reflected youth received healthcare services orientation upon admission to the program, as indicated by the youth's signature and

date of the healthcare orientation packet. The program's healthcare orientation included access to medical care, sick call, medication monitoring, what constitutes and "emergency," the right to refuse, what to do in the event of sexual assault, and the non-disciplinary role of healthcare providers.

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

The program has a written policy and procedures in place to ensure the designated health authority (DHA) is notified of all youth admitted with certain conditions. The program's practice is to notify the DHA for all new admissions to the program. Documentation in three youth individual healthcare records (IHCRs) reflected documentation of the DHA being notified by telephone for each youth. Two of the three youth reviewed were eligible for notification for a chronic condition. None of the three reviewed youth required notification for the need of emergency services. The DHA notification was documented in the nurse's admission notes for each youth.

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

Three youth individual healthcare records (IHCRs) were reviewed for completion of a Health-Related History (HRH) form. Three youth IHCRs contained a HRH form which was completed on the day of admission by the registered nurse (RN). Documentation further reflected each HRH was subsequently reviewed by the designated health authority (DHA). 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.

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

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. Two youth records reviewed were noted as a medical grade one and one records included a youth with the medical grade five. The results of the TST were observed to be documented on the CPA and Infectious Communicable Disease (ICD) forms in all five records reviewed. The CPA was completed in accordance with the Department's Health Service Manual requirements. The nurse was interviewed and confirmed CPAs are completed within seven days of admission and prior to any strenuous activity or being subjected to extreme environmental stress.

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

A review of three individual healthcare records (IHCR) determined the youth were clinically screened and evaluated for sexually transmitted infections (STIs). None of the youth screened reported being sexually active and did not agree to STI testing. Three youth records were reviewed and found all three youth were offered counseling, testing, and treatment for HIV upon admission to the program. All youth 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. The program utilizes the Liberty County Health Department for youth who consent to STI and/or 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. An interview with the nurse revealed, the HIV results are given directly to the youth from the Liberty County Health Department. Three youth were interviewed and all three reported they can ask for an HIV/Aids test.

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

Three youth individual healthcare records (IHCRs) were reviewed for sick call. Two of three youth IHCRs were applicable for sick call; therefore, the program provided an additional record for review. None of the three applicable youth reflected similar sick call complaints three or more times within a two week period. None of the three youth present with complaints in which medical staff were unfamiliar with. All three youth completed sick call request forms which were placed in a locked box and then provided to the nurse. Completed sick call request forms were observed to be filed with the corresponding progress note for each youth, in reverse chronological order. All three sick calls were completed by either the registered nurse (RN) or licensed practical nurse (LPN). None of the youth were applicable for restricted housing. Sick calls were documented on the youth's sick call index in the IHCR, as well as the Sick Call Referral log. Nurses are on-site seven days a week from 7:00 a.m. to 7:00 p.m. and able to take sick calls seven days a week, from 3:00 p.m. – 5:00 p.m. Sick call hours and sick call forms were observed to be posted in cafeteria, youth dorms, and in the medical office. Sick call is conducted by the RN or LPN. No sick calls were placed during the week of the annual compliance review; therefore, sick call was unable to be observed. The program does not have a computerized system to document medical information. Three youth were interviewed and all three youth reported the response to sick calls are within one day and three staff interviewed reported the nurse conducts sick calls. The nurse reported in her interview, youth have unimpeded access to medical.

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

The program has a written policy and procedures in place to ensure the program maintains written healthcare procedures and practice for on-site episodic care. Three youth individual healthcare records (IHCRs) were reviewed for episodic care. One of the three IHCRs reviewed were applicable for episodic care; however, the youth record documented three instances of episodic care. Documentation reflected the youth was given over-the-counter (OTC) medications. None of the three applicable youth reviewed were referred for off-site care. Progress notes contained all required elements, referral needed, parental notification, and plans for follow up/future care observed. On-site care was provided by the registered nurse (RN) and subjective, objective, assessment, and place (SOAP) format was observed. The episodic care log documented all instances of first aid/emergency care. Logs for the previous six months corresponded with all on-site/off-site events observed in youth IHCRs. Emergency medical and dental care including EMS services are available twenty-four hours a day.

First aid kits are located in each youth dorm, supervisor's office, medical, and vehicle kits are kept in administration. The first aid kits were fully stocked with designated health authority (DHA) approved contents. The first aid kits are monitored monthly by nursing staff to ensure they are secured and to ensure inventory. The program has one automated external defibrillator (AED) which is located outside the medical office. Instructions are located inside the AED. Nursing staff inspects the AED once a month. AED inspections for the previous six months were available for review and found inspections were completed, as required. The registered nurse (RN) performed a self-test of the AED during the annual compliance review in which the AED was found to be in working order. The AED pads were last changed in May 2019, and the current pads expire May 2021. The AED batteries were last changed in May 2019 and the current batteries expire in December 2022. A review of drill documentation reflected the program conducted drills quarterly and on each shift since the last annual compliance review. Documentation further reflected drills included the demonstration of CPR/AED annually. The program has a list of emergency numbers, including Poison Control Information Center which are inaccessible to youth. A review of training records indicated they have completed the required training. All three interviewed youth stated they could see a doctor and ask to see a dentist for any tooth pain. Three interviewed staff reported they can personally call 9-1-1 if a youth has a medical emergency. The nurse reported in her interview, episodic care is documented on the episodic encounter form and filed under chrono notes after the DHA has reviewed and signed the form. Episodic care is then documented in the episodic binder. The shift supervisor will notify the on-call nurse and receive orders for care per protocols. This is documented on the OTC medication form.

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

Three youth individual healthcare records (IHCRs) were reviewed for off-site care. All three records included examples of non-emergent off-site care. Parental notification was observed in the three applicable IHCRs. The Summary of Off-Site Care form was observed in all three

IHCRs. Documentation reflected the designated health authority (DHA) initialed all three forms. None of the youth required follow-up in which the appointments were tracked.

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

The program has a written policy and procedures to ensure the program is proactive in providing care for chronically ill youth. Three youth individual healthcare records (IHCRs) were reviewed for chronic conditions. Two of the three youth IHCRs were applicable for a chronic condition. One of three youth was identified with a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. One of three youth was taking prescribed medication on an ongoing basis. Two of the youth entered the program as a medical grade five and two youth entered as a medical grade one. The two youth were observed to be identified as having a chronic illness on the program's internal alert roster. None of the youth reviewed were taking ant-tuberculosis medication. Periodic evaluations are tracked by the registered nurse (RN) using the chronic roster which indicates the dates in which the youth needs to be evaluated. Periodic evaluation documentation was observed in each youth's IHRC. Evaluations were conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly distinguishable for clinical staff. None of the periodic evaluations were conducted off-site. There was no indication of any missed or lapsed periodic evaluations in the documentation observed. The Problem List for each youth was updated in accordance with the Health Service Rule 63-M. The designated health authority (DHA) revealed in an interview, periodic evaluations are ensured by a log kept on all youth being treated for chronic conditions with the last seen and next seen date noted. The nurse was interviewed and confirmed the youth are seen by the DHA on their next on-site visit. DHA is notified by phone and verbally when a youth with a chronic condition is admitted. The youth is then placed on the DHA's list. All appointment dates for Chronic Illness Clinic are documented on the calendar.

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

The program has a written policy and procedures to document the program maintains a system of medication administration which ensures all medications are administered safely and effectively as ordered by the physician. Three youth individual healthcare records (IHCRs) were reviewed for medication administration. One of the three reviewed IHCRs reflected the youth entered the program on prescribed medication and one youth was prescribed medication after admission. Prescription verification for the one youth was observed in the chronological progress note in the record. Documentation further reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist to resume the medications. All medications were observed to have a current, valid order and were given pursuant to a current prescription. Practitioner Order Forms were also observed for both youth records and their prescribed medications. None of the youth reviewed were applicable for restrictive housing. Two of the three youth reviewed were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form, in which medication was administered according to approved protocols. The Medication Administration Record (MAR)

utilized by the program is pre-printed by the pharmacy. Staff initialed each administered medication. There were no undocumented explanations for lapses or errors in medication administration. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both licensed and non-licensed staff. One youth record contained refusals which was observed on the MAR and Refusal Form found in the youth's IHCR. The Facility Entry Physical Health Screening (FEPHS) forms for indicted all youth were noted and one youth was found to be taking prescribed medication upon admission to the program. Appropriate notifications to the parent/guardians were made for all three youth, when applicable.

All medications were observed to be in a separate, secure areas, inaccessible to youth. All non-controlled medications (prescribed and OTC) are stored in a separate, secure, locked area, inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are stored separate from specific youth medications. Expired medication is destroyed by the pharmacy and in the presence of a nurse. Medication pass was able to be observed during the annual compliance review with no issues noted. Three youth interviewed included the two youth taking medications, reporting the nurse provides the medications. All three staff interviewed reported the nurse provides medication to the youth and one staff also included the supervisor. Interview with the nurse reported monthly MAR reviews to check for expired medications. Expired medications are collected and given to the pharmacy for disposal.

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

Medical equipment classified as sharps were observed securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were observed to be separated. Observations of all controlled substances were maintained behind two locks, stored separately from other medications, and had a perpetual inventory. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was observed to be documented on the youth's individualized Controlled Medication Inventory Record. A shift-to-shift count of controlled medications was observed. The program maintains an approved list of supervisory level, non-health care staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. Training was observed to be completed for each staff member on the approved list. Observations of the nurse inventory, two youth medications both of which were narcotic/controlled medications, three OTC medications, and three sharps all of which matched the perpetual inventory. Perpetual inventories of medications and sharps for the previous six months were available for review. The nurse was able to explain procedures for inventory discrepancies as well as secure storage and routine inventories of medication, disposal of medication, and the practice for securing controlled substances.

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

The program'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. The program's infection control procedures includes common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. 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 reviewed annually and located in the building utilized for medical services and also the administration building. Interview with the nurse revealed the program's training coordinator conducts infection control training for all staff. Youth are provided infection control education at admission and periodically throughout their stay.

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

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

Standard 5: Safety and Security

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

The program has a written policy and procedures requiring staff to maintain active supervision of 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).

During the annual compliance review, program staff were observed maintaining active supervision of youth and interacting positively with youth during all activities. Staff were engaged in a full schedule of constructive activities, while closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff were aware of the number of youth under their supervision at all times. The staff and youth were observed during groups, school, recreation, meals, and movements, the staff-to-youth ratio of one-to-six was maintained, and counts were conducted before and after every movement. Formal counts are conducted every hour. If a count is unable to be reconciled, the program will stop all movement and conduct additional counts and search the facility, until the youth is located. The program has the full schedule of activities posted in the living unit.

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

The program has a policy and procedures in place concerning the behavior management system (BMS). The BMS is clearly written, and the program has not made any changes to the BMS since the last annual compliance review. The BMS contains all of the required elements. A review of three individual youth records confirmed each youth reviewed, singed, and acknowledged they received orientation to the BMS upon entry to the program. During the annual compliance review, the BMS was observed daily in all youth and staff interactions. It is the program's policy, to provide a minimum four-to-one positive to negative consequences according to their BMS. Three staff and three youth were interviewed concerning the BMS, each youth and staff were knowledgeable and had a clear understanding of the BMS system and were able to explain the BMS.

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 requiring the behavior management system (BMS) to be monitored by the programs supervisors, they are responsible for the implementation of the BMS and ensure the use of rewards and consequences are administered fairly and consistently. The program's BMS allows for staff explain to the youth the reason for any sanction imposed, the youth is given an opportunity to explain his behavior, and staff and the youth discuss the behavior's impact on others. Room restriction is not utilized at the program; therefore, it is not a part of the BMS. Program staff completed the required BMS training and staff trained in the jointly combined BMS plan to include use of BMS during school. Observations during the annual compliance review confirmed, program staff monitors the daily progress of each youth and provides ongoing interventions, level system, and point system. Each of the three youth reported the consequences they are write ups and lose of levels. According to the program director, staff receive yearly performance evaluations and coaching sessions by supervisor concerning the BMS.

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

The program has a policy and procedures requiring staff to observe youth at least every ten minutes while the youth are in their sleeping quarters. The program does not have any cameras. A review of ten-minute checks was conducted on three random days, December 1, 2019, January 8, 2020, and February 7, 2020, between the hours of 9:30 p.m. and 6:30 a.m. The review of ten-minute checks confirmed the program completed the checks, as required. It is the program's practice to radio to direct care staff to conduct ten-minute check. The checks accrue between eight to ten minutes randomly. Checks were documented in real time and included the staff's initials. Three staff were interviewed, each one was aware of the responsibility to conduct ten-minute checks.

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

The program has a policy and procedures to address census, counts, and tracking of youth. The program ensures each youth is always accounted for through a system of physically counting youth at various times throughout the day and utilizing their radios to communicate movements and counts to supervisor. A review of the logbook and observations revealed the program conducts and documents counts at the beginning of each shift, after each outdoor activity, and during emergency situations, formal counts are conducted every hour. If a count is unable to be reconciled, the program will stop all movement and conduct additional counts and search the facility, until the youth is located.

Two interviewed staff reported head counts are conducted every hour and the remaining youth reported counts are conducted morning, afternoon, evening, and night. Each staff reported conducting recounts if the count is not accurate.

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

The program has a policy and procedures requiring staff to maintain a chronological record of events, incidents, and activities in a central logbook which is maintained in the administration office, in accordance with Florida Administrative Code. A review of the logbook was conducted. The logbook is hardbound and in good condition, without any missing pages. Staff used ink for all entries and there were no entries removed, no whiteout was used, or other methods to erase entries.

Logbook entries included the date, time, description of the event, including names of staff or youth, as appropriate, and the name and signature of the person making the entry. The logbook documented staff received a briefing from the previous shift, as well as the incoming shift's review of the logbook and Internal Alert System (IAS). The IAS and logbook provided documentation of emergencies, youth behavior incidents, counts, security checks, transports,

admissions/releases, and escape incidents, as well as calls to the Department's Central Communications Center and/or the Florida Abuse Hotline. The program implemented a highlighter color code system to easily identify vital information.

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 governing the control and use of facility keys. The program's key inventory was reviewed and matched the keys in use. Random staff were checked for their personal keys and all of their keys were previously turned in and work keys were obtained. The supervisors, program administration, and three interviewed staff were knowledgeable of the program's policy regarding key control and accountability. Staff interviews and observations revealed, everyone entering the program must turn their personal keys, which are then locked in a secured box located in the lobby for visitors and supervisors' offices for direct care staff until they depart. Staff are only given keys matching their level of permissions/area of employment. According to staff interviews, if keys are missing staff are required to reports the incident to master control, search the facility and youth. If keys are damaged, the supervisors are notified, personal keys are stored in the supervisor's office in exchange for facility keys, and a maintenance request is made to replace the damaged key. According to the assistant program director, only the program director and the assistant program director have key access to every area of the facility.

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

The program has a policy and procedures in place concerning contraband, which aligns with the Department's recommended guidelines. The policy defines contraband and details the methods to detecting contraband and preventing introduction by utilizing searches of the youth, physical plant, grounds, mail, and other areas. The policy clearly states staff discovered with contraband face disciplinary action, up to and including dismissal. The policy also states any illegal contraband discovered requires the notification of law enforcement authorities and the surrender of the contraband to the responding agency. The policy also addresses the documentation and disposition of non-illegal contraband. Youth are provided with a list of items considered contraband during orientation. The logbook documented regular and random searches of various areas, as detailed by policy. The youth handbook outlines a list of items considered to be contraband. The program conducts random contraband searches and document them in the logbook and in the contraband binder. According to the program director and documentation reviewed, it is the responsibility of the program director to conduct perimeter checks daily, youth are searched prior to each movement and after visitation, and incoming and outgoing mail is searched for contraband. Documentation and observations during the annual compliance review confirmed searches are conducted as outlined in the policy. According to the program director, evidence and contraband must be placed in plastic bags and properly identified and labeled. Illegal substances and evidence will be stored in a locked drawer or cabinet in the Program Director's office until it can be turned over to the appropriate law enforcement department.

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

The program has a policy and procedures requiring staff to performs searches to ensure no contraband is introduced into the facility. During the annual compliance review, multiple searches were observed. Searches were observed after recreation, after lunch, after school, and prior to movements. Prior to conducting the searches, staff explained the purpose of the search and instructed the youth to get in line for the search. Staff avoided using unnecessary force and youth were treated with dignity and respect to minimize the youth's stress and

embarrassment. All searches were conducted by the appropriate number of staff and staff of the same gender. All three staff interviews revealed searches are conducted after every movement, and one staff also stated youth are searched when returning to campus. Youth interviews revealed searches are conducted after returning from off-campus, work detail, when items are missing, and after meals, after work detail, and when staff think contraband may have entered the facility.

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

The program has a policy and procedures ensuring all vehicles used to transport youth are appropriate maintenance and contain safety and emergency equipment to ensure they are operating in a safe manner. The program has six vehicles, four of which are used to transport youth. One of the two remaining vehicles is currently in the shop for repairs and the other vehicle is only used to transport food. Five of the six vehicles received an annual safety inspection and are equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. In addition, an approved first aid kit used for transport is maintained in the administrative office and the cell phone used for transport is located in the supervisor's lockbox. It is the program's practice for each youth and each staff to wear seat belts during transportation, and no youth can be attached to any part of the vehicle by any means other than the proper use of the seat belt.

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

The program has a policy and procedures concerning the ratio of staff to youth while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public. A random check of personal vehicles and facility vehicles was conducted, and all vehicles were locked when not in use except one. It is the program's policy to meet the minimum ratio of one staff for every five youth during transportation; however, according the assistant program director it is their practice to exceed the minimum requirement by providing an additional staff member on all transports. A review of all staff who transport youth personnel records confirmed the program conducts driver's license checks to ensure staff have a valid and current driver's license. An interview with the program director revealed staff do not use their personal vehicles to transport youth. Staff interviews revealed transporting staff are provided a cellular phone in case of an emergency. Staff also reported they are not allowed to use their personal vehicles for transporting youth. During the annual compliance review, the end of a transport was observed. Two staff accompanied the youth one male and one female. According to the youth, staff ensured he had a seatbelt on prior to moving.

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

The program has a policy and procedures in place requiring weekly safety and security audits. A review of the program's policy was conducted, and the policy meets all of the requirements, as outlined according to the Department's standards. An interview with the program director and documentation provided revealed, there is a clear process regarding the identification, tracking, and correcting deficiencies which requires staff to complete a maintenance request and it is address as soon as it received and logged. The program grounds are inspected by the assistant program director weekly due to the wildlife surrounding the program. Any deficiencies are noted and a work order for repair is completed and submitted to the maintenance department. Maintenance conduct weekly testing on the facility's emergency generator and fire detection/suppression equipment.

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 documented since the last annual compliance review. All staff reviewed were found to have completed training for the intended and safe use of tools. Tools are maintained in the locked closets. During the program tour, all tools were observed securely stored and inventoried behind locked doors and not accessible to youth. According to the youth and staff interviews, youth are not allowed to use any tools.

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

The program has a policy and procedures concerning the supervision requirements when youth are using tools. The policy details the supervision requirements, including ratios, issuance/collection of tools, and search requirements. Each youth receive risk assessment prior to having access to tools. The staff-to-youth ratio is one-to-five during activities involving tools. Three youth were interviewed, and reported they are not allowed to use tools.

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

The program has a policy and procedures which establish guidelines for outside contractors, which includes information about tool control and restrictions. According to the policy, the site safety and security coordinator is responsible for the oversite of tool control. The program utilizes a signed agreement for each contractor visiting the program. The agreement acknowledges the policy and documents the tools introduced into the program. The program restricts tools to those necessary to complete the job requested. Tools are checked and inventoried upon the worker's arrival and departure, and youth access to the work area is

restricted. A review of three random contractor agreements matched the sign-in sheets for their respective agreement day.

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

The program has a policy and procedures requiring the completion of fire, safety, evacuation, and disaster drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster. Documentation provided revealed, drills are conducted on each shift monthly. The program conducts multiple drills on the same day each month for each shift. The drill form included all of the required elements, to include the types of drills, dates, times, participants, brief scenarios, and the findings or recommendations. However, some of the drill documentation did not clearly document the scenarios. During the annual compliance review, staff updated the drill forms by adding a scenario drop down options to each form. Staff interview confirmed the program conducted a variety of drill including medical, suicide, escape, hostage, and weather drill. Youth interviews confirmed staff instruct youth on what to do in case of a fire. Observation during the annual compliance review conformed the program has evacuation routs posted throughout the facility. Documentation provided confirmed, the City of Bristol Fire Department inspected all of the programs fire equipment on March 1, 2019.

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

The program has a coordinated disaster plan and continuity of operations plan (COOP). The plan provides 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 public. The plan was submitted and approved by the Department on May 30, 2019. The COOP included all of the required elements. The COOP is maintained in the administrative building and is readily available to staff. An interview with the program director revealed the staff have access to the COOP which is located in the supervisor's office.

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

The program has a policy and procedures concerning maintaining strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items. It is the

program's practice only to store cleaning chemicals on-site. Bulk chemicals are stored in a locked closet in the administration building, which is inaccessible to youth and behind two locked doors. Chemicals for daily use are stored in a locked box in the supervisor's office, inaccessible to youth. A review of the inventory was compared with the actual inventoried items, all chemicals matched the inventory supply. Only supervisor, team leaders, and behavior tech have keys to the chemicals. The program provided documents of safety data sheets for the inventory of each item.

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

The program has a policy and procedures which prohibits youth handling and supervision for flammable, poisonous, and toxic items and materials. According to policy, youth do not handle any flammable, poisonous, and toxic items, materials or any of the cleaning chemicals maintained at the facility. All items are strictly maintained in the secure administrative building and are inaccessible to youth and securely locked. Three youth were interviewed, concerning handling of chemicals, each reported not handling any chemicals.

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

The program has a policy and procedures concerning the disposal of flammable, toxic, caustic, and poisonous items. The procedures also include disposal of hazardous items and toxic substances in accordance with Occupational Safety and Health Administration (OSHA). The staff are responsible for oversight of the handling and disposing of hazardous waste and/or solid waste and disposing of hazardous items and toxic materials. An interview with the assistant program director revealed the program properly disposes toxics, caustics, and poisonous items through agreements with waste management. All chemicals are used and disposed of utilizing the drainage system. 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 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. According to the policy, each youth must take a swim test before participating in water-related programming to determine the risk lever for each youth. The program currently utilizes one lifeguard who is certified with the American Red Cross. According to the program compliance coordinator, none of the youth have participated in any water activities. According to the youth interviews, all three reported not participating in water activities.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program has a policy and procedures in place allows visitation and communication for youth while in the program. The program's activity schedule specifies times for visitation, telephone calls, telephone calls, and letter writing. During the annual compliance review visitation logs, telephone logs, mail correspondences and schedules were reviewed, and confirmed youth are provided opportunities to communicate with their family daily. The program

maintains a list of approved family relative the youth are allowed to communicate with. According to the program director, the program makes special accommodations for a parent/guardian who cannot visit during the scheduled visitation time. The program accommodates parents/guardians with special telephone time in the event work schedules or other extenuating circumstances prevent telephone calls from taking place at the scheduled times. According to the youth interviews, all three reported having the opportunity to communicate with family members by mail, telephone, or at visitation.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program does not utilize controlled observations; therefore, this indicator rates as non-applicable.

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

The program has a written policy to conduct an on-going safety planning process for each youth. A review of three youth safety plans revealed each was completed within fourteen days of admission and contained all the required elements and recommendations from collateral sources, and previous clinical assessments, and were reviewed monthly during treatment team meetings. Three youth were interviewed, and each stated they were involved in the development of their safety plan and believe staff are really trying to help each youth do well. According to staff interviews, safety plans are located in the supervisor's office and the plans are reviewed by staff daily.