**STATE OF FLORIDA**
**DEPARTMENT OF JUVENILE JUSTICE**

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## Annual Compliance Report

## Walton Academy for Growth and Change

***Rite of Passage***

**(Contract Provider)**
**286 Gene Hurley Road**
**DeFuniak Springs, Florida 32433**

***Review Date(s): February 3-7, 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:

Tara Frazier, Office of Program Accountability, Lead Reviewer (Standard 1)
Regina Berry, Escambia Regional Juvenile Detention Center, Major (Standard 5)
Jill Foy, Office of Program Accountability, Regional Monitor (Interviews)
Jessica Gibson, Office of Programming and Technical Assistance, Technical Assistance Specialist (Standard 2)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 3)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Walton Academy for Growth and Change
Provider Name: Rite of Passage, Inc.
Location: Walton County / Circuit 1
Review Date(s): February 4-7, 2020

MQI Program Code: 1443
Contract Number: 10358
Number of Beds: 39
Lead Reviewer Code: 166

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

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 1.10 Delinquency Intervention and Facilitator Training | 1.07 Pre-Service/Certification Requirements * |
| 3.07 Treatment and Discharge Planning * | 1.08 In-Service Training |
| 3.12 Suicide Precaution Observation Logs * | |
| 3.13 Suicide Prevention Training * | |

# Standard 1: Management Accountability
# Residential Rating Profile

## Indicator Ratings

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

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

# Standard 2: Assessment and Performance Plan
# Residential Rating Profile

## Indicator Ratings

| Standard 2 - Assessment and Performance Plan | | |
|---|---|---|
| 2.01 | Initial Contacts to Parent/Gaurdian and Court Notification | Satisfactory |
| 2.02 | Youth Orientation | Satisfactory |
| 2.03 | Written Consent of Youth Eighteen or Older | Satisfactory |
| 2.04 | Classification Factors, Procedures, and Reassessment for Activities | Satisfactory |
| 2.05 | Gang Identification: Notification of Law Enforcement | Satisfactory |
| 2.06 | Gang Identification: Prevention and Intervention Activities | Satisfactory |
| 2.07 | Residential Assessment for Youth (RAY) | Satisfactory |
| 2.08 | Youth Needs Assessment Summary (YNAS) | 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 * | Non-Applicable |
| 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 * | Limited |
| 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 * | Limited |
| 3.13 | Suicide Prevention Training * | Limited |
| 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 * | Non-Applicable |
| 5.22 | Visitation and Communication | Satisfactory |
| 5.23 | Search and Inspection of Controlled Observation Room | Satisfactory |
| 5.24 | Controlled Observation | Satisfactory |
| 5.25 | Controlled Observation Safety Checks and Release Procedures | Satisfactory |
| 5.26 | Safety Planning Process for Youth | Satisfactory |

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## Program Overview

Walton Academy for Growth and Change (WAGC) is a thirty-nine bed program for males ages thirteen to eighteen years of age, located in Defuniak Springs, Florida. The program is operated by Rite of Passage, Inc., through a contract with the Department. The program provides Substance Abuse Treatment Overlay Services (SAOS) and Mental Health Overlay Services (MHOS) which includes innovations in delinquency programming. Services include academic, vocational, anger management, substance abuse, and mental health services. The educational needs are served by the Walton Learning Center through a partnership with Walton County School District and the Rader Group. The Walton Learning Center offers an educational program including all course requirements for students to complete middle school progression requirements and earn a standard high school diploma. The Walton Learning Center is a Type 3 program and career education opportunities which includes the Home Builders Institute (HBI) Pre-Apprenticeship Certificate Training certification. This program is an approved GED® test site and Postsecondary Education Readiness Test (PERT) site. The key staff positions for the program includes the program director, clinical director/licensed mental health professional, nursing staff, designated health authority, designated mental health clinician authority (acting as the clinical director), transition services manager, and recreation therapist. The program currently has a registered nurse, clinical counselor, and two direct care vacant positions. The program has two housing units and one master control room with a master control operator. The program has fifty-two cameras with all cameras operational during the annual compliance review.

# 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.* | |

Fourteen personnel records were reviewed for initial background screenings. All fourteen had background screenings completed prior to hire, criminal history reports reviewed, and received and exemption prior to working with youth. One of the fourteen staff had a break in service as indicated in staff verification system (SVS). Nine of the fourteen staff were required to take the pre-employment assessment tool test and all nine received passing scores. All fourteen staff were added to the clearinghouse employment roster. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's Background Screening Unit (BSU) on January 21, 2020. The teachers are provided through the Walton Learning Center and completed the Annual Affidavit of Compliance with Level Two Screening Standards on February 5, 2020. The principal also provided letters verifying all teachers completed the screening process as required according to the school board policy, as well as fingerprints. The program director stated the program reviews each potential new hire by reviewing the Department's Central Communication Center (CCC) person involvement history report, SVS, Florida Department of Law Enforcement (FDLE), Agency for Healthcare Administration (AHCA), reference checks, and the pre-employment assessment test.

| 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 had one staff eligible for a five-year rescreening at the time of the annual review compliance. The rescreening was submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the staff's five-year anniversary date.

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

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

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

The program has a written policy and procedures in place addressing an abuse-free environment. The policy addresses the steps involved to report abuse as the staff member must immediately contact the shift supervisor, human resources, and the program director (PD). An incident report will be written and submitted within one hour of reporting. Immediate notification to the local county Department of Social or Human Services or the police department by the PD or designee. The program has the Florida Abuse Hotline and Department's Central Communications Center (CCC) numbers posted throughout the facility. The program is scheduled to complete the Trauma Responsive and Caring Environment (TRACE) self-assessment at the end of February 2020. The PD provided a copy of the 2019 TRACE self-assessment report. The program had five staff involved in incidents of allegations of abuse. In all five incidents, the CCC was notified. In three of the five incidents, the Florida Abuse Hotline was also notified. Three of the five allegations were substantiated.

Five youth were interviewed if they have ever been stopped from reporting abuse to the Florida Abuse Hotline or CCC since they have been at the program. All five stated they have not needed to call but three added they could if needed or wanted to. The same five interviewed youth were questioned if they have ever heard staff use profanity when speaking with them or other youth and if so how often. All five stated never. Five staff were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All five staff replied they notify the supervisor and the supervisor will take the youth to make the call. All five staff also stated they always allow the youth to make the call and the second staff added to notify the PD. The same five interviewed staff were questioned if they have ever observed a co-worker tell a youth they could not call the Florida Abuse Hotline. All five staff stated no. The five staff were interviewed if they have ever observed a co-worker use profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth. All five staff stated no. The PD was interviewed on what is included in the program's staff code

of conduct and what actions are taken if physical abuse, threats, or profanity towards youth is used. The PD stated every employee is to conduct themselves in a manner to further the mission of providing high quality, professional, courteous, and efficient services to the youth they serve. Staff are to act as positive role models for the youth they work with. All violations of the code of conduct are corrected using progressive discipline.

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

The program had five incidents which were either physical, psychological, or emotional abuse in nature since the last annual compliance review. Three of the five incidents were substantiated. The program provided evidence documenting management took immediate action to address the incidents and corrective action was taken. The program director (PD) was interviewed on how the program ensures staff and youth are knowledgeable in contacting the Florida Abuse Hotline and/or Central Communications Center (CCC) and how does the program incorporate the results into management meetings. The PD replied staff are trained annually in in-service training. The youth are trained at intake and posters are located in the dorms informing the youth of their rights. The youth also have the information in their student handbooks. The PD was also questioned on how many staff had disciplinary actions due to allegations of abuse towards a youth since the last annual compliance review. The PD stated there were three staff who received disciplinary actions due to alleged abuse towards youth.

| 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 had a total of twenty-nine Central Communications Center (CCC) reports since the last annual compliance review. A sample of five incident reports were reviewed and all were reported within two hours of staff becoming aware of the incident. Four of the five reports were documented in the master control log book. The program had a total of ten CCC reports the previous six months. The program director (PD) was interviewed on the reason for the increase and stated many of the CCC reports involved certain youth who have been transferred, arrested, and/or are now in jail Additionally, staff are to call the CCC when in doubt regarding if the incident is reportable or not. The PD is working with staff to maintain a trauma-informed environment. The program is screening youth upon admission to eliminate conflicts with other youth as a preventive method. The PD also holds a monthly safety meeting. The PD was able to explain the program's incident reporting process and stated all youth have unimpeded access to call the Florida Abuse Hotline or CCC if the youth is eighteen years of age or older. The shift supervisor will assist the youth in completing the call and document the call in the master control logbook. If there is an allegation of abuse by a staff member, the staff member is removed from contact with youth until the completion of an investigation. Following the Florida Abuse Hotline call, the CCC is notified of the call and notified of the actions by the program to keep the youth safe.

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

The program had a total of six Protective Action Response (PAR) incidents since the last annual compliance review. A sample of five incidents were reviewed and all five reports were completed by the end of the day by all staff involved. All five reports were reviewed by a PAR certified instructor/supervisory staff, a Post-PAR interview was conducted with the youth by the administrator within thirty minutes, and a review of the PAR report by the administrator within seventy-two hours of the incident excluding weekends and holidays. A copy of all five PAR reports were placed in a centralized binder within forty-eight hours of being signed by the administrator. The program director (PD) provided documentation of the monthly summaries of all PAR incidents submitted to the Department's regional office by the fifteenth of each month. The program had a total of two PAR incidents the previous six months. The PD was able to explain the reason of the increase by stating many of the PAR incidents involved certain youth who have been transferred, arrested, and are now in jail. The program's PAR rate during the annual compliance review period was 1.28, which is below the Residential statewide rate of 2.35. The program is currently participating in the Right Interaction Pilot Project. Documentation in the Department's Learning Management System (SkillPro) was not available at the time of the annual compliance review neither were the proper forms. The PD was able to explain the program's process for monitoring PAR incidents and use of force by reviewing each use of force through video review as well as interviews with both the youth and staff. The PD stated the program also explore ways in which a PAR could have been avoided in those situations.

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

A review of five staff records was conducted. One staff completed one hundred and sixty hours of training, while the second staff completed one hundred and eight-six hours. One staff completed one hundred and five hours and another staff only completed ninety-eight hours of training. The two staff failed to complete the mandatory one hundred and twenty hours of pre-service training within one hundred and eighty days of hire. One staff completed one hundred and ten hours in which the staff one hundred and eighty days of hire is on February 11, 2020. One of the five staff completed cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid prior to having any contact with youth. All five staff completed Protective Action Response (PAR), professional and ethics, standards of conduct, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with the youth. Four staff completed the full six hours of suicide prevention/intervention. The remaining staff had five hours and forty-five minutes. None of the five staff completed emergency procedures training. According to the contractual agreement, none of the five staff received training in restorative justice, post-traumatic stress disorder (PTSD), and lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) training with a post-test. Majority of the training was not documented in the Department's Learning Management System (SkillPro). All instructors were qualified to deliver the training provided. A list of the program's pre-service training was submitted on January 22, 2020 to the Department's Office of Staff Development and Training

which included the course names, descriptions, objectives, and training hours for instructor-led training based on the above topics. During the time of the annual compliance review, the program has not received the pre-service training document from the Office of Staff Development and Training. The program is currently participating in the Right Interaction Pilot Project. Documentation in the Department's Learning Management System (SkillPro) and the proper forms were not available at the time of the annual compliance review.

| 1.08 In-Service Training | Failed 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.*<br><br>*Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.* | |

A review of five staff records was conducted. All five staff exceeded the required minimum annual twenty-four training hours. None of the five completed cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), first aid, and suicide prevention/intervention. All five staff completed Protective Action Response (PAR) and four staff completed professional and ethics including standards of conduct. According to the contractual agreement, none of the five staff received training in restorative justice, post-traumatic stress disorder (PTSD), and lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI) training with a post-test. Two staff holds a supervisory position in which one supervisory staff received over eight hours of annual training in management, leadership, personal accountability, employee relations, communication skills, and fiscal training. The second staff only received two of the eight hours in communication skills.

Two licensed nursing staff records were reviewed for certifications in CPR with AED and both had current certifications. Majority of the training was not documented in the Department's Learning Management System (SkillPro). All instructors were qualified to deliver the training provided. A list of the program's in-service training was submitted on January 22, 2020 to the Department's Office of Staff Development and Training which included the course names, descriptions, objectives, and training hours for instructor-led training based on the above topics. During the time of the annual compliance review, the program has not received the pre-service training document from the Office of Staff Development and Training. The program is currently participating in the Right Interaction Pilot Project. Documentation in the Department's Learning Management System (SkillPro) and the proper forms were not available at the time of the annual compliance review. The program provided a copy of their annual in-service training calendar which is updated as changes occur. The director of student services was able to identify which staff are considered direct care staff and are counted for in the staff to youth ratio by stating coach counselors, lead coach counselors, and shift supervisors if they are relieving a coach counselor.

| 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.*<br><br>*Completed grievances shall be maintained by the program for a minimum of twelve months.* | |

The program has written policy and procedures in place addressing the grievance process and training requirements. Four of the five pre-service staff and two of the five in-service staff reviewed completed grievance training. The program's grievance process includes the informal phase where the youth must attempt to rectify the situation by informally discussing the matter with the staff member. The staff member will meet with the youth within twenty-four hours of the youth's one on one request. The formal phase is where the grievance is written and placed in the cottage grievance box. Once received, a response must be completed by the appropriate department within seventy-two hours, excluding holidays and weekends. The appeal phase is where the designated administrator has seventy-two hours to provide the youth with a written response to the appeal, excluding holidays and weekend. The program maintains copies of grievances for the past twelve months. The program had a total of forty grievance in the past twelve months. A total of five grievances were reviewed and each were resolved in the formal phase. Three of the five grievance were resolved within the 24-hour time frame. The remaining two were resolved in a 48-hour time frame.

Five youth were interviewed and able to explain the program's grievance process. Three youth stated they have not needed to fill a grievance form but all five understood the process of filling out a form and placing it in the box for staff to respond. The five interviewed youth were also stated there were able to request assistance in completing a grievance form. Five staff were interviewed and able to explain the program's grievance process. All five staff understood the process of the youth filling out a grievance form and placing it in the box for staff to respond; however, only three staff were aware there were three phases. One staff was aware each phase had an associated time frame. The program director (PD) was able to explain the grievance process by stating in the first phase, the program attempts to resolve the issue at the lowest level by attempting to resolve the issue on the dorm with the staff involved. In the second phase, if the youth is not satisfied, the youth completes a grievance form and places it in the box. The grievance manager attempts to resolve the issue or assigns it to the appropriate manager for resolution. During the third phase, if the youth is not satisfied with the decision, the youth may file an appeal to administration who must provide a written response to the appeal within seventy-two hours excluding weekends and holidays. The completed grievances are placed in the grievance binder.

| 1.10 Interventions and Facilitator Training | Limited 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.* | |

Four staff records were reviewed for interventions and facilitator training. All four staff had the required level of education and work experience according to the contract, necessary to deliver

delinquency intervention services. According to the program's contract, Delinquency Intervention provided to youth include Impact of Crime (IOC), Gender Specific groups, Boys Council, Aggressive Replacement Training (ART), Seeking Safety, and Thinking for Change (T4C). A review of the program's activity schedule confirmed the program is providing structured, planned programming, or activities at least 60% of the youth's awake hours. A review of the youth sign-in sheets indicated all groups are being delivered as scheduled, except for IOC and T4C. IOC started on October 14, 2019. There were three staff trained in the program during the gap but no groups were started. During an interview with the director of student services, there was no reason as to why IOC groups were not started. The program did not provide the youth with IOC from August 2019 to October 14, 2019. T4C groups started on February 25, 2019 and ended on October 1, 2019. However, there was a two to three week absence of groups between February 2019 and July 2019 and an absence between May 21, 2019 to July 25, 2019. The group continued on July 25, 2019 and completed on October 1, 2019. The previous facilitator resigned in June 2019, but the program has other trained staff available to teach the group during these absences. A review of staff training records indicated the appropriate training was received.

A review of five youth records was conducted. Two of the five youth were involved in an evidence-based, promising practice, a practice with demonstrated effectiveness, and/or any other intervention approved by the Department. The remaining three youth were not involved in an intervention group at the time of the annual compliance review. Two of the five youth were involved in a delinquency intervention which addressed a priority need identified on the Residential Assessment for Youth (RAY). The program director (PD) was able to explain how staff member's education and work experience were considered when determining which staff would deliver life skills training or groups. The PD stated there are minimum requirements and training to give various groups. Staff need to meet those requirements prior to completing groups. Therapy groups requires a master's-level degree and certification training in the specific area such as ART, mental health, substance abuse, and Seeking Safety. The PD was also able to explain how youth are matched to staff/counselors/case managers and intervention groups by stating the program has therapeutic managers who are assigned to youth who receive mental health and/or substance abuse treatment. The PD also stated each therapeutic manager is trained in the various curriculums. The PD stated the program utilizes IOC and T4C as the delinquency intervention models to address the priority needs of the youth.

| **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 Thinking for Change (T4C) and Aggression Replacement Training (ART) for life and social skills intervention services. This curriculum addresses communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking, including problem-solving and decision-making. According to the program's contract, Substance Abuse Overlay Services (SAOS), Mental Health Overlay Services (MHOS), Delinquency Intervention, Impact of Crime (IOC), Gender Specific, Boys Council, Aggressive Replacement Training (ART), Seeking Safety (SA), Cognitive Behavioral Therapy (CBT), and Thinking for Change (T4C) are the services to be provided to the youth. CBT is the only service provided by the program considered to be evidence-based. A review of youth sign-in sheets indicated the T4C group is not being held consistently, whereas ART is being conducted on a consistent basis. Five youth were interviewed if they participated in any groups and all five youth

stated yes. The five interviewed youth were able to identify what groups they have participated in while at the program and able to describe the new skills or behaviors they were taught while in groups. All five interviewed youth indicated they practice these skills through role play.

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

The program utilizes community service opportunities and the Impact of Crime (IOC) curriculum as of October 14, 2019, to increase the youth's awareness and empathy for crime victims and survivors. This activity and/or curriculum is provided to assist youth to accept responsibility for harm they may have caused by their past criminal actions, teach them about the impact of crime on victims, their families and their communities, expose youth to victims' perspectives through victim speakers, and provide opportunities for youth to plan and participate in reparation activated intended to restore victims and communities. A review of four staff training records indicated the appropriate training was received. A review of five youth sign-in sheets indicated four youth are receiving restorative justice through community service opportunities or IOC. The program director (PD) was able to explain what types of restorative justice groups are provided to the youth. The PD stated community service opportunities and IOC. The PD also indicated youth are exposed to victim's perspective through victim speakers and as part of the curriculum of IOC, the youth are exposed to the impact of their action on others. The PD added the program has guest speakers who come and share with the youth. The PD was able to explain youth are permitted to participate in activities intended to restore victims and communities by receiving credit for the time they spend cleaning. These hours are sent back to the youth's community to count against their service hours. Home Builders Institute (HBI) builds projects for local churches to give to those in need.

| 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.* | |

According to the contract, the program uses Boys Council as the gender-specific treatment service. The program director (PD) was trained in Boys Council in November 2019 and started the class on January 30, 2020. The class meets every Friday. The program also utilizes the Rite of Passage (ROP) health education as a gender-specific service.
A review of youth sign-in sheets indicated youth are receiving the ROP health education and now Boys Council. The PD was indicated the program utilizes the Boys Council, health education, and the ROP concept manuals to address the needs of a targeted gender group.

| 1.14 Internal Alerts System and Alerts (JJIS) (Critical) | Satisfactory Compliance |
|---|---|
| *The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status.*<br><br>*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 written policy and procedures in place to determine how alerts are identified, documented, updated, and communicated to staff. The program maintains an internal alert system which consists of security, dietary and/or food allergies, and medical alerts. All dietary and/or food allergies are posted in the kitchen with the youth's picture. All security alerts are written on the white board in master control. Medical alerts are distributed by the nurse every Wednesday during the program's management meetings. If there is a change in medication or after an intake, the nurse will notify the supervisor who will update the medical alert roster. All internal alerts are updated after each intake. A review of the internal alerts compared to the alerts in the Department's Juvenile Justice Information System (JJIS) was conducted and there were no discrepancies found. Five interviewed staff were able to explain how they are informed of the youth's alerts including mental health, medical, and security. All five staff replied the alert board and one staff added staff debriefings. The program director (PD) was able to explain the formalized procedure the program has have in place with the healthcare staff to review the important medical issues pertaining to the youth at the program and how often they meet. There is medical staff training for all staff once a month and in pass on meetings. The PD also added the medical staff conducts training and medical drills. The PD stated the program has a main board in the master control room which has all the youth and alerts updated in real time. Food allergy alerts are in the dining hall along with the youth's picture.

| 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:*<br>• *An individual healthcare record*<br>• *An individual management record.* | |

The program maintains an individual healthcare record, a mental health/substance abuse record, and an individual management record. The file tab on the individual management and mental health/substance abuse record contains the youth's name, Department of Juvenile Justice Identification Number, date of birth, county of residence, and committing offense. The individual management records are divided into sections by legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. All records were marked "confidential" and are stored in a locked room.

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

The program currently has a formal process in place to promote constructive input by youth. The youth have a community group such as town hall and a youth advisory board which meets monthly. The youth and parent/guardians complete surveys when the youth completes the program. The program provides a suggestion box in the dining hall for youth who are still in the program. Five interviewed youth were stated the program has a student and RAM council which allows youth to provide input about the program. The program director (PD) was able to explain how youth can make a recommendation for resolutions to improve conditions and enhance the quality of life for staff and youth in the program. Youth have one on one request which they can speak to anyone in administration. The program have monthly town hall meetings where youth provide feedback on program elements. Youth can provide input on meals, snacks, and the behavioral management system (BMS) during the monthly student athlete advisory board meetings.

| 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 an advisory board which meets quarterly as verified by the sign-in-sheets, agendas, and an interview with a board member. A copy of the list of names and their titles of the of the advisory board members was provided and consisted of a law enforcement representative, judiciary community, other community partners, business community, school board or district, and faith community. The program director (PD) indicating making several attempts to recruit victims and parent/guardians of previously children involved in the juvenile justice system, but none have committed. A telephone interview was conducted with one of the members of the advisory board. The member confirmed the meetings are held quarterly meetings and have been a member of the advisory board for the last three programs at this site. The member indicated they believe in the program, it Is one of the best program seen, and is doing good for the kids. The member attends almost all board meetings, graduations, open houses, and has toured the facility. The PD was able to describe the youth community advisory board including the meeting times, membership, and involvement with the program. The advisory board have members of the community including two volunteers who meets with the program on a quarterly basis and meals are provided with this meeting. The PD indicated the community advisory board (CAB) is a resource and an advocate for the program in Walton County. The volunteers on the board make recommendations for improving the volunteer services at the program. The CAB also keeps the program up to date with all the current events in Walton County.

| 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 in place addressing effective communication and staff incentives. The program completes youth and parent/guardian surveys when the youth is released from the program. The program maintains a record of the surveys. The Walton Academy for Growth and Change (WAGC) opened in June 2017. The program director (PD)

reviewed previous Comprehensive Accountability Reports (CARs) for the previous program, but the reports does not apply to the population until this year. The program has not received a copy of the 2019 report, a copy of the 2018 report was provided which would not apply to the program. The PD utilizes the quality improvement reports and supplementals in program planning as well as the Commission on Accreditation of Rehabilitation Facilities (CARF) report. The program has daily shift debriefings meetings which are held to discuss any pertinent information needed to pass from the previous shift. The PD also conducts a weekly management meeting and meets with all staff every Wednesday and Thursday morning for third shift, during pass on meetings. The program offers staff an opportunity for a retention bonus and has an Employee Referral/Sign-On Bonus Program (ERBP). The program also has staff appreciation luncheons with raffle prizes for the staff.

The program has a clinical director, registered nurse, and two coach counselor vacant positions. The PD stated the program reviews the monthly Sight Operations Summary (SOS) report distributed by Rite of Passage in the weekly management meetings. The PD reviews the statistical monthly reports to verify there is nothing alarming about the staff member.
Five staff were interviewed on how often staff meetings are held. All five stated weekly and one staff added daily during shift debriefing and big meetings every Wednesday. The five staff were able to provide the topics discussed during the meetings are valuable and informative discussions on how things are going in the program, issues with the youth, and training. All five staff stated they are briefed on annual reports and/or youth and parent/guardian survey results. Four staff indicated the effectiveness of the communication among staff at the program is fair and one stated good. The five interviewed staff stated they have the ability to provide input and feedback into the program operations at any time. One staff added their feedback is not always taken into consideration. The PD indicated the program utilizes the data as feedback and develop plans to correct and improve the program. The program also utilizes the Trauma Responsive and Caring Environment (TRACE) for trauma informed practices. The CAR report is data on the outcomes of programming and provides feedback on how the program is doing. The PD has not seen the current data since the opening of the program in 2017.. The data is scheduled to be available in the 2019 report, which was not available at the time of the annual compliance review.

| **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 ensuring a system for evaluating staff. The policy states staff will receive an initial ninety-day evaluation followed by annual evaluations which documentation was provided for both. The program started implementing the initial ninety-day evaluations in November 2019. The program provided samples of job descriptions along with the performance evaluations which matched the position. All key positions are being maintained in the program; however, during the annual compliance review, the recreational therapist's degree does not meet the contractual requirement. Five interviewed staff indicated they receive a formal evaluation yearly of their performance based on their performance summary. The program director (PD) stated staff are evaluated annually and can receive up to a six percent pay increase based on their performance.

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

The recreational therapist (RT) was hired on August 15, 2019 with a Bachelor of Science and Master of Science in Human Services. This degree does not meet the contractual requirement of a bachelor's-level degree in Therapeutic Recreation or equivalent with one to three years' experience. The program has a policy and procedures in place for providing youth with a variety of recreation and leisure activities. The program's activity schedule provides the allotted times for the youth to participate in health and wellness, dorm activities, game room, movie night, and recreation time. All youth are encouraged to explore interests and engage in constructive use of leisure time. The RT was able to describe the recreational activities as agility training, the super band, gravity trainer, have the youth run eight laps, dash run, long jump, tug of war, basketball, flag football, field day, board games cards, and checkers. A random review of the logbook confirmed the youth are receiving the activities according to the program's activity schedule. The program uses the heat index guidelines as a precautionary measure to extreme weather before taking youth outdoors. The index guidelines are posted in administration. The RT added the nurses keeps track of the weather and advise if conditions are too extreme for outdoor activities. A review of five youth records revealed all five treatment team plans incorporated the youth's therapeutic activity. The program currently has a formal process in place to promote constructive input by youth. The program has a town hall and youth advisory board community group, which meets monthly. The youth also completes a survey when they completes the program, as well as having a suggestion box in the dining hall for the youth who are still in the program.

Five youth were interviewed on the physical and leisure activities provided for at least one hour and to describe what activities are provided. Five youth replied basketball, four stated football, one youth replied sometimes the youth enjoy the fresh air for a couple of hours, and one youth stated agility workouts. Each of the five interviewed youth indicated they are provided with varying degrees of mental and physical exertion through the day.
Five staff were interviewed on the types of indoor and outdoor activities are provided to the youth and how long are the activities. Five staff stated basketball, four stated football, three stated laps for about an hour or more outside, and one staff stated workout, pull ups, and walk around. .

# 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.* | |

Five youth case management records were reviewed for initial parent/guardian contact by telephone within twenty-four hours of admission. All case management records had documentation the program notified the parent/guardian by telephone within twenty-four hours of admission. Four records had documentation the program notified the parent/guardian in writing within forty-eight hours of admission. Four records had documentation of the court, juvenile probation officer, and post-residential services counselor being notified within five working days of the youth's admission. One record had documentation of the court, juvenile probation officer, and post-residential services counselor being notified two days late.

| 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.* | |

Five youth case management records were reviewed for orientation requirements. All five youth case management records reviewed had documentation the program provided each youth with an orientation to begin on the day of, or prior to admission. The program's orientation included services available, daily schedule was posted, the expectations and responsibilities of the youth, written behavioral management system conspicuously was posted and provided in the residential handbook to allow easy access for youth including rules governing conduct and positive and negative consequences for behavior, and availability of and access to medical and mental health services. The program had the telephone numbers posted on each of the dorms for the access to the Florida Abuse Hotline and Department's Central Communications Center. There were signed sheets in all five records the youth was notified of the numbers available. All five records had documentation the youth were notified of the program's zero-tolerance policy regarding sexual misconduct, including how to report incidents or suspicions of sexual misconduct. Five youth records provided documentation the youth were notified special accommodations are available to ensure all written information about sexual misconduct policies, including how to report sexual misconduct, is conveyed verbally to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled. Five out of five records had documentation the youth were notified of their right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures. All five youth had documentation of being notified of items considered contraband including illegal contraband, possession of which may result in the youth being prosecuted. All five youth records had documentation of the youth being notified of the performance planning process involving the development of goals for each youth to achieve. All five youth records had documentation of the youth being notified of the dress code and hygiene practices, procedures on visitation, mail, and use of the telephone, expectations for release from the program, including the youth's successful completion of individual performance plan goals, recommendation to the court for release based on the

youth's performance in the program, and the court's decision to release. All five youth records had documentation the youth were notified of community access, grievance procedures, emergency procedures, including procedures for fire drills and building evacuations, facility tour, and general layout of the facility, focusing upon those areas accessible, and not accessible to youth, assignment to a living unit and room, treatment team, and medical topics as outlined in Chapter 63M-2. A youth admission was observed on Thursday, February 6, 2020. The orientation included all elements as outlined in the program's policy.  youth were interviewed indicated orientation began within twenty-four hours of admission.

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

The program 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. Three youth records had documentation of written consent being obtained if youth were eighteen years of age or older before providing or discussing with the parent/guardian, Agency for Persons with Disabilities, and Department of Children and Families, if applicable information related to physical or mental health screening, assessment, or treatment.

| 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.*<br><br>*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 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 with the potential to be used as weapons or means of escape, or participation in any off-campus activity. All youth admitted to residential commitment programs shall be screened for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) prior to room assignment. Room assignments by staff shall ensure a youth's potential for victimization or predatory risk has been reviewed. The screening shall be completed in the Department's Juvenile Justice Information System (JJIS). A review of  five youth case management records included physical characteristics, age, maturity level, identified special needs, including medical, mental health development or intellectual and physical disabilities, history of violence, gang affiliation, criminal behavior, and sexual

aggression or vulnerability to victimization. All five records had documentation of a VSAB being completed prior to a room assignment. Three of the five VSABs were not completed in JJIS. Five youth records included suicide risk, medical risk, escape risk, and security risk. A review of the JJIS alert list indicated all five reviewed youth had the appropriate documentation in JJIS. All five youth were classified for purposes of assigning to a living area, sleeping room, and youth group or staff advisor. Three of the five records had documentation the youth medical, mental health, substance abuse, security risk factors, and/or special needs identified during or after the classification process are immediately entered into the program's internal alert system and JJIS. The remaining two youth did not have any factors which required special needs. All five youth had classification reassessments prior to considering an increase in the youth's privileges or freedom of movement and participation in work projects or other activities involving tools or instruments with potential to be used as weapons or means of escape. The youth are not able to move into off-campus activities until moved into transition. The program director's interview indicated the classification factors included are mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning a youth to a living unit and/or sleeping room. The facility's operating procedures outline the classification process and include a classification system which promotes safety and security, as well as effective delivery of treatment services based on determination of each youth's individual needs and risk factors, which addresses at a minimum, items outlined in Administrative Rule. The policy should also address when reassessment is warranted based upon changes in the youth's supervision status, new/updated alerts, relevant information available to the treatment team, and/or behavioral concerns. A review of documentation revealed the program has continually updated the internal alert system and is easily accessible to program staff and keeps them alerted about who are security or safety risks, including escape risks, suicide or other mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

| **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 shall gather information on gangs and share this information with law enforcement. The program had one youth identified as a gang associate during the annual compliance review period. The program maintains a binder in the program director's (PD) office with gang documentation. The PD is the gang liaison and certification were provided for review. The gang binder included documentation of local law enforcement being notified of suspected gang activity. The youth's gang involvement was previously provided to local law enforcement prior to coming to the program. The youth's residential commitment placement is not in the youth's home county and there was documentation in the gang binder the youth's home county had been notified. There was documentation in the record the youth's gang status was shared with the educational provider providing services at the residential program and the youth's juvenile probation officer.

| 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.* | |

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 at high-risk of gang involvement. The program had one youth during the annual compliance review period identified as a gang member or affiliated gang member. There was documentation the youth is participating in gang prevention and intervention strategies. The youth's performance plan includes relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program's gang prevention awareness and intervention strategies implemented at the program are Aggression Replacement Training and Impact of Crime. The program's policy and procedures included the youth have the opportunity if they desire, to develop a plan to dis-affiliate with a criminal street gang.

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

The program shall ensure an initial Residential Assessment for Youth (RAY) assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in the Department's Juvenile Justice Information System (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 case record. Four of the five records reviewed had a RAY assessment completed within thirty days of admission. One RAY assessment was completed twenty-four days late. All five initial assessments were maintained in JJIS. Two of the five records did not require a RAY reassessment at the time of the annual compliance review. Two of the three remaining records had RAY reassessments completed within ninety-days after completion of the initial RAY assessment. One youth's RAY was completed four days late. Two of the five youth had RAY reassessments completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The remaining three youth did not require an update based upon the intervention and treatment team. All reassessment documentation was maintained in the youth case management 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.* | |

The program shall ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the YNAS. Four of five youth had a YNAS completed within thirty days of admission. One YNAS was completed twenty-four days late. All YNAS documentation was documented in the Department's Juvenile Justice Information System.

| 2.09 Performance Plan Development, Goals and Transmittal (Critical) | Satisfactory Compliance |
|---|---|
| *The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission.*<br><br>*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.*<br><br>*Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.* | |

The 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. The performance plan shall specify the 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 the completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable. Three of the five records reviewed had an individualized performance plan developed within thirty days of the youth admission. One youth's performance plan was one day late. A second youth's performance plan was twenty-one days late. All five initial performance plans were developed after the initial assessment.
All five individualized performance plans were developed with the intervention and treatment team. The intervention and treatment team included the treatment leader, youth, administrative representative, living unit representative, treatment staff, and educational staff. One of the five youth reviewed was currently involved with DCF. The DCF caseworker was not involved in the development of the case plan. There was no documentation of the DCF caseworker being notified of the treatment team meeting or performance plan development. All five performance plans were signed by the youth, intervention and treatment team leader, and all parties who have significant responsibility in goal completion. Four of five youth had the signature page sent to the parent/guardian. Three of the five youth did not get a returned signature sheet. One youth did have the parent/guardian signature on the performance plan. The one applicable youth did not have the DCF caseworker's signature and there was no documentation of the signature page or performance plan being sent to the DCF caseworker.

Three of the five performance plans included the individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. Three performance plans included the top three criminogenic needs addressed. Two performance plans did not include the top three criminogenic needs and did not have documentation the reason as to why. Four of the five performance plans included specific delinquency interventions, with measurable outcomes to decrease criminogenic risk factors and promote strength, skills, and supports to reduce the likelihood of the youth reoffending. All five performance plans reviewed did not have court ordered sanctions to complete while in the program. Three of the five performance plans reviewed had transition activities targeted for the last sixty days of the youth's anticipated stay. All five performance plans had youth responsibilities to accomplish goals, program staff responsibilities to enable youth to complete goals, and target dates for goal completion. Three of the five performance plans were sent to the committing court within ten working days of the performance plan being completed. Four performance plans were sent to the juvenile probation officer within ten working days of the performance plan being completed. Four records had documentation the parent/guardian was sent the performance plan signature page within ten working days of the completion of the plan. The one youth involved with DCF did have documentation the DCF caseworker was sent a copy of the performance plan within ten working days of the completion of the plan. Five youth interview results indicated all interviewed youth participated in the development of their performance plan and were able to state their performance plan goals. All five youth also indicated they were provided a copy of their performance plans.

| **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.* | |

Performance reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team. Three of the five records reviewed did not require an updated performance plan due to the youth being at the program less than thirty days. One closed record was reviewed along with the five open records. Two of the three records reviewed had performance plans updated because of the Residential Assessment for Youth (RAY) results. One youth had a change in the top three criminogenic needs and the performance plan was not updated to reflect the change. One of the three performance plans reviewed was updated due to newly acquired information. Four of the five reviewed performance plan revisions were updated due to the youths' demonstrated progress toward completing a goal. Three performance plans reviewed had updates due to the youth's lack of progress toward completing a goal. One of five performance plan revisions reviewed was updated to facilitate transition activities during the last sixty days of the youth's stay.

| 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.*<br><br>*Additionally, the intervention and treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program.*<br><br>*The program shall distribute the Performance Summary, as required, within ten working days of its signing.* | |

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. Two of the records reviewed did not require a performance summary be completed due to their time at the program. Two of the three applicable records had a performance summary completed every ninety calendar days following the signing of the performance plan. One performance summary was completed three days late. Two closed records were reviewed along with one open record for review of the release summary. All three records had the performance summary prepared prior to the youth's release from the program. Each of the three performance summaries reviewed had the youths' status on each performance plan goal, the overall treatment progress, youths' academic status and credits earned in the program, youth's behavior, level of motivation/readiness to change, interaction with peers and staff, overall behavior adjustment to the program, and significant positive and negative events. One of the three youth reviewed had the justification for release due to the pre-release notification being sent and the youth was being released during the week of the annual compliance review. Two youth had comments added to their performance summaries. Three was provided a copy of their performance summary. Each of the three original performance summaries were recorded in the case management record. All three performance summaries reviewed had signatures of the treatment team leader, staff member preparing the performance summary, program director or designee, and youth. All three performance summaries were sent to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian within ten working days of completion. The youth involved with Department of Children and Families (DCF) had their performance summary transmitted to the DCF caseworker within ten working days of completion. Two closed records and one open record were reviewed for release summaries. Each of the three records reviewed had the original release summary along with justification for release, sent with the pre-release notification (PRN) to the JPO. Two of the three records reviewed had the release summary along with the PRN at least forty-five days prior to the youth's planned release. One of the plans was sent three days late. Each of the three records reviewed had signed copies of the release summary retained in the youth's case management record. All three youth case management records had documentation the parent/guardian was noticed of the youth's planned release once the PRN was approved. Two of the three records reviewed had an exit Residential Assessment for Youth (RAY) completed at the time of release. Each of the three records reviewed had timely notice to the youth's JPO. All victim notifications were waived in the three closed records reviewed. All five youth interviews indicated they received a copy of the performance summary sent to the court.

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

The program encourages the involvement of the youth's parent/guardian in the case management process. Five youth case management records were reviewed for parental involvement in case management services. Youth records contained evidence of parent/guardian participation in the youths' assessment process, participation in the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. Five youth case management records contained evidence of the parent/guardian being noticed of case management activities. The parent/guardians are invited to formal treatment teams and activities through letters from the case manager. A review of all five case records contained documentation of notification letters being sent to the parent/guardian. The program director interview included information to determine how the program encourages parental involvement through treatment team invitations, family visitations, and invitations to family days. An interview with five youth indicated the parent/guardians are encouraged to participate in case management services.

| 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 youth's assigned therapeutic manager serves as the treatment team leader. Five youth case management records were reviewed for the representatives included in the treatment teams. Treatment team members include the youth's therapeutic manager, youth, administrative representative, living unit representative, treatment staff, educational staff, Department of Children and Families (DCF) caseworker, juvenile probation officer (JPO), parent/guardian, and transition services manager. The program director is the program's gang prevention specialist and attended all reviewed treatment teams. A review of five youth records contained evidence the youth's JPO was invited through written notification of participation in treatment team meetings. Two of the youth records did not have evidence of the JPOs being invited. Each of the five reviewed youth records contained evidence the youth's parent/guardian were invited to participate in formal treatment team meetings. Two youth records contained documentation other pertinent parties were invited to participate in formal treatment team meetings. Four youth records contained documentation youth, program representatives, program administration, living unit, and others directly responsibility for providing or overseeing provision of intervention, and treatment services to the youth were encouraged to attend formal treatment team meetings

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

Five youth case management records were reviewed for incorporation of other plans into the performance plan. One youth case management record contained documentation of an education plan. The second youth record indicated the youth had already obtained a General Equivalency Degree (GED) prior to placement to the program. Three youth case management records contained documentation of a treatment plan being incorporated into the youth's

performance plan. The youth involved with the Department of Children and Families (DCF) did not have the DCF case plan incorporated into the youth's performance plan.

| 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 intervention and treatment team meets bi-weekly formally and informally, to review each youth's performance to include Residential Assessment for Youth (RAY) reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. Five youth case management records indicated formal reviews were held at least every thirty days. The formal performance reviews documented in the youth case management records included the youth's name, date of review, any comments from treatment team members and others, brief synopsis of the youth's progress, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and RAY reassessment results. Five youth case management records indicated the youth were able to provide an opportunity to demonstrate skills acquired in the program. There were no documentation of informal reviews being held bi-weekly in four youth case management records. One youth was not scheduled for an informal review due to the time in the program. Four youth case management records indicated the informal treatment team reviews included the youth's name, date of review, meeting attendees, comments from treatment team members, brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment progress, and RAY reassessment results. Four youth case management records indicated the youth were able to provide an opportunity to demonstrate skills acquired in the program. Treatment teams were unable to be observed during the week of the annual compliance review due to not being scheduled until the following week. The four treatment team packets and the Department's Juvenile Justice Information System (JJIS) is updated at least every ninety days and at the sixty-day transition conference. Five interviewed youth reported they were provided the opportunity during treatment team meetings to demonstrate skills they learned in the program. The five interviewed reported staff reviews youth performance to include progress on performance plan goals, positive behavior, and treatment progress.

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

The program offers Type 3 educational programming and certifications. The career education programming includes communication, interpersonal, and decision-making skills. Three closed youth case management records were reviewed and contained documentation of a sample employment application, a résumé summarizing education, work experience, and/or career training. Two youth records included documentation indicating the location and business hours of a local Career Source Center, appropriate documents essential to obtaining employment, the youth's parent/guardian, and juvenile probation officer (JPO) are aware of the vocational plan

for the youth. The program's vocational and career education program is appropriate for the educational abilities and goals of the youth in the program. The career education programming is appropriate for the length of stay and custody characteristics of the youth in the program. The program provides Career and Professional Education (CAPE) courses which lead to pre-apprentice certifications and industry certification. The program provides Home Builders Institute (HBI) and an internet business certification. The program director's interview indicated the program offers HBI and culinary career education services to the youth in the program..
An interview with the lead educator indicated My Career Shines is the career education services and assessments offered to youth in the program.

| 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 in such a way ensuring the integrity of the required instructional time. The program provided the program schedule and the lead teacher provided the daily school schedule and the school year calendar for the program. A review of the school schedule confirmed the youth at the program participate in educational and career-related programs for 250 days of instruction distributed over twelve months with a minimum of twenty-five hours of instruction weekly. According to the education schedule, ten days of the 250 are utilized for teacher planning and/or training. The youth receive credits for the educational and training experience at the program. The activity schedule and logbook documented minimal interference of educational instruction. The program logbook noted movement to and from school throughout the day. The youth interviews documented there was minimal interference of education instruction. The lead teacher interview indicated the youth receive 250 days of instruction with ten days of teacher planning or training.

| 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.* | |

Five youth case management records were reviewed for documentation an education transition plan was developed beginning at admission. Each of the five youth case management records had an individual educational transition plan developed which was based on the youths' post release goals. All five youth case management records participants included the youth, parent/guardian, instructional personnel in the juvenile justice education program, department personnel for youth in residential programs, personnel from the post-release school district, certified school counselor, and registrar or designee of the program's district who has access to the district's management information system. All five youth case management records had documentation the education transition plan was developed with the youth and program, education, and aftercare staff with specific plans for continuation of education and/or employment. An interview with the lead teacher indicated the educational transition plan is reviewed at the initial treatment team and is to be included in the initial performance plan. Five education transition plans included services and intervention based on the student's assessed educational needs and post-release education plans, recommended educational placement for post release based on individual needs and performance and specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services. All five youth reviewed had education transition plans which included

provisions for continuation of education and/or employment. Three of the five reviewed case management records included a sample completed employment application, a résumé summarizing education, work experience, career training, a valid Florida identification card, and documentation indicating the location and business hours of a local career source center. Two reviewed youth case management records included the appropriate documents essential to obtaining employment upon leaving the program. Three reviewed case management records included evidence the youth's therapeutic manager and parent/guardian are aware of the plan, documents, and post-release discharge plans.

| **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.*<br><br>*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.*<br><br>*Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.* | |

Three closed youth case management records were reviewed for transition conference requirements. All three closed youth case management records contained evidence of a transition conference date held sixty days prior to the targeted release date. All three records contained evidence the youth, treatment team leader, program director, and other team members attended the transition conference. All three youth case management records contained evidence the youths' juvenile probation officer, parent/guardian, education staff, and other pertinent parties were invited to the transition conference. All three included documentation the transition activities were reviewed on the youth's performance plan. None of the youth's performance plans needed to be revised at the time of the transition conference. The transition conference documentation also included the identity of additional transition activities if needed, target completion dates, persons responsible for completion, and dated signatures of the attendees' acknowledging accountability for goal completion. All three records had documentation a copy of the plan was sent with a request for return with signature to team members not in attendance who has a responsibility for completion of transition goals. All three records contained documentation a community re-entry team (CRT) meeting was conducted prior to the youth's release. Three youth case management records contained documentation the youth and therapeutic manager were invited to participate., and documentation therapeutic manager and youth attended the CRT 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 case management records were reviewed for exit portfolios. All three closed records contained evidence the exit portfolio was initiated at the transition conference. The following items were in all three records: youth's transition plan, calendar with dates/times/locations of upcoming community appointments, educational and/or vocational certificates earned in the program, all educational records and documents, school transcripts, résumé, a completed sample employment application were included in all three youth case management records. One closed case management record contained documentation of a social security card. It was stated during an interview with the director of student services, one of the youth's relative caregiver did not have the youth's social security card or birth certificate but a plan was put in place for the items to be obtained upon release. All three closed youth case management records included documentation the youth's exit portfolio was verified at the exit conference. The closed youth records included documentation the exit portfolio was completed and provided to the youth upon release. All three closed youth case management records included documentation the program staff forwarded the exit portfolio information to the juvenile probation officer.

| 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 youth case management records were reviewed for exit conference documentation. All three closed records included documentation the exit conference was conducted after the program notified the juvenile probation officer of the release date. All three records had documentation the exit conference was conducted at least fourteen days prior to release and contained the date, signatures, names of those who appeared by phone, and a summary pending transition goals. A review of the case record and the Department's Juvenile Justice Information System (JJIS) confirmed the date of admission and the date of termination correlated. Three closed youth case records contained documentation the transition activities were reviewed which were established at the transition conference and plans for the youth's release was finalized. All three records contained documentation the intervention and treatment team leader, parent/guardian, education representative, juvenile probation officer, youth, and other pertinent parties participated in the exit conference. All three exit conferences were held separate from the transition and community re-entry team 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.*<br>*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.*<br><br>*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's designated mental health clinician authority (DMHCA) is currently vacant since the end of December 2019. The program has a licensed clinical social worker who serves as the acting designated mental health clinician authority (DMHCA). The acting DMHCA's license was reviewed and found to be clear and active with an expiration date of March 31, 2021. An interview with the acting DMHCA revealed, the acting DMHCA is on-site forty hours each week, Monday through Friday to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. Review of the DMHCA and interview with the acting DMHCA revealed the role is to maintain daily group schedules, oversee precautionary observation to include implementation and training of program staff, review commitment packets of new admissions, create new intake paper work, and work as a liaison between parent/guardian, juvenile probation officer (JPO), and other outside agencies working with the youth.

| 3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical) | Non-Applicable |
|---|---|
| *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 does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator rates as non-applicable.

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

The program has four non-licensed mental health and substance abuse therapists working at the program. The acting designated mental health clinical authority (DMHCA) assures the non-licensed clinical staff working under their supervision were performing services they are qualified to provide based on education, training, and experience. Each of the non-licensed

clinical staff have a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. Each of the non-license mental health and substance abuse clinical staff were trained to conduct Assessments of Suicide Risk (ASR) and received twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and assessment of suicide risk or crisis assessments contacted on-site in the physical presence of a licensed mental health professional and in accordance with the current contract and 63N-1 FAC rule. This training was documented on the on-licensed mental health clinical staff person's training in ASR form (MHSA 022). Each of the four staff received at least one hour a week of on-site face-to-face direct supervision with the licensed clinical social worker within the last six months completed on a comparable form for Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direction Supervision Log.. The program is a service provider licensed under Chapter 397, F.S. and a copy of the licensure was provided.

| **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.* | |

A review of five youth mental health and substance abuse records revealed each youth was screened utilizing the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). The MAYSI-2 was administered on the day of each youth's admission in a confidential manner. Evidence in all five youth records were found to confirm youth information was reviewed such as commitment packets, reports, and records of existing mental health and substance abuse issues. Four of the five youth records indicated the MAYSI-2 screenings were completed by a trained staff utilizing the Department's Juvenile Justice Information System (JJIS). A review of one youth record during the annual compliance review included the MAYSI-2 questionnaire was completed but not entered in JJIS until a month later. The program director ensures an Assessment of Suicide Risk (ASR) is conducted and all youth admitted to the program receive an ASR within twenty-four hours of admission and a comprehensive evaluation. There were three applicable youth with suggested suicide potential at intake which also received an ASR as required. Other instruments used to assessment youth are the Adverse Childhood Experience (ACE), How I Think (HIT), Substance Abuse Screening Inventory (SASSI), BECK Depression Inventory-Two (BDI-2), and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). Not all assessments in the youth records reviewed were completed at intake but an interview with the acting DMHCA reported they are now completing all assessments on the same day as the youth's admission to the program. An interview with the program director also confirmed several assessments were utilized. Evidence in all five youth records revealed the program director is responsible for contacting the DMHCA or licensed mental health professional who conducts or supervises assessments of suicide risk and confer regarding cases viewed as urgent. The program developed written facility operating procedures (FOPs) for the implementation of a standardized admission/intake mental health and substance abuse process which were signed and dated by the program director and the DMHCA at the time. The FOPs included all required elements.

| 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.* | |

A review of the five youth mental health and substance abuse records found each of the youth were referred for a mental health/substance abuse assessment. Four of the five youth records had mental health and substance abuse assessments completed within thirty days of the youth's admission date. One record included a youth who received assessments of suicide risk twenty days after intake due to the self-report and observations of the youth. A referral for the assessment was made and the comprehensive mental health and substance abuse assessment was completed within thirty days of the referral. All of the assessments were completed by non-licensed clinical staff and subsequently reviewed and signed by a licensed mental health clinical staff within the required time frame of ten days. Each of the assessments were new and included the youth's identifying information, reason of evaluation, relevant background, behavioral observations, mental status examinations, discussion of findings, and recommendations. There was documentation of each youth providing consent for substance abuse services.

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

A review of five youth mental health and substance abuse records found each youth was assigned to a multidisciplinary treatment team upon arrival to the program. The treatment team comprised of the youth, program administration, residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. Three of the applicable youth determined in need of substance abuse treatment received individual and group counseling provided by clinical staff either licensed or under the supervision of a qualified professional, in accordance with the youth's initial or individualized substance abuse treatment plan. Each youth had a properly executed Authority to Evaluation and Treatment (AET) and a signed Substance Abuse Consent and Release form. Mental health treatment notes were documented on Counseling/Therapy Progress Notes form and individual psychotherapy or counseling were conducted by a mental health clinical staff professional for youth with mental health diagnosis. Observations and review of group sign-in sheets confirmed group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer for substance abuse treatment groups. All mental health and substance abuse staff are qualified and provide substance abuse groups. Five direct care staff were interviewed and reported they did not facilitate any mental health or substance abuse groups. All five interviewed youth reported they participate in group and specialized therapy and most youth were able to articulate the type of group therapy involved.

| 3.07 Treatment and Discharge Planning (Critical) | Limited 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.*<br><br>*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.* | |

Five youth records were reviewed for initial mental health treatment plans. All initial treatment plans were created using a comparable form to the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each of the plans were developed within seven days of the onset of treatment. Four of the five plans were signed by the mental health clinical staff and all treatment team members who participated in development of the plan. One youth record contained an initial treatment plan where the licensed clinical supervisor signed outside the ten-days of completion. One record was of a youth who entered the program with psychotropic medications, which made the youth applicable for psychiatric services and was included in the youth's initial treatment plan. Five youth records were reviewed for individual mental health treatment plans. All individual treatment plans were created using a comparable form to the Department's (MHSA 016) forms. Four of the five records contained an individualized treatment plan developed within thirty days of admission. One youth record included an individual treatment plan was approximately one hundred and thirty-six days later and the thirty-day requirement. Four of the five individualized treatment plans were signed by the mental health clinical staff completing the plan and all treatment team members who participated in the development of the plan. One individualized treatment plan was signed by the licensed clinical supervisor outside the ten-days of completion. Each youth participates in individual and group counseling, and psychiatric services when needed. Two youth records included psychiatric services for the youth which was not documented as a need, nor did the youth receive services. Four of the five youth selected were applicable for a treatment review. One of the four applicable records received the first treatment review in October 2019 but had not received the three reviews since. Three closed youth records were reviewed for discharge plans. Each youth had a discharge plan documented on Mental Health/Substance Abuse Treatment Discharge Summary form. There was documentation indicating the discharge plans were discussed with the youth, parent/guardian (when available), and juvenile probation officer (JPO) during the exit conference. An interview with the assistant program director and supervisor of the therapeutic managers, reported copies of the discharge plans were provided to the youth, parent/guardian, and JPO. None of the youth were applicable for being on suicide alert or suicide precautions upon discharge from the program.

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

The program provides Mental Health Overlay Services and Substance Abuse Treatment Overlay Services to youth as the specialized treatment service. The program provides

individual, group, and psychiatric therapy as part of the youth's treatment plan, seven days a week. Daily therapeutic activities are provided by a mental health clinical staff professional. Caseloads do not exceed sixteen youth according to the therapeutic counselor. Substance abuse clinical staff are on-site seven days a week. The program contracts a psychiatrist who is on-site bi-weekly to provide psychiatric evaluations, medication management, and participate in treatment planning for youth receiving psychotropic medication. The program is licensed under Chapter 397 which allows the program to provide substance abuse services. The designated mental health clinician authority (DMHCA) indicated youth are placed in two categories in the program, Substance Abuse Overlay Services (SAOS) and Mental Health Overlay Services (MHOS). Youth who have a dual diagnosis may receive both services. The program ensures all youth receive at minimum, one service a day and distribution of services to each youth to fit their need. Youth are provided counseling seven days a week throughout their stay and receive a minimum of two individual sessions a month. Services are monitored through rosters, staff reports, and coordination.

| **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.*<br><br>****Tele-psychiatry is not currently approved for use in Residential Programs**** | |

The program has a written policy and procedures to provide psychiatric services to the youth they serve. These services are provided by a fully licensed, board certified psychiatrist with certification in child and adolescent psychiatry with the American Board of Psychiatry meeting the requirements of Rule 63N-1, Florida Administrative Code. A review of two of the five youth records received psychiatric services, an additional youth record was reviewed. One youth entered the program on psychotropic medications and was referred for a psychiatric evaluation within fourteen days of entering the program. One youth previously on psychotropic medications which was not currently taking them was referred for a psychiatric evaluation. One youth was referred for a psychiatric evaluation based on shelf reported issues and observations. All three youth were seen by the psychiatrist for a psychiatric evaluation which was completed in two youth records. One youth was reported to have walked out during the psychiatric interview and the evaluation was not complete. The two completed initial diagnostic interviews included the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders-IV-TR diagnosis, and treatment recommendations. The third youth records revealed the youth was later prescribed a psychotropic medication for approximately thirty days and then taken off, without a completed initial psychiatric evaluation completed. All three youth records contained page three of the Clinical Psychotropic Progress Note (CPPN) explaining the need for the medication related to the youth's diagnosis, target symptoms, potential side effects, risks and benefits of taking the medication, and frequency of medication monitoring/management. All three youth taking prescribed psychotropic medications were seen for a medication review by the psychiatrist, at a minimum of every thirty days. There were no change to the existing psychotropic medication regimen in two of the youth records. All three records had page three of the CPPN completed with the psychiatric review within every thirty days, as specified in Rule 63N-1 Florida Administrative Code. The program does not employ or contract a psychiatric advanced practice registered nurse (APRN). According to the provider's contract, the psychiatrist is on-site for a minimum of two days every month for two hours each visit and is available for emergency

consultation twenty-four hours a day, seven days a week. The psychiatrist sign-in sheets were provided and reviewed. Two periods in October and in December 2019, indicated the psychiatrist visited the program on the third week rather than every other week, as contracted. Three initial psychiatric evaluation were able to be observed during the annual compliance review. An interview with the psychiatrist reported the psychiatrist does not have coverage for time taken off and "flexing" out time is what the psychiatrist does when taking off time. The psychiatrist's evaluation and recommendations are incorporated into the youth's mental health or substance abuse treatment plans. The psychiatrist has ultimate responsibility for the prescription and monitoring of psychotropic medications in the program, as well as actively participates in, manages, and supervises psychotropic medication services.

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

The program has a written plan detailing suicide prevention and procedures. The plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. The suicide prevention plan is reviewed annually by the program or as-needed. The program's suicide prevention plan was reviewed and signed by the program director and designated mental health clinician authority.

| **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.*<br><br>*Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.*<br><br>*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.* | |

All five youth records revealed all youth receive an Assessment of Suicide Risk (ASR) at intake, regardless of any suspected suicide risk. Three of the five youth records reviewed had suicide risk hits during intake screening. All five reviewed youth records and ASRs resulted in the youth being placed on standard supervision at intake. One of the five reviewed youth records included suicide risk and placement on precautionary observation (PO) outside of intake. Two additional youth records were reviewed for precautionary observation placement and logs. All ASRs were completed on the required Department's Assessment of Suicide Risk form within twenty-four hours. All three applicable records reviewed had precautionary observation authorized and mental health staff provided supportive services. Follow-up ASRs were completed in all three applicable records and included all elements required by the mental health/substance abuse manual. A conference was held by the program director and licensed mental health professional to reduce level of supervision, including the date and time the youth's supervision was down-graded, in all three records. One record revealed an incorrect documentation of the youth's supervision status. The youth had been stepped down from precautionary observation to close

supervision one day after placement on PO. The youth  stayed on close supervision for two days, but the follow-up ASR reported the youth being taken off PO (again) and placed on standard supervision. The youth on close supervision was maintained until determined no longer necessary by a licensed mental health professional. There was documentation confirming the ASR was administered prior to the youth being stepped down to standard supervision. All records included parent/guardian and juvenile probation officer (JPO) notifications were made of youth's potential suicide risk, as indicated on the ASR. All ASRs were completed by a mental health clinical staff under the supervision of a licensed professional unless completed by the licensed professional with the results of the suicide assessment documented on the ASR. JJIS suicide alerts were entered for all youth placed on suicide precautions and closed upon youth's removal from precautionary observation. Precautionary observation allows the youth to participate in selected activities with other youth and did not restrict the youth's movement. Review of the facility's logbook revealed youth a heightened suicide risk supervision level was logged accordingly. The program director reported the program does practice secured observation supervision but there were no examples in the last six months' time frame to review. The suicide prevention plan documented a review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide established by the program director. The suicide prevention plan includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Five staff were interviewed as to what steps to take when a youth expressed thoughts of suicide. All five staff reported they would notify mental health, place the youth on PO, document supervision, and notify the supervisor. All five interviewed staff reported the knife-for-life kits were located in master control.

| **3.12 Suicide Precaution Observation Logs (Critical)** | **Limited 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.* | |

One of the five youth records reviewed were applicable for suicide precaution observation (PO) logs. An additional two youth records were reviewed to fulfill a sample of three youth records to review. The program utilized the Department's Suicide Preventions Observation Log form for the suicide precautionary observation logs. Two of the three applicable youth records included logs maintained for the duration of the youth on suicide risk supervision. One youth record included a youth which was stepped down to close supervision for two days and there were no close supervision logs produced for review. All PO logs contained the appropriate level of supervision and observations or the youth's behavior were documented in real time and did not exceed the thirty-minute interval and no working signs were observed. Two of the three records contained logs which were reviewed and signed by each supervisor while the youth was on PO supervision. One youth record had four shift supervisor reviews and signatures missing of the seven shifts applicable for review. All PO logs contained a signature by a mental health clinical staff. Two of the three reviewed records included warning signs noted on the logs. One of the three reviewed youth records documented safe housing requirements. An interview of three youth with a history of PO placement reported they were not left alone at any time and were with staff.

| 3.13 Suicide Prevention Training (Critical) | Limited 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.* | |

A review of ten staff training records included five pre-service records and five in-service records. Four of the five pre-service staff and none of the in-service staff had the required six hours of suicide prevention training to include two hours of training in the Department's Learning Management System (SkillPro) and four hours of webinar or instructor-led training. Each of the ten staff participated in mock suicide drills monthly on each shift. The mock suicide drills included over fifty percent of all program staff and all of the required actions to be taken by staff. There was documentation confirming staff members who were not present during the mock drills were able to review the drill scenario and procedures to understand the process and receive the necessary training.

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

The program has a written crisis intervention plan. The plan includes notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review.

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

The program did not have any crisis assessments to review since the last annual compliance review. The program has a policy and procedures in place for crisis assessments. The mental health clinical staff performing the crisis assessment will document a clear description of the crisis situation or event, a description of any events or circumstances which appeared related to the crisis, action taken to intervene, the youth's symptoms or behavior, relevant medical or mental health history, and current behavioral observation. Once the crisis assessment is completed, the program director and the designated mental health clinician authority are notified of any findings and special instructions. The program director then notifies the supervisor on-duty and the incident is documented on the shift pass on report. The control room is then

notified and the alert is posted on the dry erase board in the control room. A level of supervision is then recommended for the youth. A mental health clinical staff continues to follow-up with the youth in accordance with the follow-up plan on the crisis assessment until a mental status examination has been conducted by a mental health clinical staff and it is determined the youth's crisis has been resolved.

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

The program has an emergency mental health and substance abuse services plan. The plan includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Ch. 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 F.S. (Marchman Act), documentation, training, and review.

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

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

# Standard 4: Health Services

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

The program has a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida who serves as the designated health authority (DHA). The DHA's license expires on January 31, 2020 and has specialty training in family practice. The program does not have a physician assistant or an advanced practice registered nurse (APRN). The DHA is scheduled to be on-site every Monday from 8:00 a.m. until 10:00 a.m. The DHA's role at the program is to perform Comprehensive Physical Assessments, periodic evaluations, sick calls, and policy and procedure development as well as provide on-site clinical services. A review of the sign-in logs for the six months prior to the annual compliance review, confirmed the DHA was on-site weekly for at least two hours on Mondays. The DHA is also available twenty-four hours a day, seven days a week by telephone to address concerns at the program. When the DHA is on vacation or has scheduled absences, coverage is arranged by the DHA. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

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

The program has facility operating procedures (FOPs) and treatment protocols for all health-related concerns. The FOPs were found to be well organized in a three-ring binder. The policies, procedures, and treatment protocols were reviewed and signed by the designated health authority (DHA). All FOPs and treatment protocols contained the signature of the DHA and the program director dated January 13, 2020. There was documentation of all newly employed healthcare personnel receiving a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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

A review of five youth individual healthcare records (IHCRs) found each record contained an Authority for Evaluation and Treatment. None of the IHCR contained an original AET but contained a legible copy of the original AET with the word "Copy" stamped on the AET. Copies of completed parental notifications were maintained behind the AET in the IHCR. One of the youths was in the care of the Department of Children and Families (DCF) and the court authorized all treatment and procedures. The registered nurse revealed the program contacts the youth's juvenile probation officer to obtain a new or current AET. If a youth is eighteen years of age or older, the youth signs an Authorization for Release/Request of Information.

| 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.* | |

A review of five youth individual healthcare records (IHCRs) found each record contained parental notifications. Each of the youth had parental notifications for vaccinations or immunizations not consented for on the Authority for Evaluation and Treatment form. Two of the youth were taken off-site for medical treatment and there was documentation of a parental notification in the IHCR. For each parental notification, there was documentation of telephone calls, attempts, and verbal approvals which were witnessed. A review of the youth IHCR revealed vaccinations were verified within thirty days of the youth admission. The nurse interview revealed parental notifications are printed and mailed the same day the youth is seen. The nurse utilizes Florida Shots to get immunization records on each youth.

| 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.* | |

A review of five youth individual healthcare records (IHCRs) found a Facility Entry Physical Health Screening Form (FEPHS) was completed on the date of admission for each youth. The screening was completed by the registered nurse (RN). There was a change in physical custody since two of the youth arrived at the program. There was documentation of a new FEPHS re-screening being completed for both youth on their return date to the program.

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

A review of five youth individual healthcare records (IHCRs) found each youth received a general care orientation upon admission to the program. The healthcare topics included access to medical, how to use and access sick call , what constitutes an "emergency" and who to notify, medication process and side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers. Each youth signed a form along with the nurse documenting the youth received an orientation.

| 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.* | |

A review of five youth individual healthcare records (IHCRs) found one youth applicable for a known or suspected chronic condition. Additional records were requested and one was provided. Neither of the youth were identified as in need of an emergency response. The DHA was notified verbally for youth you and by telephone for the other youth. Each notification was documented in the youth's chronological progress notes in the (IHCR).

| 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.* | |

A review of five youth individual healthcare records (IHCRs) found each youth has an updated or completed health-related history (HRH) within seven days of admission. Each of the HRH was completed by a licensed nurse or the practitioner and reviewed by the designated health authority (DHA) as noted on the Comprehensive Physical Assessment (CPA) for each youth. Each of the HRH was completed before the CPA was completed.

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

The program has a policy and procedures related to Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCRs) found the program utilized the Department's CPA form. Each of the CPA were completed within seven days by the medical doctor. Each youth's medical grade was documented on the CPA. All sections of the CPA were marked with an "O" or an "X". There was when any part of the exam is refused by the youth the doctor wrote "Youth Refused". The youth signed a refusal form which reflected the refused portion on the CPA exam and matched the date of the exam. The Department's Problem List was updated for each youth. The nurse revealed a new CPA is completed every two years if medical grade one with no changes and annually if medical grade two or higher. A review of the facility operating procedures related to tuberculosis skin test (TST) was found to be in compliance with the Centers for Disease Control and Prevention (CDC) new 2006 recommendations and Occupational Safety and Health Administration (OSHA) standards. Each of the youth had at least one verified (TST) documented in the IHCR on the Infectious and Communicable Diseases Form and the Facility Entry Physical Health Screening form (FEPHS). The nurse revealed TST screening are conducted annually.

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

The program has policy and procedures related to sexually transmitted infection (STI) and human immunodeficiency viruses (HIV) screenings. A review of five youth individual healthcare records (IHCRs) found each of the youth were screened and evaluated for STIs. The nurse revealed youth are screened for STIs using Department's Sexually Transmitted Infections Screening form. Testing was ordered for four of the five youth but one youth refused testing. The testing, screening results, clinical evaluation, and diagnosis were documented on the Department's Infectious and Communicable Diseases (ICD) form. There was evidence in each youth's record of the youth being offered counseling, testing, and treatment in each of the five IHCRs. The program utilizes OASIS Florida to conduct HIV education and testing. OASIS Florida provides HIV education to groups and individuals based on disseminating information on the rates of HIV in the community, what groups are most affected or a risk, prevention methods, and the services offered by OASIS Florida as well as other organizations to be utilized. To conduct the test OASIS Florida uses OraQuick which is a rapid test using an oral swab. There was documentation two of the five youth consented to HIV testing. Documentation of pre-test

and/or /post-test counseling was documented on the Individual Health Education Record. The test results were filed in a sealed envelope marked “CONFIDENTIAL” consistent with Florida Statue 381.004. The program’s copy of the providers 500/501 certification by Department of Health was reviewed. Five youth stated they can request a HIV test.

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

A review of five youth individual healthcare records (IHCRs) found none of the youth presented similar sick call complaints three or more times within a two-week period. None of the five youth complained of any severe pain with which staff was unfamiliar. Once a youth completes a sick call, the request is place in a locked box located in the dining hall. The training and compliance manager has a key to the locked box. Each of the sick calls were documented on the Sick Call Index and Sick Call Referral Log. A review of the IHCR found the nurse completed sick call request form filed with the progress notes in the youth record in reverse chronological order. The program has procedures in place when there is not a licensed nurse on-site to review sick call request within four hours after the request is submitted. If the license nurse in not on-site the staff notifies nurse and follow direction of the nurse. The program has regularly scheduled sick call posted hours. Sick call is available every day at 7:00 a.m., 12:00 p.m., 5:00 p.m., and as needed. With a youth’s verbal permission, a sick call was observed. The youth was seen in a private with no other youth present to hear or see the examination. The youth was examined by a licensed person. The staff was observed outside of the door with a window to have a visual on the youth. Five staff interviews revealed nurses responds to sick calls. Five youth stated they can see a nurse within one day of making a sick call request.

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

The program has a policy and procedures for the provision of episodic care, first aid, and emergency care. A review of five youth individual healthcare records (IHCR) found none of the youth received episodic/first aid care by a non-healthcare staff. Three additional youth records were requested. There was evidence of the center maintaining an Episodic Care Log to document the provision of episodic care and first aid treatment. The non-health care staff documented the date/time of episodic care, nature of the complaint, treatment provided, over-the-counter medication given, referral to off-site care if needed, and the youth were placed on call-out to see the nurse. There was evidence of parental notification to the youth’s parent/guardian. Emergency medical and dental care, including emergency medical services (EMS) services are available twenty-four hours a day. The program has one automated external defibrillator (AED) which is located in master control. There was documentation of the AED being checked monthly by medical staff. The AED batteries expires on April 2023 and the pads expires on July 2021. The instruction guide for the AED was located beside the AED. The program has a total of eight first aid kits located throughout the facility. Documentation and interviews confirmed the nursing staff review, inventory, and restock all first aid kits monthly. Three first aid kits to include kits used for transportation were checked and found each were

fully stocked with designated health authority approved content. A review of medical drills confirmed the program conducts mock emergency medical drills monthly on each shift. The mock emergency drills included CPR/AED demonstration once annually. The program director revealed the program conducts drills monthly in and effort for all staff to participate in a mock emergency drill every quarter. Five interviewed staff reported they are able to call 9-1-1 when a youth is identified with a medical emergency. All licensed healthcare staff have a current CPR/AED certification. Four interviewed youth stated they could see a dentist if they had tooth pain. The remaining interviewed youth stated no.

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

The program has a policy and procedures in place in reference to off-site care for youth. A review of five youth individual healthcare records (IHCRs) found one of the youth was applicable. Additional records were requested and two were provided. There was documentation of two of the youth's parent/guardian being notified. The remaining youth is eighteen years of age and did not require parental notification. The IHCRs contained a summary of off-site care form and discharge instruction documents when applicable. The designated health authority reviewed and signed all off-site care findings instructions and information. Two of the youth required follow-up testing, referrals, or appointment and there was documentation the referrals were tracked., The youth received appropriate, timely follow-up care as needed.

| 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 for the delivery of treatment to youth identified as having a chronic medical condition. A review of five youth individual healthcare records (IHCRs) found one youth was identified with a chronic medical condition and/or taking prescribed medications. Additional records were requested and one additional record was provided. One of the youth was taking prescribed medication on and ongoing basis. The remaining youth was undergoing treatment for physical health condition with includes body mass index greater than thirty. Both youth were classified with medical grade two through five. There was documentation of both youth receiving periodic evaluations at no greater than three months intervals. The periodic evaluations were tracked on the Chronic Physical Health Conditions Roster form which was found in each IHCR. Documentation was also found in the progress notes located in the youth's IHCR. The designated health authority revealed periodic evaluations are conducted for youth with chronic conditions every three months.

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

The program has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of five youth individual

healthcare records (IHCRs) found two youth were prescribed medication prior to their admission to the program. One additional record was requested. In each of the three IHCRs, the medication was verified by medical staff and the youth was continued on medications. There was documentation of the designated health authority (DHA) being contacted to obtain the order to resume the specified medications the youth is prescribed prior to admission. The nurse interview revealed medications are verified against the medical record, the Medication Administration Records, the physician orders, the patient, and the pharmacist. Non-healthcare staff verify medications against the youth transport card, non-licensed staff medication record, medication receipt, transfer and disposition form, and the Medication Administration Record (MAR). The program utilized the standard Department's MAR to document consumption and refusal of medications. The MAR documented all the required information including demographic information of youth, medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff documented weekly side effect monitoring on the MARs. There were no refusals documented; however, the program's practice is to clearly document refusals on the MAR and refusal form, when applicable. A tour of the medical clinical found all medications were in a separate, secure area, inaccessible to youth. Narcotics and other controlled medications were found stored behind two locks. Oral medications were not found to be stored with injectable or topical medications. Syringes and sharps were found to be secured. The program has a secured refrigerator designated for medication requiring refrigeration. The medication cart was found to be clean, organized, and stocked items were separated from youth specific medications. An interview with the registered nurse (RN) revealed disposal and destruction of expired and/or discontinued medication requires two nurses. The medication is then placed in a solution called Rx Destroyer. The destroyed medication is documented on a log located in the medical clinical. A medication pass was observed during the annual compliance review, after the youth gave verbal consent to observe. The RN verified the six rights of medication administration (right youth, right med, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking the youth's mouth. One interviewed youth stated the nurse gives medication to youth. The remaining four interviewed youth stated they do not currently take any medications.

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

The program has a written policy and procedures ensuring medications and sharps are secured and inventoried by using a routine perpetual inventory. Medications were found stored in a locked medication cart, cabinets, and in the locked refrigerator all of which are situated in the medical clinic. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. All sharps were found secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed. There was documentation of a perpetual and a weekly inventory of all sharps and stock over-the-counter (OTC) medications being conducted. A random inventory of three youth medications to include one narcotic, three different sharps, and three OTC medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the previous six months medications revealed all counts and inventories matched medications on available. The nurses interview revealed medication is disposed using the RX Destroyer and is

witnessed by two nurses. Controlled medications are witnessed by the nurses and the pharmacy consultant. If two nurses are not available, the facility administrator can act as a witness with the nurse and the pharmacy consultant.

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

The program has an infection control procedure in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases according to the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control (CDC) guidelines. A review of the program's Exposure Control plan was conducted and confirmed the plan included all the required elements outlined in the department's standards. The plan was reviewed and signed by the program director (PD). The PD revealed the exposure control plan is reviewed annually and maintained in the medical department.

| 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 is non-applicable.

# Standard 5: Safety and Security

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

The program has a policy and procedures regarding youth supervision. The program operates utilizing two rotating shifts, A Shift and B Shift. Policy requires staff to youth ratio of one to eight during awake hours, and a ratio of one staff for every twelve youth during sleeping hours. Off-campus activities require a ratio of one to five staff-to-youth. During the annual compliance review, the youth were observed daily during their daily activities which included recreation, school, breaks, meals, and movement from one location to another. Staff were always able to account for the youth under their supervision and none of the youth were observed roaming around unsupervised. The daily schedule was posted in all required areas for access to the youth and/or staff. When direct care staff were questioned on the number of the youth they are supervising, there were no discrepancies. The staff were also able to explain the procedures to reconcile count.

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

The program has a policy and procedures addressing the behavioral management system (BMS) which involves daily interactions between youth and staff, and youth and their peers. The BMS system is founded on a leveling system referred to as Proactive Levels of Intervention (PLI). The PLI is designed to assist in redirection of anti-social behavior or violations of rules. The BMS requires interventions at the lowest possible level to a youth's negative behavior. The BMS has a positive reward system available to all youth who are progressing through the level system. Some of those positive rewards include a movie night, achievement awards, additional phone privileges, later bed time, and/or special events, such as off-campus activities. The BMS policy does address the minimum of a four-to-one ratio of positive to negative consequences. The BMS is included in the youth's handbook and was observed to be posted in the housing areas. Five youth were interviewed about the rewards and consequences used in the program. All five youth discussed losing points and/or incentives for consequences, while all five discussed movie nights, games, and other incentives for rewards. All five youth were consistent with the BMS system policy. Five staff were able to explain the BMS system. All five staff were able to name the levels and explain how the youth reach those levels. All five staff were consistent with the BMS system policy. These same five staff were questioned on what types of rewards are used in the program. All five staff stated movie nights and snacks. The third staff added A/B honor roll party. All five staff reported nothing could be taken away from the youth as a consequence. The program director (PD) reported the program uses a level system for the

BMS in the program. The program utilizes daily points which the youth need to earn each day, so they can make a green week. When the youth make eight green weeks, they move up in status. The PD was also questioned how rewards are monitored and how does the program ensure the rewards outnumber consequences four to one. The PD stated staff are challenged to utilize positive reinforcement and give five positive affirmations to each youth for each redirect. The PD also reported administration reviews the point sheets and incident reports weekly to ensure fair and equal treatment.

| 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.*<br><br>*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's behavioral management system (BMS) policy does not include extending the length of stay for youth, denying youth basic rights or services, promotion of group punishment, punishment of youth by other youth, or disciplinary confinement. During the annual compliance review, there were no circumstances where room observation was used as a behavior modification. The BMS provides on-going feedback to youth concerning status and works with them to progress through the program. Group staff counselors, shift supervisors, the clinical director, compliance training, transition services manager, therapeutic manager, and program manager all play an important role in the implementation and smooth operation of the BMS. A copy of the training roster was provided and documented twenty-five staff completing training on the BMS. The program's BMS plan does include the use of BMS during school hours. Five youth were able to explain the difference between each level and how you move from level to level. All five youth knew the names of the levels and responded with "being good" in how to move levels. Two youth added completing the packets. All five youth reported they were not allowed to punish other youth. The five youth were also able to explain how staff are consistent in use of rewards. All five youth said the staff are fair and pretty much treat all youth the same. These same five youth rated the BMS system as fair, good, and very good. Five staff were interviewed on how youth are informed of the consequences and are they able to explain their behaviors. All five stated they will tell the youth immediately and give the youth a chance to explain their behavior. These same five staff were able to explain how supervisors provide feedback to staff regarding the implementation of the BMS. Four of the five staff stated they get feedback all the time, whereas the fifth staff said as needed. The program director was questioned on how is the BMS implemented to ensure it is administered fairly and consistently amount all staff. The PD stated administration reviews the point sheets and incident reports weekly to ensure fair and equal treatment. We also evaluate the staff's implementation.

| 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 video monitoring system located in the master control room. The system has a total of thirty-eight operating cameras. There are three separate digital video recorders (DVRs) with the ability to capture video for up the thirty days. Video from six random days from both housing units, including A and B shifts, was reviewed. All checks were completed in real time and conducted in the required frequency. Each staff was observed stopping by each room to visually check the youth. All five interviewed staff reported room checks are conducted every ten minutes when a youth is placed in his room for sleeping or non-punitive reasons.

| 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.*<br><br>*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.*<br><br>*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.*<br><br>*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 maintain sight and sound supervision, as well as accountability, safety, and security of youth at the program. The program maintains a continuous and accurate count of all youth assigned, as well as documenting movement counts, and any youth admission and/or releases. During the annual compliance review, formal counts at the beginning/ending of the day shift, as well as informal counts during the shift were observed. All counts and tracking of youth were documented in the master control log book. Five staff were interviewed on how and when youth counts are conducted and what happens if there is a discrepancy, including emergency counts. The first and third staff stated, beginning, middle, and end of shifts and recount if the count is wrong. The second staff said, beginning, middle, and end of shifts, like every four hours of so. The fourth staff replied at the beginning of every shift. The fifth staff stated we do counts at the beginning and middle of every shift. If count isn't right, we stop movement and recount.

| 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 written policy and procedures in place regarding maintaining logbooks and entries. There is one logbook maintained in the master control room by the control room staff. All logbooks were reviewed and found to be in good condition, no obliterated entries, with staff initials at the end of each entry, tracking of counts and movement, daily activities, emergencies, Central Communications Center (CCC) and/or Florida Abuse Hotline calls, including the dates and times. All entries were made in ink with no erasures or white outs. The program does not maintain living until log books, instead the program utilizes shift reports to summarize events, incidents, and activities. The shift supervisor also verbally briefs the incoming staff about the shift report and contents. The shift reports are maintained in the housing units for forty-eight hours.

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

The program has a policy and procedures regarding key control. Personal keys are stored and secured in administration before entering the secure area of the program in exchange for a numbered token. All program keys are secured on keyrings which also contain numbers identifying the number of keys assigned to the ring as well. The master key log was observed matching all keys assigned to the program. The key log documents issuing, breaks, and returning of keys. Observations confirmed the key log is utilized to assign and track all keys during the shift. Only authorized staff have access to restricted keys. All youth are prohibited from accessing or using any keys. Staff are responsible for reporting lost or damaged keys to the supervisor and master control immediately. When keys are missing, the program is placed on no movement and a search of the premises is conducted. Five staff were interviewed and able to explain the program's key control process. All five stated their personal keys are placed in a box by the receptionist up front and four of the five said they receive the program keys at master control. In these five staff's explanation of key control, all five understood the process included: a key is replaced for damaged keys, the youth and program are searched for missing keys and to notify master control, youth do not have access to keys, keys are inventoried, and the program's key log. Four of the five knew program keys are assigned to staff. Two of the five staff had knowledge of a token being provided to visitors for their personal keys.

| 5.08 Contraband Procedure | Satisfactory Compliance |
|---|---|
| *The program's policy must address illegal contraband and prohibited items.*<br><br>*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.*<br><br>*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 addressing contraband. Youth rooms are searched daily on each shift. These searches are logged into the logbook to include any findings. A review of contraband log entries found no indication contraband was found.

Staff receive a copy of the policy and training while the youth are both advised during intake and receive a copy of the handbook on what is deemed contraband. All incoming mail for the youth is checked by the therapeutic manager to prevent contraband introduction. The program's policy addresses if staff were found in possession of contraband, as well as any illegal items found, local law enforcement officers will be notified. An interview with the program director revealed the program conducts searches prior to youth movements, random room searches, and as needed if there is suspicion of contraband. The program also searches everyone who enters the program by checking their pockets, having them remove their shoes, and electronically search them. Contraband is disposed of according to policy.

| 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 in place regarding contraband. During the annual compliance review, youth searches by male staff were observed before and after youth movements and groups. Observations found youth were treated with dignity and respect. Staff thoroughly searched the youth and explained to each youth prior to the search of its purpose. All searches were conducted in accordance to the Protective Action Response (PAR) training manual. Each of the five interviewed youth reported searches occurred after every movement. All five interviewed staff reported youth searches occurred after every youth movement, with one adding if there is suspicion of contraband.

| 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 regarding the maintenance of the four vehicles assigned to the program. All four vehicles are equipped with all required emergency items including a seatbelt cutter, fire extinguisher, window punch, and first aid kits. All seatbelts in the vehicles were accounted for and operational. A random check of vehicles was conducted with no issues. A review off all four vehicles' annual inspections and routine maintenance records was completed.

| 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 regarding the transportation of youth. The program has cellular phones available for all transports. Per policy, the program's ratio is 5:1 staff-to-youth during all transports, as well as one male. A random check of vehicles was conducted with no issues. An inspection of the four vehicles was conducted and found the vehicles were equipped with a safety screen separating the front seat or driver's compartment from the back seats or rear passengers' compartment. A transport did not occur during this annual review compliance. Youth and staff are required to wear seat belts during transports and only staff who have a current valid driver's license are permitted to operate the program vehicles. At no time shall the youth be permitted to drive program or staff vehicles, nor shall staff leave youth unsupervised in a vehicle. All five interviewed staff reported they are given a cell phone during transports. One staff also reported they are given a first aid kit. Three of the five staff reported they are also given a radio during transports.

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

The program has a policy and procedures for conducting safety and security audits. The program's policy addresses the development and implementation of corrective actions warranted due to safety and security deficiencies identified during any internal or external review, audit, or inspection. The internal system to verify the deficiencies includes correcting and improving existing systems or implementing new systems as needed. The program director (PD) is responsible for ensuring weekly audits are completed regarding all areas of the program. Documentation was provided of the safety and security audits completed weekly.

An interview with the PD revealed the program completes weekly audits, which have follow-up items which must be completed. The Department does quarterly security audits and gives us a list of corrective action to address.

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

The program has a policy and procedures regarding the issuance, handling, and storage of tools. Tools were maintained in two areas within the program, the maintenance shed and kitchen. All tools were accounted for and there were no reports of any missing tools. Tools are inventoried daily, weekly, and monthly. A sample of the inventory issues, including the master inventory list was reviewed. All five interviewed staff reported only those youth participating in the Home Builders Institute use 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 regarding supervision of youth handling tools, which requires sight and sound supervision be maintained. The program's staff-to-youth ratio involving vocational training is two-to-three. The program works with the Home Builders Institute (HBI), an independent program located within the program, to provide supervised trade training for youth. Youth allowed to work in this area receive a risk assessment to ensure compatibility, as well as to main safety and security. Youth are searched prior to leaving the HBI program. Five interviewed youth reported only youth participating in HBI are allowed to use tools; however, four youth also reported using mops and brooms.

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

The program has a policy and procedures in place to inform contractors of contraband requirements, the handling of tools, and youth and personal safety. The program guidelines for contractor tools include: tools checks upon arrival and departure, tool restrictions while in the program, youth are restricted from the work area, and missing tool follow-up. The completed contractor sign in/out logs were observed and up-to-date. Documentation was provided of invoices submitted to the program by the vendor, which matched sign-in sheets of the vendors was completed.

| 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 which include fire, safety, and evacuation drills. A review of the program's drills revealed drills were conducted monthly, on each staffing shift, which covered any of the following emergencies: fire, severe weather, disturbance or riot, bomb threat, hostage situation, chemical spill, flooding, and/or terrorist threats or acts. All drills were documented with date/time, scenarios, staff signatures, as well as logbook entries.
The program has egress plans posted throughout the program and the fire extinguishers were inspected annually.

Three of the five interviewed youth reported fire drills are completed once a month. One youth reported fire drills are completed a couple times a month, and the remaining youth recently arrived to the program, but participated in a drill the previous week. All five interviewed staff reported they participated in fire and medical drills. Three of the five stated they participated in suicide drills. Two staff also included weather drills, another stated said major disturbance drills, while another said bomb threat drills. An interview with the program director revealed the program has conducted multiple drills monthly, including fire, medical, suicide, flood, bomb threat, and hurricane drills.

| 5.17 Disaster and Continuity of Operations Planning | Satisfactory Compliance |
|---|---|
| *The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.*<br><br>*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 Continuity of Operations Plan (COOP) in place for 2019, which was reviewed and approved by the regional director. The current plan does not expire until April 2020; therefore, the program has not yet submitted the COOP plan for 2020. The approved 2019 COOP had the following annexes approved annually: delegation of authority, new cooperative agreements, vendor contract list, emergency and staff contract numbers, and county cooperation checklist. The COOP is located in the program director's (PD) office. Alternative re-location sites for youth are noted and secured, as well as all other required areas of the COOP. The program maintains an emergency administrative hard copy file easily accessible and mobile for emergency purposes which included all the minimal requirements. The PD was questioned if the COOP plan is available for staff to access and where is it posted. The PD replied there is a copy in master control and in administration.

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

The program has a written policy and procedures in place to maintain strict control of flammable, poisonous, and toxic items. All materials are accounted for, along with the Safety Data Sheets (SDS) sheets matching all the materials. All materials were secured and stored in a secure area, the kitchen and maintenance shed, inaccessible to youth. The program maintains a list of staff who are authorized to handle these materials.

| 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.*<br><br>*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.*<br><br>*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 in place prohibiting youth from handling toxic, flammable, or poisonous materials. All items are kept secured in separate restricted locations; the kitchen and maintenance shed. During the annual compliance review, no youth were observed in possession of these materials. Five youth were interviewed and reported they do not use any chemical or cleaning products.

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

The program has written policy and procedures in place regarding the disposal of flammable, toxic, caustic, and poisonous items. The program's maintenance staff is responsible for the disposal of these items in accordance with Occupational Safety and Health Administration (OSHA) Standards and Safety Data Sheets (SDS). The maintenance staff completed the required training. A review of the program's log was conducted. All items are kept secured in separate restricted locations. Liquid waste from work details are disposed in plumbing drains, while the kitchen liquid waste is disposed in the kitchen. Grease is placed in a separate container for disposal. The program's chemical spills are cleaned-up in the following manner: upon becoming aware of a chemical spill, staff shall notify master control of the location, who will shut down the ventilation system and close all windows and doors at the direction of the on-scene supervisor. Contact for assistance from outside the program will be made, consistent with emergency procedures. The program director (PD) was questioned on the program's practice for disposal for flammable, toxic, caustic, and poisonous items is. The PD replied the program follows the guidelines outlined in the Facility Operating Procedures to ensure the safe handling of all harmful items.

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

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

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

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

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

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

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

| 5.22 Visitation and Communication | Satisfactory Compliance |
|---|---|

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

The program has a policy in place regarding visitation and communication for youth while in the program. The program holds visitations for all youth on the weekends and all official holidays. A copy of the visitation schedule is posted throughout the housing units. A review of the visitation and mail log was conducted. An alternative to visitation can be accommodated through additional telephone time or other arrangements, as deemed necessary. Five youth were interviewed and all five yielded they are given opportunity for visitation and communication with family.

| 5.23 Search and Inspection of Controlled Observation Room | Satisfactory Compliance |
|---|---|
| *The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.* | |

The program has a written policy in place to address youth searches and room inspections prior to placing a youth on controlled observation. A review of documentation revealed no incidents of controlled observations since the last annual compliance review.

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

The program has a written policy and procedures in place regarding the placement of youth in controlled observation when non-physical interventions would not be effective. A review of documentation revealed no incidents of controlled observations since the last annual compliance review. Five youth were interviewed if they were ever sent to their room as a form of punishment. All five stated no.

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

The program has a written policy in place addressing safety checks for youth on controlled observation. A review of documentation revealed no incidents of controlled observations since the last annual compliance review.

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

The program has a policy and procedures in place to create, maintain, and follow-up safety planning for all youth. Nine youth safety plans were reviewed and were found to include warning signs, the youth's baseline behaviors, crisis recognition, evidence of jointly developed coping strategies, invention strategies, and debriefing preferences. All plans were created the same day of the youth's arrival into the program and contained input from the youth and parent/guardian. When the plan was created, a review of youth's previous documents was used in creating the plan. All plans were reviewed and updated every thirty days. All five interviewed youth reported they were asked about their triggers when they arrived to the program. One youth also added staff asked him how he works with people. Each of the five interviewed staff reported the safety plans were located in master control. Staff revealed safety plans were reviewed when the youth first arrives to the program, once a month, twice a month, when information is passed along from the therapeutic managers, and the remaining staff was unsure.