STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Walton Academy for Growth and Change
Rite of Passage
(Contract Provider)
286 Gene Hurley Road
DeFuniak Springs, Florida 32433

Review Date(s): March 12-15, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Warren Garrison, Office of Program Accountability, Lead Reviewer (Standard 1)
Michael Allshouse, DJJ Probation, Circuit 1, Juvenile Probation Officer (Standard 2)
Jessica Gibson, Office of Programming and Technical Assistance, Technical Assistance Specialist (Standard 2)
Shyron Johnson, DOVE Vocational Academy, Assistant Program Director (Standard 5)
Crain Swain, Office of Program Accountability, Regional Monitor (Standard 4)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Walton Academy for Growth and Change
Provider Name: Rite of Passage, Inc
Location: Walton County / Circuit 1
Review Date(s): March 12-15, 2019

MQI Program Code: 5365
Contract Number: 10358
Number of Beds: 39
Lead Reviewer Code: 122

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- _____ # Case Managers
- _____ # Clinical Staff
- **1** # Food Service Personnel
- **1** # Healthcare Staff
- **1** # Maintenance Personnel
- **2** # Program Supervisors
- **5** # Staff
- **5** # Youth
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☐ Supplemental Contracts
- ☒ Table of Organization
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- **5** # Health Records
- **5** # MH/SA Records
- **5** # Personnel Records
- **5** # Training Records/CORE
- **3** # Youth Records (Closed)
- **5** # Youth Records (Open)
- _____ # Other: _____

Observations During Review

- ☐ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☒ Transition/Exit Conferences
- ☒ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

* 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	Limited
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

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

* 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 4: Health Services
Residential Rating Profile

Indicator Ratings

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

* 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 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	Limited
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Satisfactory
5.25	Controlled Observation	Satisfactory
5.26	Controlled Observation Safety Checks and Release Procedures	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).

Program Overview

The Walton Academy for Grown and Change is a thirty-nine bed program, for thirteen to eighteen year old males, located in DeFuniak Springs, Florida. The program is operated by Rites of Passage, Inc., through a contract with the Department.

With the trajectory of minimizing risk to reoffend, the integral service goals are encompassed with, but not limited to, the following: a trauma focused, restraint-free environment, comprehensive medical, mental health and substance abuse treatment which includes individual, group, and family counseling, parenting skills, evidence-based and promising practices such as Impact of Crime (IOC), Thinking for a change (T4C), and Aggression Replacement Training (ART). In addition, the program also provides mental health and substance abuse overlay services.

Pivotal to the program functionality are the staffing positions making up the administration. Administrative positions include the program director, the assistant program director, who also acts as the clinical director, the training and compliance manager, the human resource and administrative assistant, the recreation therapist, and the transition services manager.

Case management and mental health staff are essential to assessing the youths' individual needs. The case managers also act as the youths' therapeutic manager. Having an astute gauge of the youth needs consequential to administering assessments, together the youth and case mangers map out a trajectory for completing the program. Case management is replete with six staff, one of the staff being deemed the clinical director, who also serves the assistant program director. Case managers are referred to as therapeutic managers. The program employs six. They have one vacant position open.

Medical services are provided by a psychiatrist, medical doctor, and pharmacy consultant, as well as two registered nurses and a nurse practitioner. One of the registered nurses also serves as the health services administrator. The Walton County School Board provides the educational services at the program. The Home Builder's Institution is also located at the program. Youth have the potential to earn high school credits, a diploma, a General Equivalency Diploma (GED), or vocational certifications while at the program.

Care and custody services are provided twenty-four hours a day, seven days a week. The program utilizes twenty-nine coach counselors, of which four positions are vacant. Shifts are schism between night and day shifts. As indicated by the schedule and observations, youth occupy the program's three sleeping quarters, the cafeteria, medical building, and designated outdoor areas for recreation. The program has a total of thirty-seven cameras with thirty-six of which were operational at the time of the annual compliance review. Video recordings are stored for thirty days.

Ancillary services include a maintenance/janitor position, dietary supervisor, and two cooks. The program utilizes a full-service kitchen with industrialize appliances and a walk-in refrigerator and freezer. The two cook positions and the dietary supervisor positions are vacant. The janitor is utilized as a cook until the vacancy is filled.

Strengths and Innovative Approaches

- Program youth are viewed and regarded as student athletes. Staff are called coaches. The program refrains from using pejorative labels, such as juvenile, client, correctional officer, and delinquent. This practice is woven into and included in their logbooks, student surveys, grievances, case management, etc. The program provides staff and youth Under Armor clothing, akin to what professional athletes wear. The youth at the program associate Under Armor with professional athletes and it helps promote an atmosphere of self-improvement.

Standard 1: Management Accountability

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

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

The program utilizes six teachers who are paid by the school board and do not require a background screening by the Department. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit (BSU) prior to January 31, 2019.

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

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

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

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

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

A review of the program's alleged abuse complaints revealed two alleged incidents of abuse since the last annual compliance review. One of the alleged abuse incidents involved a youth reporting he did not receive lunch; however, after requesting an abuse call, the youth refused, and completed and signed a refusal form. The other alleged abuse incident was substantiated for improper conduct and use of force, and the program provided documentation of immediate discipline action resulting in termination of the staff in question. Five staff and five youth were interviewed. Each youth understood they have unhindered access to allege abuse to the Florida Abuse Hotline and reported they have not been stopped from reporting abuse to the Florida Abuse Hotline or the Central Communications Center (CCC). Neither the formal or informal interviews indicated the youth were subject to threats or intimidation by staff. Each youth reported staff were respectful and they feel safe at the program. Each of the five staff reported they have not observed a co-worker tell a youth they could not call the Florida Abuse Hotline and have not observed a co-worker use profanity, threats, intimidation, or humiliation when speaking with the youth. Two of the five youth reported they have occasionally heard staff use profanity when speaking to the youth.

The program director reported the program's code of conduct includes guidelines outlining how staff are to conduct themselves. Staff records maintain signed code of conduct forms clearly communicating expectations for ethical and professional behavior. All abuse allegations are investigated, and sustained allegations are immediately addressed. All youth and staff are required to report all cases, even suspicion, of abuse. Staff are to refrain from using threats, abuse and profanity. Youth are never denied a call to the Florida Abuse Hotline. All abuse calls are documented and maintained in an abuse logbook. The Florida Abuse Hotline and CCC contact numbers were posted in the administration hallway, medical hallway, and both youth dorms.

When youth request to make a call to the Florida Abuse Hotline, both the supervisor and program director are notified. The supervisor will make the call for the youth and then allow the youth to report the alleged abuse incident.

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 one verified incident substantiated for improper conduct and use of force since the last annual compliance review. Documentation showed administration immediately removed the staff from all youth contact at the program and the staff was subsequently terminated.

The program reports each youth is made aware of their right to report abuse during orientation. Each Protective Action Response report prompts staff to ask each youth if they want to report abuse. The grievance forms utilized by the youth also ask the youth if they would like to report abuse.

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

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

1.06 Protective Action Response (PAR) and Physical Intervention Rate	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 two incidents requiring the use of Protective Action Response (PAR) techniques. A review of the program's Department-approved PAR plan determined the program followed proper protocol for each PAR incident. Each PAR report was completed by the end of the staff worker's workday and included statements from all of the staff involved. Each report included a review by a PAR certified instructor/supervisory staff and the post-PAR interview was conducted with the youth within the required timeframe. The PAR incident reports were reviewed by an administrator, or designee, within seventy-two hours of the incident. The program's PAR rate during the annual compliance review period was .95, which is below the statewide residential PAR rate of 1.47. The program submitted monthly summaries of all PAR incidents to the Department by the fifteenth of every month for the past six months.

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

A review of five staff training records found each of the staff completed the required 120 hours of pre-service training within 180 days of hire. All of the staff completed training in cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), professionalism and ethics, child abuse reporting, emergency procedures, suicide prevention, and Prison Rape Elimination Act (PREA). All of the trainings were documented in the Department's Learning Management System (Skill Pro). A list of pre-service training was submitted to the Office of Staff Development and Training on January 30, 2019.

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

A review of five staff training records determined each of the staff completed all required in-service training hours. A list of in-service trainings was submitted to the Office of Staff Development and Training on January 30, 2019. Two of the staff training records reviewed were supervisory staff. As a part of the in-service training requirements, both supervisors completed eight hours of training in management, leadership, personal accountability, employee relations, and fiscal. all of the trainings were documented in the Department's Learning Management System (SkillPro). The annual in-service training calendar provided by the program included all in-service training and was submitted and approved by the Office of Staff Development and Training.

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

Each of the five reviewed pre-service training records reflected the staff were trained in the program's grievance procedures. The program's grievance process includes an informal, formal, and appeal phase. The written procedures allow youth to grieve actions of the staff or program. Each youth has the right to file a grievance. Procedurally, attempts are made by the staff and youth to resolve an issue. A written response from the supervisor is required. The final attempt to resolve a grievance of the youth requires the program director to address the matter to attempt to resolve it. Each step in the process must occur within the policy's timeframes.

Five staff and youth reported they understood the program's grievance procedures. Each were well versed in the grievance procedures. The program director explained the program's

grievance procedures in detail, as he reported the youth transmit their grievances to direct care staff and then to the supervisor and program director, if needed.

All grievances are maintained in the program's grievance binder for one year. The binder was organized into sections by month. Incidents were listed according to the date and time of occurrence. Names of youth and staff were accurately documented. Two reviewed grievances included the informal phase and formal phase documented within the timeframes, as required by the program's policy and procedures. Each grievance was resolved at the informal or formal phases and did not require escalation to the appeal phase.

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

Three staff are trained to deliver the program's delinquency intervention model. Each youth at the program participates in Impact of Crime (IOC). IOC is an evidence-based curriculum. The program director reported each staff's education and history of delivering evidence-based services were considered in selecting the facilitators. A review of the staff training records for staff facilitating groups found two of the staff have master's degrees and one has a bachelor's degree, and all have over five years of experience working with delinquent youth. All three facilitators completed all required training for IOC. The program reported youth are matched to staff and are mindful of any staff history with youth in a further attempt to ensure appropriate service delivery. The staff facilitators work in accordance with the program's contract and guidelines. A review of group sign-in sheets validated IOC was provided twice a week for one hour each day, as required. A review of five youth records found each of the youth were participating in IOC and each of their performance plans included IOC as a goal. The program offers an array of structured, planned programming, and activities for at least sixty percent of the day, as indicated on the program activity schedule.

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

The program activity schedule includes Thinking for a Change (T4C) and Aggression Replacement Training (ART). T4C is provided twice a week for one hour each session, and ART is provided once a week for one hour. The program utilizes the licensed mental health specialist and one of the program's therapists to facilitate the curriculums. A review of training records found each facilitator completed training in the curriculums they are facilitating. A review of five youth records found each of the youth were participating in groups, as outlined in their treatment plans. Sign-in sheets mirror the program's activity schedule. The program director described T4C as replete with cognitive behavior needs to guide youth in healthy smart choices. The functionality of ART was reported to be used to teach the youth anger control, moral reasoning, and social skills.

Two of five interviewed youth indicated they have partipcaited in IOC while at the program. Four youth reported they have participated in substance abuse groups and the remaining youth did not know the names of the groups. Four of the five youth were able to describe new skills or behaviors they have been taught and confirmed they have practiced these skills in group.

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

To adequately increase the youth's awareness of crime victims and personal accountability, the program utilizes the Impact of Crime (IOC) curriculum. The curriculum allows for youth to have an opportunity to feel what it is like to be the victim of a crime, and learn to empathize with victims. The youth also participate in community service projects as part of the process.

IOC is held twice a week for one hour, as evidenced by a review of sign-in sheets and activity schedule. A review of staff training records indicated all three staff providing groups were trained to facilitate IOC. Observations of an IOC group provided insight on how the groups are conducted, as the youth were able to describe what the victims experience. Youth were able to show empathy and offered solutions. The program director provided insight on the community opportunities provided at the program. He also reported youth are able to participate in the program's Home Builders Institute (HBI) program located on-site, to complete community service hours.

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

The program provides gender-specific programing twice a week to all of the youth at the program. The activity schedule has the courses labeled as a special topic. The registered nurse is trained to provide the services to the youth. The curriculum reviewed instructs youth on the physical and psychological development of the adolescent, Kohlberg's theory of moral reasoning, male diet and nutrition, exercise, and testicular self-examination. Sign-in sheets were reviewed and found groups were delivered, as required. The program director reported how pivotal this service is to the program's population.

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

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

Five internal alerts were reviewed and were found to be consistent with the JJIS alerts. None of the alerts required a youth's current status to be changed or downgraded. The program director reported the program's alert process begins at intake for the youth. The program also utilizes an alert board located in master control. The alert board was observed, and found it was consistent with JJIS for each of the youth on the board. Alerts are also discussed during shift change. In the kitchen, dietary alerts are maintained and evident. The dietary alerts were consistent with JJIS for each of the five youth.

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

The program maintains a separate individual management record and an individual healthcare record for each youth. Records are clearly labeled "confidential." The healthcare records include the youth's medical, mental health, and substance abuse information. The management records are organized into separate sections. The sections are labeled as legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Records are secured in a locked file cabinet also labeled "confidential," located in a locked room.

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

The program has a formal process for youth input. The program utilizes a youth special request form. Forms capture the date, time, case manager, and youth's name. Each form is reviewed by the program director. The form includes what the youth would like to talk about and the staff's response. All forms are signed and dated by the youth and staff. The program director reported the forms allow youth an opportunity to express any ideas or input. The program had nine forms completed within the past six months. Each form was completed within the months of September and October 2018. One youth requested donations for the Home Builders Institute, another youth requested to speak with the program director regarding his completion date, and the remaining seven youth requested to speak to the program director regarding their points, levels, and treatment team.

Four of five interviewed youth reported meetings are held at the program to allow the youth to provide input. The remaining youth reported there are special request forms they can give to staff. The program director reported request forms are completed for youth input.

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

The program has a policy and procedures to establish and maintain an advisory board. Procedures require a session of court officials, law enforcement, local businesses, the community at large, and victims. Letters of introduction shall be extended. The board is to serve as program advocates. The advisory board will elect board officials, inform the public of the program's mission, and regulate proceedings.

The program maintains documentation for all advisory board meetings. The program met each quarter. Approximately twelve board members attended each meeting. Attendee members included all appropriate members of the community. The program maintains a roster for all attendees. The roster included the names, titles, both electronic and physical mailing addresses, and telephone contact numbers for all attendees. A review of the detailed minutes from the advisory board meetings found documentation of each meeting opening in prayer, introductions of participants, a review of goals and objectives, and the participant's comments. The program provides lunch from their dietary department.

The program director reported members of the community discuss the current happenings at the program during the meetings. A board member was not available for interview during the annual compliance review week.

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

The program has a policy and procedures labeled effective communication and planning. The policy establishes a system for staff to be involved in communicating issues and developing policies and procedures. Subsequently, agendas are established for all planned meetings. Procedurally, staff meetings occur weekly with the management team. Supervisors complete

weekly meetings with staff. Lastly, the facility administrator meets with the Department's monitors to discuss on-going updates with the program. The meeting topics include team building, feedback, issues concerning programming, treatment services, educational and vocational opportunities, management concerns, operations, etc. The program maintains a binder including management and staff meetings. The subject matter includes all appropriate topics. Meetings are held weekly for one hour.

A survey is provided to the parents/guardians which includes a customer service comment card to capture comments and ratings. The youth complete a survey labeled Trauma Responsive and Caring Environment (TRACE) assessment and a program satisfaction survey. The program also has family days, which occurs every other month. Surveys are completed by the youth and parent/guardians during family day. The program director stated the program provides food, activities, and transportation for the family.

Four of the five interviewed staff reported staff meetings are held every Wednesday. Two staff reported shift briefings are also held daily. The staff reported topics covered during staff meetings include alerts, trainings, drills, any youth issues, counts, distance training, and group norms. Two of five staff reported they have been briefed on the Comprehensive Accountability Report (CAR) report, annual compliance reports, and youth and parent/guardian survey results. When asked how effective communication is amongst the staff at the program, each staff reported communication is good.

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

The program has a policy and procedures which delineates the staff's performance process. The program is required to motivate staff to work at their highest capacity. The objective is to inform management and the staff of their job performance. The application of the policy includes feedback, both formal and informal and an annual evaluation.

Five direct care personnel records included a staff performance review form. The form included a rating scale and overall rating scale, interpersonal factors, and the direct care performance rating. The direct care rating scale included the implementation of the program's behavior management system, and delivery of delinquency intervention services. Each staff had an informal and formal evaluation. Each evaluation was signed and maintained in the staff record.

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

Three of the five interviewed staff reported they receive a formal evaluation yearly on their performance. One staff reported they receive an evaluation twice a year, and one staff reported they receive an evaluation weekly.

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. Each of the five records had documentation of the parents/guardians being contacted by phone within twenty-four hours and in writing within forty-eight hours of the youth's admission. The committing court, juvenile probation officer (JPO), and post-residential services counselor were notified in writing within five days of admission.

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

Five youth records were reviewed for orientation requirements. Each had documentation of the youth receiving an orientation. The orientation includes a handbook which covers all of the services available and required elements. A review of the program's logbook validated the orientation process. Five youth case management records were reviewed, and each confirmed the youth's orientation began within twenty-four hours of admission.

An admission was observed during the annual compliance review. All services were explained to the youth during the orientation. Five interviewed youth reported they participated in the program's orientation within twenty-four hours of admission.

2.03 Written Consent of Youth Eighteen Years or Older	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.	

Five youth case management records were reviewed. Three of the five records were for youth who were eighteen years of age. Each of the records contained signed consent forms for each of the three youth. The program obtained written consent prior to providing the youth's information to their parent/guardian and, when appropriate, the Department of Children and Families (DCF).

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

The program's policy and procedures, in accordance with Florida Administrative Code, clearly delineates the classification process and includes a classification system. The policy 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 also addresses when a reassessment is warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and/or behavioral concerns.

Five youth case management records were reviewed. Each record contained the appropriate review of classification factors and each youth was assigned to a dorm room. Each youth warranted a reclassification for an increase in the privileges. The program updated the internal alert system, when warranted, as staff completed specific follow-ups or precautionary measures. Documentation of reclassification of the youth was evident in the program's logbook, treatment team notes, performance summaries, and performance plans.

The program director reported the program utilizes factors such as the youth's age, prior victimization, health, and cognitive performance prior to assigning the youth to a dorm room.

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

Five youth case management records were reviewed. Three of the youth were identified with suspected gang activity. Two of the three records did not contain documentation indicating the program shared this information with local law enforcement, education, juvenile probation officer, or the post-commitment counselor. The remaining record contained all required notifications.

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

The program utilizes assessments, an established classification process, and observations to identify applicable youth to participate in gang prevention or intervention activities. Impact of Crime (IOC) is utilized by the program. Three of the five reviewed youth records were applicable for gang prevention and intervention activities. The program's documentation indicated two of the youth were identified as gang members or an affiliated gang member and one youth was not. Each of the three youth were participating in IOC groups, as required on their treatment plans.

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

Five youth case management records were reviewed. Each youth received an initial Residential Positive Achievement Change Tool (R-PACT) assessment within thirty days of admission. The initial assessments were also maintained in the Department's Juvenile Justice Information System (JJIS). R-PACT Reassessments were completed within ninety-days of the initial assessments for two of the five youth case management records. One youth was not yet applicable for a reassessment, as he had not been in the program long enough. The remaining two youth reassessments were sixteen and three days late; however, the program provided documentation indicating they were unable to access JJIS. Documentation included work orders, logbook entries, and e-mails noting technical issues. Once JJIS was functioning properly, the program completed the reassessments. The R-PACT Reassessment documentation was maintained in the youth's official case management record, as well as in JJIS.

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

Five youth case management records were reviewed. Four of the five records had an Youth Needs Assessment Summary (YNAS) completed within thirty days of admission. One YNAS was completed three days late. Documentation of the YNAS was maintained in the Department's Juvenile Justice Information System (JJIS).

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

Five youth records were reviewed. The intervention and the treatment team, including each youth, met and developed the youth's performance plan, based on the findings to their initial assessment within thirty days of admission. The plan stipulated goals for each of the youth to achieve prior to release. For each youth goal, the plan specified target dates for completion and responsibilities. Each plan was measurable, individualized, and based on the priority of needs derived from the initial assessment as it included all the appropriate risk factors. A transmittal letter and a copy of the plan was sent to each youth's assigned juvenile probation officer (JPO) within ten days. Each record had documentation of signature sheets returned to the program from the parents/guardians and attached to the youth's original performance plan, filed in the official case record. Signatures were limited to only the appropriate parties. Each of the performance plans included targeted court-ordered sanctions. Four of the five reviewed performance plans included the top three criminogenic needs identified for the youth. In the remaining record, the performance plan did not include the top three criminogenic needs and there was no reason documented in the case management record as to why they were not addressed.

Five youth were interviewed and each reported participating in the development of their performance plan and knew their current performance plan goals. Each interviewed youth reported having a copy of their performance plan.

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

Five youth records were reviewed. Each of the youth's performance plans were revised to meet each of the youth's needs. The plan revisions were completed due to the youth's progress. The Residential Positive Achievement Change Tool (R-PACT), newly acquired information, and educational goals were also utilized by the treatment team to revise the plans.

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

Five youth case management records were reviewed. Four of five records were applicable for performance summaries. Each of the four eligible youth's performance summaries were completed every ninety calendar days. Two of the four youth records were for youth who were pending discharge from the program. Each of the two youth's discharge summaries were prepared prior to the youth's release from the program and included a justification for release from the program. The other two youth were not yet eligible for release. Each performance summary included the youth's status on each goal, overall treatment progress, academic status, grades, credits earned in the program, performance and behavior in school, youth's overall behavior, level of motivation and readiness to change, interaction with peers, interaction with staff, overall behavior adjustment to the program, and significant positive and negative events. Each summary included comments prior to signing the performance summary, the youth was provided a copy of the performance summary, and the original performance summary was found in each case management record.

Each of the five reviewed case management records provided documentation the performance summaries were signed by the treatment team leader, program director or designee, and youth. The treatment team leader prepared all the summaries. With the exception of the two youth anticipating discharge, the other two youth had documentation indicating the summary was mailed within ten working days to the youth's committing court, juvenile probation officer (JPO), youth, and the parent/guardian. The pre-release notification was sent along with the initial performance summary within the appropriate timeframes for the two youth. The signed copies of the pre-release notifications were retained in the youth's case management record.

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

Five youth were interviewed. Each youth indicated they received a copy of their performance summaries.

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 youth's assessment process, participation in the

development of the youth's performance plan, and progress reviews. Five youth case management records contained evidence of all parents/guardians being notified and participating in formal treatment team meetings. There was evidence in each case management records of parent/guardian participation by phone. A review of the program's contract determined the outlined performance expectations were met. Four treatment team meetings were observed during the annual compliance review. The parents/guardians participated in the treatment team meetings by phone and one parent/guardian attended the treatment team meeting in person. The parents/guardians were notified by letter of all treatment team meetings. The program also sends invitations by email, phone calls, and letters for visitation days and program activities.

Five youth were interviewed and reported their parents/guardians are invited to participate in case management services by telephone. The program director reported the program involves the parents/guardians through treatment teams, performance plans, phone calls, family days, and mail. The outlined performance measures of the program's contract coincide with the program's practice.

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 case manager serves as the treatment team leader. Five case management records were reviewed. Treatment team members include the youth's case manager, youth, administrative representative, direct care staff, treatment staff, educational staff, juvenile probation officer (JPO), parent/guardian, living unit representative, transition coordinator, and the Department of Children and Families (DCF) case worker for one applicable youth. There was no gang representative at the treatment team meeting as required. The JPO often participated by phone.

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. Each of the youth's performance plan was incorporated into their academic progress monitoring plan. One of the five youth was involved with Department of Children and Families (DCF), and the performance plan did not incorporate a behavior support or case plan through DCF. The youth's case management record did not include legal documentation or the youth's DCF case plan, as required.

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

Five youth case management records were reviewed. Three of the five youth records documented formal treatment team meetings occurred every thirty days, unless scheduling conflicts required it be moved. Two of the five youth records documented two treatment team meetings were held late; one was eighteen days late and the other was twenty days late. Each youth is assigned a specific date and time for their treatment team meetings. During formal treatment team meetings, all parties are encouraged to attend to include the youth's juvenile probation officer, parent/guardian, case manager, nursing staff, direct care staff, transition coordinator, therapist, and teacher or education representative. Five reviewed case management records documented a formal treatment team packet, which included a form from case management, an education packet, and a nursing form. Five treatment team packets included the youths' name, date of review, meeting attendees, administrative personnel or representative, direct care staff, education staff, medical staff, parent/guardian, and juvenile probation officer, as well as signatures from each of the participants. The treatment team packet included any comments from the treatment team members and other attendees, a brief synopsis of the youths' progress, performance plan revisions, performance plan goals, positive and negative behaviors, treatment progress, and Residential Positive Achievement Change Tool results. None of the youth treatment team packets indicated the youth had behaviors resulting in physical interventions.

Five youth case management records indicated informal treatment team reviews are held on a bi-weekly basis. Four of the five informal treatment teams did not occur bi-weekly. Informal treatment team reviews are documented on a separate packet. Documentation in the chronological notes reported issues with Assessments.com as to the reason the informal treatment teams were not documented bi-weekly. Chronological notes reflected the appropriate informal treatment date for the four youth. The informal treatment team review documentation included the youth's name, date of review, meeting attendees, comments from treatment team members and others, synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, treatment progress, and changes on the Residential Positive Achievement Change Tool results. A review of five youth treatment team packets indicated none of the youth had behaviors resulting in physical altercations.

A formal treatment team was observed during the annual compliance review. The youth attended the treatment team meeting, as well as, all required staff including the case manager for the youth, nursing staff, direct care staff, therapist for the youth, and the transition specialist. The treatment team packets were reviewed and included the youth's progress on performance

plan goals, positive and negative behaviors were discussed, youth's treatment progress discussed, and all members actively participated in the youth's treatment team. The parent/guardian and juvenile probation officer (JPO) were given time for questions and feedback.

The five treatment team packets were reviewed and the Department's Juvenile Justice Information System (JJIS) was updated at least every ninety days and at the sixty-day transition conference, reflecting the case managers reviewed the treatment team packets.

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

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

The program offers Type 3 educational programming. The program works with the youth from admission to collect items required for employment throughout the youth's stay. Three closed youth case management records were reviewed. Each of the case management records had documentation of completed employment applications, a resume, appropriate documents essential to obtaining employment, and documentation indicating the parent/guardian and juvenile probation officer (JPO) were made aware of the youth's vocational plan.

The program director's interview reported career education programs offered include Home Builder's Institute (HBI), Junior Achievement, and ServSafe, a food handler course.

An interview with the lead educator for career education indicated career education services and assessments include Career Skills, career classes, and employability skills. The youth at the program also can visit the local day treatment program and participate in CAPE Certifications: My Career Shines, Financial Literacy, and Personal Career & Finance.

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

The lead teacher reported each youth's educational needs are assessed upon arrival. The youth and teacher map out an educational plan which includes an exit plan from the program. The teacher reported youth can identify key figures responsible for their post-educational needs, such as the district the student will be zoned for and the county school representative responsible for placement after release from the program. Three of five interviewed youth

reported there are not a lot of interruptions during educational instruction. One youth reported there are interruptions with new youth being admitted and displaying negative behaviors.

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

Three closed youth case management records were reviewed for documentation showing an education transition plan was developed beginning at admission. The three records had an individual education transition plan developed based on youth's post-release goals. Each of the three closed case management records reflected participants involved in the development of the education transition plan included the youth, parent/guardian, education representative, post-release staff/re-entry personnel, certified school counselor, and a registrar or designee of the program's district. In all three closed records reviewed, a transition plan was developed with youth and program director or designee, education, and aftercare staff with specific plans for continuation of education and/or employment. All three closed case management records documented education transition plans included services and interventions based on youth's assessed educational needs and post-release education plans. The education transition plans included the recommended educational placement for post-release based on youth's individual needs and performance. All three plans also addressed the specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services.

Three closed youth case management records were reviewed to verify the youth who had employability as a transition goal included the required information in the educational transition plan. All three closed youth case management records included provisions for continuation of education and/or employment, a sample completed employment application, a resume summarizing education, work experience, and/or career training. An appointment with the Career Resource Center within the vicinity where the youth will be seeking employment was not in the case management records. Per education leadership, the Career Resource Center refuses to set appointments with the youth at the program prior to release; however, the program does provide the address and phone number for the youth's local Career Resource Center to schedule an appointment when the youth meets with their juvenile probation officer (JPO) upon release from the program. The three closed youth case management records included the appropriate documents essential to obtaining employment upon leaving the program. All three closed case management records included evidence the youth's case manager and parent/guardian were aware of the education transition 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. *During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.* *Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*	

Three closed case management records were reviewed for transition conference requirements. All three closed case management records contained evidence of the transition conference being held sixty days prior to youth's release. All three records contained the appropriate documents essential to obtaining employment upon leaving the program. All three closed case management records contained evidence the youth's juvenile probation officer, and parent/guardian were aware of the plan, documents, and post-release discharge plans.

Three closed case management records were reviewed for transition conference documentation and each record included signatures for the youth, treatment team leader, program director or designee, and other team members. The juvenile probation officer (JPO), parent/guardian, education staff, and any other pertinent parties were invited to attend and participate in the transition conference.

The three closed case management records included documentation of transition activities on the performance plans, revised performance plans, identified additional transition activities, identified targeted completion dates, and identified persons responsible for completion. All three transition conference forms included the attendees' dated signatures. Copies of the three transition plans were sent with a request for return with signature to anyone not in attendance.

Three closed case management records were reviewed for documentation of Community Re-Entry Team (CRT) meetings. All three closed records had documentation indicating a CRT meeting was conducted prior to the youth's release and invitations were sent requesting participation from the CRT team members. All three records also had documentation showing the youth and juvenile probation officer participated in the CRT meetings.

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

Three closed case management records were reviewed for exit portfolios. All three closed records contained evidence showing the exit portfolio was discussed and initiated during the transition conference. Each closed record contained a state-issued identification card, copy of

the youth's transition plan, and a calendar with all dates/times/locations of follow-up appointments in the community.

Two of three closed case management records included the youth's social security card, birth certificate, vocational certificates earned in the program, all educational records, school transcripts, resumes, and completed sample job applications. There was evidence indicating education staff forwarded the exit portfolio information to the receiving school district. The transition specialist also forwarded the education portfolio to the parent/guardian and provided a copy to the youth upon leaving the program. All three closed case management records had documentation the youth's exit portfolio was verified at the exit conference and the exit portfolio was completed and given to the youth upon completion of the program. The portfolio information was forward to the juvenile probation officer (JPO). The program's practice coincides with the contract, as all requirements were met.

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

Three closed case management records were reviewed for exit portfolios. An exit conference was conducted for each of the youth subsequent to the juvenile probation officer (JPO) being notified of the youth's projected release date. Each of the JPOs were notified within fourteen days of the youth's projected release date. The exit conference was conducted within the required time frames and included all required parties. All of the treatment team leaders invited all required participants and encouraged them to attend by mailed letters. All of the exit conferences were separate from the transition and Community Re-Entry Team meetings. Each record documented the date of admission and date of termination matched the dates in the Department's Juvenile Justice Information System (JJIS).

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA). The DMHCA's license and position description were reviewed and found to be clear and active until the expiration date of March 31, 2021.. An interview with the DMHCA revealed she is on-site forty hours each week, Monday through Friday, to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place. The DMHCA revealed her role is to maintain a daily group schedule, 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)	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.	

A review of the program's contract found staffing was in accordance with contract and 63N-1 Florida Administrative Code. An interview with the designated mental health clinical authority (DMHCA) revealed licensed clinical staff working under their supervision were performing services in which they are qualified to provide based on education, training, and experience. The program has one licensed mental health professional. The license of the mental health professional was reviewed and found to be clear and active until the expiration date of March 31, 2021

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 three non-licensed mental health and substance abuse therapists working at the program. The 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 degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. Each of the three therapist missed two weeks of on-site face-to-face direct supervision with the licensed clinical supervisor within the past year. There was documentation as to why the on-site, face-to-face direct supervisions were missed. Only one of the non-licensed staff were trained to conducted Assessments of Suicide Risk (ASR). The other two were not at the program long enough and had not yet completed all required training. The one eligible non-licensed staff received twenty hours of training and supervised experience in conducting ASRs. The training included administration of, at a minimum, five assessments of ASR or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. The training was documented on Non-Licensed Mental Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 002).

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 records revealed each youth was screened using 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. The screenings were completed by a trained staff utilizing the Department's Juvenile Justice Information System (JJIS). The program director's interview revealed he was familiar with the screening process used to identify youth at risk for mental health and substance abuse problems. The program director developed written facility operating procedures (FOP) for the implementation of a standardized admission/intake mental health and substance abuse process. The FOP included all required elements. There was documentation indicating the staff conducting the screenings reviewed each youth's commitment packet information, reports, and records for existing documentation of mental health or substance abuse problems.

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 mental health records found each of the youth were referred for a mental health/substance abuse assessment. Each assessment was completed within thirty days of the

youth's admission date. 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. Each of the assessments included the youth's identifying information, reason of evaluation, relevant background, behavioral observations, mental status examinations, and discussion of findings and recommendations. There was documentation of each youth giving 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. *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 records found each youth was assigned to a multidisciplinary treatment team upon arrival to the program. The treatment team consisted of the youth, program administration, residential living unit, and other staff responsible for delinquency intervention and treatment services for the youth. A multidisciplinary treatment team meeting was observed during the annual compliance review. A review of progress notes found each youth was receiving treatment services as indicated on their treatment plan. Each youth had a properly executed Authority to Evaluation and Treatment (AET) and a signed Substance Abuse Consent and Release form. All of the therapists provided substance abuse groups and are qualified to provide substance abuse education. Mental health treatment notes were documented on form MHSA 018. An interview with the designated mental health clinical authority (DMHCA) revealed group therapy is limited to ten or fewer youth for mental health groups and fifteen or fewer for substance abuse treatment groups. A review of sign in sheets validated groups of fifteen or fewer. All mental health and substance abuse staff are qualified and provide substance abuse groups. Each of the five interviewed staff revealed they do not facilitate mental health or substance abuse groups. DMHCA also stated the youth participate in treatment services such as Thinking for A Change (T4C), Aggression Replacement Training (ART), Impact of Crime (IOC) and Seeking Safety.

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

A review of five youth mental health records revealed each youth had an initial treatment plan developed on Department form MHSA 015. Each of the plans were developed within seven days of the onset of treatment. The plans were signed by the mental health clinical staff and all

treatment team members who participated in development of the plan. Each record also contained an individualized treatment plan developed within thirty days of admission or within thirty days of the initiation of treatment. One of the five youth selected required psychiatric services as it was incorporated in the individualized treatment plan. The 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. Each youth participates in individual, family, and group counseling. Four of the five youth selected were applicable for a treatment plan and review as documentation validated each of the four received a review.

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. A copy of the discharge plan was 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 specialized treatment services to youth. The program provides Mental Health Overlay Services and Substance Abuse Treatment Overlay Services to youth. The program provides individual, group, and family therapy as part of the youth's treatment plan. 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 them to provide substance abuse services.

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

Psychiatric services are provided by a psychiatrist licensed under Chapter 458. The psychiatrist is clear and active until the expiration date of January 1, 2020. The psychiatrist's license was reviewed during the annual compliance review and was found to be clear and active. Two of the five youth records reviewed were applicable for psychiatric services; therefore, one additional record was reviewed. Each of the youth records contained an Initial Diagnostic Psychiatric Interview, which was completed within fourteen days, as required. The initial diagnostic psychiatric interview was documented on the Department's form entitled Clinical Psychotropic Progress Note (CPPN) and contained all of the required elements. Each of the three youth were receiving psychotropic medication. Each of the three youth received a psychiatric evaluation within thirty days of admission. There was documentation indicating each youth was seen for medication management by the psychiatrist, at a minimum of, every thirty days. Each of the three youth had page three of their Clinical Psychotropic Progress Note (CPPN) completed as consent was obtained y the parent/legal guardian subsequent a new Psychotropic Medication

being prescribed, discontinued, or significantly changed. An interview with the designated mental health clinical authority (DMHCA) revealed the psychiatrist was on-site bi-weekly on Wednesday's and available to evaluate and monitor youth as needed. The psychiatrist is also available for emergency consultation twenty-four hours a day, seven days a week. An interview with the psychiatrist revealed he provides medication management and therapy, psychiatric evaluations, adolescent evaluation of danger to self and others, security evaluation, follow-up care, discharge planning, and any necessary labs.

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

The program has a written plan detailing suicide prevention procedures. The plan 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 plan was reviewed on January 25, 2019. The program director revealed the program conducts mock drills monthly to include medical suicide, disaster, and fire drills.

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

Four of the five reviewed youth records were applicable for suicide prevention services. The remaining youth did not exhibit any suicide behaviors while at the program. Three of the youth were determined to be at risk during the admission screening. The other youth was determined to be at risk by staff observations. Each of the youth were placed on precautionary observation and the Assessment of Suicide Risk (ASR) was completed on the required Departmental form (MHSA 004) within twenty-four hours. There was documentation of one of the non-licensed clinical staff completing twenty hours of required training by licensed professional, including five co-assessments. The suicide precaution observation logs were completed for each youth. A follow-up ASR was completed before each youth was removed from precautionary observation. There is documentation on the ASR indicating a conference was held with the program director and licensed mental health professional to reduce the level of supervision. A suicide alert was initiated for all youth placed on suicide precautions and closed upon youth's removal from precautionary observation. One of the youth was stepped down form precautionary observation to close supervision. Documentation of the close supervision was documented in accordance with the program's suicide prevention plan. The youth on close supervision was maintained until determined no longer necessary by a licensed mental health professional. There was documentation showing the ASR was administered prior to the youth being stepped down to

standard supervision. A review of five staff interviews revealed when a youth expresses suicidal thoughts, the staff is to notify the DMHCA, search the youth's room, placed the youth on constant sight and sound, notify the parent/guardian, and document the supervision. Four of five interviewed staff reported the suicide response kit is maintained in master control, with the remaining staff indicating they were uncertain what the suicide response kit was located. The program does not use secure observation. 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 multidisciplinary review includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

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

Four of the five reviewed youth records contained suicide precaution observation logs. The remaining youth did not exhibit any suicidal behaviors while at the program. Each of the suicide precaution observation logs for the four applicable youth on precautionary observation were reviewed. The suicide precaution observation logs were maintained for the duration of each of the four youth. There were no warning signs noted on the logs for any of the four youth. Each of the precautionary observation logs were reviewed and signed by each shift supervisor and mental health clinical staff. Each log documented safe housing requirements. Three youth who were placed on precautionary observation were interviewed and revealed staff were watching them at all times and they were never left alone for any period of time.

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

A review of ten staff training records included five pre-service records and five in-service records. Each 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 all of the required actions to be taken by staff. There was documentation showing 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 has not had any crisis assessments 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 FS (Baker Act), transport for emergency substance abuse assessment and treatment under Ch. 397 (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 this annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program contracts with a licensed physician. The medical doctor serves as the designated health authority (DHA). The DHA specializes in internal medicine. The DHA holds an unrestricted license and meets all of the requirements for independent and unsupervised practice in the State of Florida. For the past six months, sign-in sheets revealed the doctor was on-site for a total of two hours weekly other than one week the doctor missed because he was sick. The program had no documentation of any arrangements during this week.

According to the health care staff, the DHA is responsible for communication with program staff regarding youth medical needs, twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. According to the registered nurse and the program director, the DHA is on-site for at least two hours each visit. According to the DHA interview, he is responsible for completing comprehensive physicals assessments, periodic evaluations, developing procedures, seeing kids as needed, ordering labs, medications, and electrocardiographs (EKG) and is available by phone for questions.

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

The program has a policy and procedures to address health-related procedures and protocols utilized at the program. Documentation showed the health-related policies and procedures were reviewed by the designated health authority (DHA) and the program director on January 2, 2019. Nursing staff signed and dated the cover page of all treatment protocols. The annual review of all treatment protocols was reviewed by the DHA on January 2, 2019. Both documents contained the signatures of all required parties on top of the policies. Each facility operating procedure contained the signature of the program director and the DHA. The provided documentation showed all medical staff received the required comprehensive clinical orientation.

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

The program has a policy and procedures to ensure the completion of the Authority for Evaluation and Treatment (AET), authorizing specific treatment for youth admitted to the program. A review of five individual healthcare records (IHCR) found four contained an AET marked “copy.” The remaining youth was in the care of the Department of Children and Families and contained a limited court-ordered AET. Two youth turned eighteen years old while in the care of the program. Both youth signed a release of information to inform their parents/guardians of their health care status.

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

The program has a policy and procedures to inform the youth's 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 (IHCR) revealed the program documented parental notifications were sent regardless of the telephone notification. All telephone calls were witnessed and documented by the caller and a witness.

A review of five youth IHCRs concluded in three instances, youth with chronic conditions had medications changed, and in one instance, the youth was prescribed psychotropic medication. In three instances, offsite emergency care was needed. In one instance, the youth received a non-routine dental procedure. Documentation showed in each situation, the parents/guardians were notified of over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET), when the youth was prescribed a new medication, when the medication prescribed prior to the youth's admission was discontinued, and when the youth were taken off-site for medical treatment, when applicable.

In two youth IHCRs, the parental notification was not required due to the youth being at least eighteen years old or older; however, the parents/guardians were informed due to the release of information signed by the youth. One youth was in the care of the Department of Children and Families (DCF), and the notifications were sent to the DCF case manager to be forwarded to the court. Each youth's vaccinations and immunizations were up-to-date.

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

The program has a policy and procedures to inform the youth's parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments. When a psychotropic medication is initially prescribed, discontinued, and/or a significant dosage adjustment is made, notification to the parent/guardian must be made and consent obtained.

Two of the five individual healthcare records (IHCR) reviewed were applicable for notifying the parent/guardian of changes to the Clinical Psychotropic Progress Notes (CPPN). One additional applicable record was reviewed. In all three applicable IHCRs, the program informed the parent/guardian and case manager of all changes and initiations of prescribed psychotropic medication. The program used certified mailed to deliver the required notification, and each notification was accompanied by the CPPN with explanatory information in two of the three youth records after receiving verbal consent. The remaining youth was in the care of the Department of Children and Families (DCF) and the judge gave the program a window to adjust the youth's medication freely without requiring consent or notification; however, the program provided notification regardless. The program documented all verbal consent and each note contained two staff signatures, one being the witness who listened to the entire conversation.

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

The program has a policy and procedures in place to ensure a youth's immunization history and status is verified to meet state and Department requirements, and subsequently, to provide necessary immunizations/vaccinations with parent/guardian consent. Five individual healthcare records were reviewed. Documentation confirmed the immunization records for each youth was verified within thirty days of admission. Each record documented the youth was up-to-date on all immunizations. According to nursing staff, shot records are verified using Florida Shots official website.

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

The program has a policy and procedures to ensure youth are screened upon admission for health care concerns which may need a referral for further assessment by health care staff. Five individual healthcare records (IHCR) were reviewed for health care admission screenings. In all five IHCRs, the program completed the Facility Entry Physical Health Screening form on the day of admission. Each youth was screened by the registered nurse (RN). Documentation showed the RN notified the designated health authority (DHA) and/or the psychiatrist concerning the youth each youth admission.

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

The program has a policy and procedures to ensure all staff are made aware of each youth's medical and mental health concerns which affect the safety and security of the youth in the program and/or require emergency responses while ensuring preservation of the youth's privacy. Five individual healthcare records (IHCR) were reviewed for medical alerts. Each youth's IHCR documented the youth's chronic conditions, medical grades, allergies, medication side effects, physical limitations, and special conditions. Each IHCR matched the program's internal alert system and the Department's Juvenile Justice Information System. Two youth medical grades were between three and five. Two youth had known allergies. Three youth had chronic medical conditions.

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

The program has a policy and procedures requiring all youth to be oriented to the general process of health care delivery services at the program. Five individual healthcare records (IHCR) were reviewed for youth orientation to health care services upon admission. The program provided documentation confirming each youth received an orientation to health care

services. The orientation included all of the required topics. The orientation topics cover sheets were signed and dated by the youth acknowledging the completion of the course orientation.

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

The program has a policy and procedures which require a referral to the designated health authority (DHA) to be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission. A review of five individual healthcare records found the DHA was notified upon admission for each of the three applicable youth with chronic conditions. None of the youth required an emergency response upon admission. The DHA was informed by telephone of the youth admitted to the program.

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

The program has a policy and procedures to ensure a health care admission rescreening is completed each time the physical custody of a youth changes and they are subsequently returned or readmitted to the program. Two of the five reviewed individual healthcare records (IHCR) reviewed were applicable for health care admission rescreenings. One additional applicable record was reviewed. In each of the three applicable IHCRs, the program completed a health admission rescreening using the Facility Entry Physical Health Screening (FEPHS) form upon the youth's return to the program. Each screening was completed by the registered nurse upon the youth returning to the program.

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

The program has a policy and procedures requiring the standard Department Health Related History (HRH) form to be completed for all youth admitted into the physical custody of a Department facility. Five individual healthcare records (IHCR) were reviewed. In each record, the program completed a new HRH form on the day the youth was admitted to the program. Each of the five HRH forms were documented on the Department required form by a registered nurse. In each IHCR, the HRH form was completed before the comprehensive physical assessment (CPA). Each HRH form contained the signature of the designated health authority (DHA), indicating it was reviewed.

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

The program has a policy and procedures concerning comprehensive physical assessments (CPA). All five reviewed individual healthcare records (IHCR) contained a CPA completed on the required Department form. Reviewed documentation confirmed the designated health

authority (DHA) completed a new CPA for each youth within seven days of admission to the program. The program updated the Department's Problem List in each IHCR. Each section of the CPA was completed in accordance with health services requirements and documented each youth medical grade. All sections of the CPA were marked with an "O" or an "X." Each of the five youth refused a portion of the exam and the youth's signature documented the portion refused.

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

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

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

The program has a policy and procedures requiring all youth to be screened for tuberculosis, and accurate documentation of results to be maintained by the program. Five individual healthcare records (IHCR) were reviewed for tuberculosis screenings. Each of the IHCRs contained screening documentation of the tuberculin skin test (TST) within the last year. Each test was completed within seventy-two hours of admission. Each youth was assessed prior to being placed in general population. The results of the TSTs were documented on the youth's Comprehensive Physical Assessment (CPA) and the Infectious and Communicable Disease (ICD) forms.

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

The program has a policy and procedures to ensure all youth are evaluated and treated, if necessary, for sexually transmitted infections (STI) after consent is obtained. A review of the Health Related History (HRH) and STI forms revealed three youth were applicable for STI screenings. Each record contained consent to be tested, the order date, and the date performed, which was within twenty-four hours of admission. In each IHCR, the results documented none of the youth required any further referrals. The results of tests were noted on the Infectious and Communicable Disease (ICD) forms and located within the individual health care records (IHCR) for each of the three youth.

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

The program has a policy and procedures concerning Human Immunodeficiency Virus (HIV) testing. A review of the HIV Risk Assessments and Sexually Transmitted Infections (STI) forms, as well as the Health Education Record (HRH) and progress notes revealed three of the five selected youth were applicable for receiving HIV testing. Each applicable youth consented to testing and were offered pre- and post-counseling. The pre- and post-testing counseling was

documented on the Individual Health Education Record and/or in the progress notes. The results of the tests were filed in a confidential manner within the youth's IHCR. According to the youth interviews, all five youth reported they can ask for HIV/AIDS testing.

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

The program has a policy and procedures concerning the sick call process. Five youth individual healthcare records (IHCR) were reviewed for sick calls. None of the youth complained of a similar sick call three or more times in a two-week period. Each sick call form was filed in the youth's progress notes, in reverse chronological order. Sick calls are conducted by licensed nursing staff seven days each week, between 11:00 a.m. and 1:00 p.m. Each of the sick calls reviewed were completed by a registered nurse or the designated health authority. Sick call hours and sick call request forms were posted throughout the program. There were no sick call complaints in which the medical staff were not familiar with.

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

The program has a policy and procedures in place regarding responding appropriately, in a timely manner, and documenting all sick call encounters, as required by the Department. Five individual healthcare records (IHCR) were reviewed. In each IHCR, the sick call was conducted by the registered nurse (RN) or designated health authority (DHA). Documentation confirmed the RN and DHA reviewed each sick call. All sick calls were documented in the sick call log, youth progress notes, and IHCR in reverse chronological order. All of the required signatures were documented on each of the sick call forms. The program conducts sick calls in the privacy of the medical room. All youth have access to sick call forms. A sick call was observed during the annual compliance review. The youth was seen by the DHA in the presence of the RN. The youth gave permissions for Department staff to observe the sick call. The DHA was familiar with medical concerns presented. According to youth interviews, four youth reported they were seen by the nurse within one day after making a sick call request and one youth reported they were seen by the nurse immediately after the request is made. According to interviews, all five staff reported the nursing staff conduct sick calls.

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

The program has a policy and procedures which requires all youth in room restriction/controlled observation to have timely access to medical care, as required by the Department. Five youth individual healthcare records (IHCR) were reviewed; however, none of the youth had been placed in room restriction or controlled observation..

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

The program has a written policy and procedures to ensure the provision of episodic/first aid care to the youth at the program. The program has ten first aid kits throughout the facility. Three of the first aid kits were observed to be fully stocked and well maintained with all of the required contents. It is the program's policy for the nursing staff to monitor the first aid kits monthly. On-site episodic care was documented using problem-oriented subjective, observation, assessment, and plan (SOAP) elements.

Five individual healthcare records (IHCR) were reviewed, all of which were applicable for episodic/first aid care. Each youth was seen by either the designated health authority (DHA) and/or the registered nurse (RN). Each incident documented all of the required elements. Two of the five youth required off-site care after being seen on-site by the RN, and both youth were taken to the hospital. All incidents were documented on Episodic Care Log and required. According to the youth interviews, all five youth reported they can see a dentist if they have tooth pain, and can see a doctor if needed.

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

The program has a policy and procedures to provide emergency care when necessary. The program has one automated external defibrillator (AED) which is located in master control. The program maintains the AED instructions with the AED. Reviewed documentation confirmed licensed medical staff conducted monthly checks of the AED. The AED battery expires in August 2023. The pads expire on August 31, 2019. The AED batteries were last changed on February 1, 2019, and the AED pads on June 31, 2017. The program stocks additional batteries and pads within the AED container. The registered nurse conducted a check of the AED during the annual compliance review, and it was determined the AED was fully functional.

Documentation reviewed confirmed the program conducts mock medical drills monthly on each shift with all of the required elements. The program maintains a list of emergency numbers in each administrative office in the facility which includes, the kitchen, medical staff office and master control. Reviewed documentation showed all health care staff and some supervisory-level staff were trained in the administration of an epinephrine auto injector. According to interviews, all five staff reported they can call 9-1-1 in the case of a medical emergency.

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

The program has a policy and procedures to provide for timely referrals and coordination of medical services. Three of the five reviewed individual healthcare records (IHCR) were applicable for off-site care. Each of the youth's IHCRs contained documentation indicating the youth's parent/guardians were notified. The summary of off-site care form was utilized and maintained in the youth IHCR along with all of the required documentation. The designated health authority (DHA) reviewed and signed all of the off-site care findings and instructions.

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

The program has a policy and procedures to ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-ups. Five individual healthcare records (IHCR) were reviewed for chronic conditions identified on the Facility Entry Physical Health Screening (FEPHS) forms. One youth record was applicable for a youth entering the program with a chronic condition. The program was able to provide two additional applicable youth records for review.

Each youth was placed on the chronic illness list and internal alerts were entered, as required. Two of the three youth received a medical grade between two and five. Each youth was seen by medical staff and treated, as required. Each youth received periodic evaluations which were documented and maintained in the youth's IHCR. There was no lapse in service while the youth were in the care of the program. According to the program director, medical personnel are involved in weekly management meetings, weekly shift pass on meetings, and staff meetings in which medical issues are discussed during these meetings.

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

The program has policy and procedures to ensure medications are verified upon admission. One of the five youth reviewed was applicable for entering the program with medication. The program was able to provide two additional applicable individual healthcare records (IHCR) for review. Reviewed documentation confirmed each youth admitted to the program are seen by a licensed nurse upon admission. The nurse verified the medications and documented results in the progress notes and the IHCR. Documentation confirmed the designated health authority (DHA) and psychiatrist are then notified to resume medication. In each IHCR, documentation was provided showing the parent/guardian was notified of the continuation of medication.

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

The program has a policy and procedures to address medication management. A review of five youth individual healthcare records (IHCR) found three were applicable for medication management. Each of the records contained current/valid orders and all medication was administered pursuant to a current prescription.

Medications prescribed prior to the youth's admission were renewed or refilled for the life of the prescription if there were no changes in the total dosage or route. When a youth's current medication was continued, discontinued, changed, or new medications were ordered, the designated health authority (DHA) included an order within the section of the IHCR reserved for practitioner orders. Additionally, the clinical psychotropic progress notes confirmed the psychiatrist's medication orders and the youth's medication regimen.

In three applicable records, over-the-counter medications, not listed on the Authority for Evaluation and Treatment (AET), were administered according to the approved nursing protocols and according to the practitioner's orders.

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

The program has policy and procedures ensuring all medications are secured and separated in a locked area inaccessible to youth. Observations of the medical clinic found all controlled medications securely stored and inaccessible to youth behind six locks and stored in the medication cart. Over-the-counter medications are stored behind five locks and stored in the medication cart. Bulk inventories and sharps are stored behind four locks and in the cabinet of the medical clinic.

Oral medications were not stored with injectable or topical medications. The medication cart was observed to be well organized and clean. It is the program's practice to dispose of all controlled medications by giving them to the contracted pharmacist to discard them. The disposal process is witnessed by the by nursing staff and the contracted pharmacist. For non-controlled medications the program utilizes Rx-destroyer to dispose of medications.

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

The program has a written policy and procedures in place concerning the inventory of medication and sharps. All medications and sharps are inventoried in accordance with the Department's requirements. The program conducts a perpetual daily and weekly running inventory of all utilized medications and sharps. All inventories are documented, along with the utilizations. Counts are conducted at the beginning and end of each shift by the nursing staff and shift supervisor, and all counts are documented and signed by staff.

Three randomly selected sharps, three randomly selected over-the-counter (OTC) medications, and two randomly selected controlled medications was inventoried, and each matched the count indicated on the inventory sheets. The program did not have a third controlled medication to review.

A review of the program's documented counts for the past six months confirmed the program consistently maintained counts of all equipment and medication. All inventories were verified on a weekly basis by the health services administrator. There are written standing procedures for detecting and responding to inventory discrepancies, in which the nursing staff would conduct a corrective count.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance

All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.

The program has a policy and procedures ensuring all controlled medications are inventoried, stored, and documented, as required by the Board of Pharmacy and the Department. A review of the program's documented counts for the past six months confirmed the program consistently maintains a count of all equipment and controlled medication.
Counts are conducted at the beginning and end of each shift by the nursing staff and shift supervisor and all counts are documented and signed by staff. Observations of the medical clinic found all medications were securely stored and inaccessible to youth. Controlled medications were securely locked in the medication cart. All sharps were securely locked in the cabinets. The program did not have any medications which required refrigeration; however, the program did have a refrigerator to store medication. The program was only able to provide two randomly selected controlled medications, which were inventoried, and each matched the count indicated on the inventory sheets. The program did not have a third controlled medication to review.

Nursing staff are on-site seven days a week from 7:00 a.m. to 5:30 p.m. which eliminates the need for any of the four-supervisory level non-health care staff who are trained to deliver medication to conduct medication passes.

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

The program has a policy and procedures in place regarding Medication Administration Records (MAR). A review of the documentation found the program utilizes a folder for each youth and each folder contains a pre-printed pharmacy MAR form. The MAR has all required elements as outlined in the health service manual. The MARs included the youth's name, Department identification number, date of birth, allergies, precautions, and medical grade. Each youth's picture was placed in the file in front of the youths MAR. According to nursing staff, it is the program's practice to have a MAR in the youth records in the event the youth is prescribed medication at a later date or the youth is given an over the counter medication.

Three of the five individual healthcare records (IHCR) reviewed were applicable for a youth receiving medication. The MARs matched each youth's medication list and indicated the youth received their medications, as ordered. Each MAR indicated clear start and stop dates for each medication. Side effect monitoring was documented on the MAR weekly. The nursing staff administer medications. Reviewed documentation reflected it is the program's practice for the nursing staff to sign the MAR along with the youth. If a youth refused a treatment, the youth's refusal was documented on the MAR and on a Refusal of Treatment form which was maintained within the IHCR. The refusal documentation reflected the date, time, treatment or medication refused.

4.31 Medication Management – Medication Administration by Licensed Staff	**Satisfactory Compliance**

Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.

The program has a policy and procedures requiring medication administration to occur, as scheduled, in a comprehensive, accurate, and organized manner in the program, only by a licensed nurse. A review of three applicable youth Medication Administration Records (MAR) confirmed medication administration occurs as scheduled.

A medication pass was observed during the annual compliance review. The medication pass takes place in the hall outside of the master control office. The youth are not allowed in the hall at the time of medication pass except the youth called by the nurse to take medication. The observed medication pass confirmed the work space was clean and organized, and the nurse was in control of the medication cart the entire time. The nurse confirmed the Five Rights of Medication Administration. The process was structured. The nurse verified the youth's allergies and alert status. To ensure the youth consumed the medication, the nurse checked the youth's mouth and gave the youth cookies after they took their medications. According to interviews, all five staff reported medications are provided to the youth by nursing staff.

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

The program has a policy and procedures in place regarding medication being provided by non-health care staff. Five records were reviewed; however, none of the records were applicable, and the program did not have any additional applicable records to review. Documentation provided showed, four supervisory staff were trained to provide assistance with self-administration of medications.

Reviewed documentation showed nursing staff and the youth sign for receipt of medication. The program has a process for medication refusals; however, none of the youth refused medications. Five youth were interviewed, four youth reported medications are provided by nursing staff, the remaining youth reported not taking medication.

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

The program has a policy and procedures in place regarding psychotropic medication monitoring. Five individual healthcare records (IHCR) were reviewed, of which one record was applicable. The program was able to provide one additional applicable youth record for review. In both records, the youth entered the program on prescribed psychotropic medications and the medications the youth was receiving prior to admission were continued. The designated health authority and the psychiatrist were notified upon the youth's admission. In each youth record, the initial diagnostic psychiatric interview was conducted within fourteen days of the youth's admission. Each youth received monthly medication management monitoring by the psychiatrist. None the youth required a referral for psychiatric services.

Each youth received an in-depth psychiatric evaluation within thirty days of being prescribed psychotropic medications after admission. The psychiatric evaluation was documented on the Department's form titled Clinical Psychotropic Progress Note (CPPN). Each evaluation addressed all the required elements to include the diagnosis, target symptoms and the signature of the psychiatrist.

There were no standing orders, as-needed orders, or any emergency treatment orders for psychotropic medications.

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

The program has a policy and procedures in place concerning the infection control plan which includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The infection control procedures include all of the required elements of the Florida Administrative Code 63M-2. The program provided documentation which confirmed they conducted a refresher infection control training on November 28, 2018.

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

The program has a comprehensive infection control education plan which includes pre-service and in-service training for all staff and youth infection control education, according to the Centers for Disease Control and Prevention (CDC) guidelines. A review of five youth individual healthcare records (IHCR) confirmed each youth received training in the prevention of communicable disease and blood-borne pathogens. Reviewed documentation revealed thirty-two staff completed infection control training on November 28, 2018.

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

A review of the exposure control plan confirms the plan meets the requirements of Occupational and Safety Health Administration (OSHA) standards, with maintenance and documentation of the plan, according to the requirements of the Department. The plan was available to all staff. The exposure control plan was reviewed and signed by the designated health authority (DHA) on January 22, 2019, and the program director on January 23, 2019. The plan includes risk assessments and methods of compliance. According to the program director, the exposure control plan is in the facility operating procedures and is reviewed annually.

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

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

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

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

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

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

Standard 5: Safety and Security

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

The program has a policy and procedures which address youth supervision. According to the policy, staff-to-youth ratios are one-to-eight during day time activities and one-to-twelve at night time when the youth are asleep. During the annual compliance review, observations were made of youth during daily activities to include school, recreation, meals, breaks and movement from one activity to another, with no exceptions noted. There is a daily schedule posted throughout the facility. When asked, staff were able to identify and provide the number of youth under their supervision. Five interviewed staff were able to explain the process if a formal head count cannot be reconciled.

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

During the annual compliance review, observations of the Behavior Management System (BMS) included daily youth and staff interactions. All interactions were appropriate and within the guidelines of the BMS. Force Field Analysis (FFA) is utilized to monitor the BMS. FFA contains daily behavioral assessment (points earned) and progress notes on each youth to include positive and negative feedback. Days are color-coded based on the type of day the youth had, with green days being positive, yellow days being neutral, and red days being negative. The program adheres to a five-to-one ratio of positive to negative feedback. Points are totaled weekly and posted in the dorms. Incentives are offered on a daily, as well as a weekly, basis. Rewards include, but are not limited to, extended bed times, movie nights, community outings, and longer telephone times. Five youth revealed, during interviews, staff are consistent in their use of rewards and they can receive rewards such as movie nights with snacks, pizza parties for the cleanest dorms, MP3 players, game room time, and off-site trips. The BMS is outlined in the Student Handbook and staff are provided with training to utilize the system daily. Orientation includes training on the BMS when youth arrive at the program.

Five interviewed staff reported they received training in the BMS and training records validated specific BMS training. Four of five staff reported items cannot be taken away as a consequence. One staff reported the youth can get their computer taken away during education and would have to complete a workbook. Five interviewed youth were able to describe how to progress to each level. The program director reported the program rewards good behavior five to one as it

relates to youth receiving negative feedback. The program director says this method is utilized to ensure consistency.

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

The Behavior Management System (BMS) is designed to aid in maintaining safety and security, provide positive and negative consequences, provides positive reinforcement while promoting conflict resolution, and minimizes the need to separate youth from general population. Staff are trained to explain to the youth why a sanction was imposed and give the youth the opportunity to explain their behavior. The BMS is not used to increase the youth's length of stay or the denial of the youth's basic rights. Program staff, case managers, and therapists are responsible for the implementation of the BMS. Within the parameters of the BMS, youth are given opportunities to express their thoughts with the Force Field Analysis. Staff provide prosocial modeling and problem resolution.

Five interviewed staff reported the program utilizes verbal praise as a reward geared toward increasing appropriate behaviors. Five interviewed youth reported they are not allowed to punish other youth. When asked how they would rate the BMS, two youth reported very good, two youth reported good, and one youth reported fair.
Five staff reported the program utilizes extra snacks, movie night, and pizza parties in the BMS. A review of five staff training records validated each staff was trained in the BMS.

There were no instances of room restriction being utilized during the annual compliance review period.

The program director reported behavior is reinforced by utilizing a point system. Team meetings are conducted each night and during these meetings, the youth are made aware of the points they earned.

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 thirty-seven cameras, and at the time of the annual compliance review, thirty-six cameras were operational. The program has the capability of storing video for thirty days. The program utilizes a youth visual check sheet to document head counts. Each dorm's visual

check sheet was reviewed. All checks were performed within the ten minute requirement with no exceptions. Staff were viewed stopping by each room a youth was occupying and pausing for a moment to observe the youth, verified by video footage. A total of six days for two shifts for each dorm was reviewed. Observations of video footage revealed each reviewed visual check sheet was accurate.

Five staff reported room checks are conducted every ten minutes.

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

The program has a policy and procedures which indicates the primary function of direct care staff is to provide supervision of youth to maintain safe, secure, and humane environment within the program. The program shall maintain and document an accurate count of all youth assigned to the program. Formal head counts were observed to be conducted at the beginning and end of each shift and after any movements.. Formal and ongoing informal counts are conducted by each shift.

A review of the facility logbook determined counts, both formal and informal, were conducted and documented within the logbook. The documentation included the number of youth, the time the count was conducted, the type of count, and staff initials.

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

The program maintains one master logbook, which is located in the master control room. During the annual compliance review, the master control operator was observed conducting and documenting head counts, movement, and security checks. Logbooks were bound and contained numbered pages. Entries were made with ink and there were no white-out areas observed. All entries included the date and time of the event, with staff initials confirming the entry. None of the logbook entries were obliterated or removed; errors were struck through with a single line and initialed by the staff correcting the error. The program maintains a

chronological record of events, incidents, and activities in the master control logbook. Logbooks documented internal incidents reported to the Florida Abuse Hotline and Central Communications Center (CCC). The program summarizes in a shift report the events, incidents, and activities documented in the program's central logbook. A copy of the shift report is maintained for at least forty-eight hours. A shift debriefing is conducted after every shift prior to a new shift.

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

The program has a policy and procedures in place to govern the control and use of keys. The procedures include a system of key assignment and usage, to include restricted keys. In addition, the policy includes inventory and daily tracking of keys, secure storage of keys, and the procedure to address lost and damaged keys. Personal keys were secured in a lock box in exchange for a numbered chit, to be returned and exchanged for the personal keys after exiting the program. Staff assigned keys are inventoried by each shift to ensure accuracy. All keys were maintained on rings and matched on a key inventory form. Restricted keys are noted as permanent and restricted in the inventory form.

Procedurally, staff have written responsibilities regarding key assignments; however, master control maintains and distributes keys by inventorying and tracking all keys. Youth are prohibited from contact with all keys. All program staff are responsible for reporting missing keys to master control and the assistant facility director immediately. When keys are missing or lost, the program is placed on red alert, youth movement is confined, an immediate search is conducted, youth are searched, and locks will be changed in the event a key is permanently lost.

Three staff randomly checked for personal keys reported not having their personal keys in the secure area.

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

The program has a written policy and procedures to address contraband introduction into the facility. The youth handbook outlines a list of items considered to be contraband. All youth sign an acknowledgment of receival of the handbook, which includes what is considered contraband and the consequences for being found with it. The program conducts weekly searches of the living units. The areas are chosen at random and are not discussed prior to the search. The program has developed a system to implement the prevention of contraband. Their policy delineates what is considered contraband. It is the responsibility of every staff to assist in the prevention of contraband. Staff are to utilize trauma-informed practices, effective communication to alleviate stress, conduct random youth and room searches, and contact law enforcement for illegal contraband.

All staff and youth are given a list of all items considered contraband. A review of items considered contraband determined the program prohibits personal cell phones, equipment, and electronic devices. Consequences include the contraband being discarded, returned to original owner, and mailed to youth’s home, or stored and returned to youth upon their release date. Illegal contraband is turned over to law enforcement. Staff are subject to disciplinary action up to including dismissal.

A review of the program’s search report revealed room searches are conducted every day on each shift. Each room search log includes the staff conducting the room search, the shift it was conducted on, dorm, and if contraband was discovered. A review of the program’s logbook validated no contraband was discovered.

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

Youth were observed during the annual compliance review being searched before and after groups, before and after transports, and before and after movement from one activity to another. All searches were conducted by the appropriate staff and gender. Prior to conducting the search, staff were observed explaining the purpose of the search. Staff were not observed using

unnecessary force or rhetoric defacing the youth's dignity or respect. Searches and full body visual searches were based on the Protection Action Response (PAR) training manual. Observations revealed appropriate searches were completed upon each movement of the youth from one area of the program to the next. Observations were conducted each day during the annual compliance review. Five interviewed staff and youth determined searches are conducted before every youth movement and before and after visitation.

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

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

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

During the annual compliance review, a transportation was observed. The appropriate ratios were maintained as there were two staff, both being the same gender as the youth and two youth. Both staff and youth utilized seat belts. Drivers have been pre-approved and found to have a valid driver's licenses. Youth are prohibited from driving vehicles and staff were not observed leaving the youth unsupervised in the vehicle. All personal vehicles were locked securely. Doors on the transport vehicle could not be opened from inside the vehicle. Five interviewed staff reported they are not allowed to use personal vehicles for transport. Staff further indicated they are issued cell phones during transports.

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

The program has a policy and procedures which outlines weekly safety and security audits. The policy indicates who is responsible for conducting the weekly audits and the implementation of corrective actions, as deemed necessary by deficiencies found during any internal and/or external review, audit or inspection. Sample weekly safety and security audit documents were reviewed and were found to meet all requirements. Audits are conducted on a weekly basis. All areas of the program are reviewed during the weekly audit.

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

The program maintains a written policy and procedures to addresses the issuance, inventory and control of all tools. The procedures outline the process for missing and/or lost tools. There were no reports of missing or lost tools during the review process. All tools are marked with an identifying number and stored on a shadow board. The maintenance staff conducts a daily inventory of all tools with sharp edges and a monthly inventory of all other tools. The perpetual inventory includes items of tools which are signed in and out. Kitchen tools were also observed and are inventoried daily. All staff were found to have completed training for the intended and safe use of tools. Tools are maintained in four areas of the program. All tools were accounted for and youth do not handle tools or are allowed in the area where tools are stored.

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

The program has a policy and procedures which instructs staff to maintain a staff-to-youth ratio of one-to-five while youth are handling tools. Staff are to maintain vigilant supervision of youth while handling tools. The program utilizes a Home Builder's Institute (HBI) program on-site. During participation in the HBI program, youth will only use tools under direct sight and sound supervision. The program procedures address youth tool handling with assessing their risk. Case managers complete a youth risk assessment monthly. Risk assessments only allow youth to handle mops, brooms, and scrub brushes. Five interviewed staff reported youth only use mops and brooms. Five interviewed youth reported only using scrub brushes, mops, and brooms. Two of the five youth reported using screw drivers, hammers, and saws during participation in the HBI program.

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

The program has a policy and procedures which provides contractors with a notice of tool/equipment instructions prior to any work occurring and restricting only the tools deemed necessary. Contractor agreement forms were reviewed and found all tools were checked upon

arrival and again at departure. During the work process, all youth are restricted from the area. Sign-in sheets were reviewed and found to be completed and signed by program staff.

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 provided documentation of each emergency drill conducted within the year. Drills were consistent with the Continuity of Operations Plan (COOP). The month of November did not contain any fire drills. All completed drills contained the type of drill, date and time, participants, and a brief scenario, including findings and recommendations. Drills using actual emergencies were utilized and drills captured multiple emergency situations. Five interviewed staff and five interviewed youth reported participating in monthly drills. Five interviewed youth reported they have been instructed on what to do in case of a fire.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

A review of the Continuity of Operations Plan (COOP) found the plan was reviewed, approved, and signed by the regional director on August 14, 2018. The plan addresses alternative housing plans, older plans, and the plan was submitted to the Department on May 18, 2017. The COOP is maintained in control room and is readily available to staff. The plan contained all the required elements.

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

All flammable, poisonous, and toxic materials are stored securely outside the secure buildings and maintained by the maintenance person, inaccessible to youth. The actual flammable, poisonous, and toxic items and materials at the program are all accounted for. An observation of the tool storage revealed two-gallon paint cans not inventoried. There was one box cutter not inventoried daily but inventoried weekly. A review of the Safety Data Sheets (SDS) determined there is an SDS for all materials. The storage area restricts access to only appropriate staff. A review of the facility's operating procedures determined the program has a formal process.

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

The program has a policy and procedures which prohibits youth from handling flammable, poisonous, and toxic items and/or materials. All items are strictly maintained outside the secure buildings and are inaccessible to youth. No youth were observed handling chemicals. Five interviewed youth revealed they are prohibited to handle any chemicals.

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

The maintenance staff is primarily responsible for the disposal of hazardous waste. Outside contractors are utilized for the disposal of all waste produced by the kitchen and medical. The operating procedures also include disposal of hazardous items and toxic substances in accordance with Occupational Safety and Health Administration (OSHA). The maintenance personnel reported the program utilizes Walton County Solid Waste Management to dispose of flammable, toxic, caustic, and poisonous items and materials.

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

The program maintains an activity schedule which documents supervised and structured indoor and outdoor recreation leisure activities for the youth. Activity schedules were posted throughout the facility. The program employs a recreational therapist, as outlined in the contractual agreement. The recreational therapist meets all requirements as outline in the contract, and is responsible for developing activities and an activity schedule for the youth. Recreational therapy is included in each youth's performance plan, as required. Five interviewed youth reported they are provided at least one hour daily of physical and leisure activities. These activities include basketball, flag football, letter writing, game room, and running. Five youth reported participating in leisure activities. A review of the logbook determined the activities are provided as outlined on the program's activity schedule.

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program holds visitation for youth on Saturdays and Sundays from 12:00 p.m. until 2:00 p.m. The schedule, including rules and regulations for visitors, is posted in the program's lobby entrance. The program maintains a policy and procedures for visitation, youth correspondence, and the use of the telephone for youth. The program provides alternative visiting arrangements, when deemed necessary. All youth are given the opportunity to speak with family by phone and correspondence. Case management records contained an approved visitation, mail, and telephone list. Five youth interviews determined all youth are given the opportunity to contact their families.

5.24 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.	

Reviewed documentation revealed the program has not utilized their controlled observation room. The program has a policy in place and procedures to address the use of controlled observation. The policy addresses the program utilizing Controlled Observation only when non-physical interventions are not effective. Delegated supervisors approve Controlled Observation.

A review of documentation revealed no youth were placed in Controlled Observation. An interview with the program director revealed the program has not had any instances warranting control observation.

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

Documentation reveals the program has not utilized their controlled observation room. The program has a policy in place and procedures to address the use of controlled observation. The policy addresses the program utilizing Controlled Observation only when non-physical interventions are not effective. Delegated supervisors approve Controlled Observation.

A review of documentation revealed no youth were placed in Controlled Observation. An interview with the program director revealed the program has not had any instances warranting control observation.

5.26 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.	

Documentation revealed the program has not utilized their controlled observation room. The program has a policy in place and procedures to address the use of controlled observation. The policy addresses the program utilizing Controlled Observation only when non-physical interventions are not effective. Delegated supervisors approve Controlled Observation.

A review of documentation revealed no youth were placed in Controlled Observation. An interview with the program director revealed the program has not had any instances warranting a control observation.

Program Name: Walton Academy for Growth and Change
Provider Name: Rite of Passage, Inc.
Location: Walton County / Circuit 1
Review Date(s): March 12-15, 2019

MQI Program Code: 5365
Contract Number: 10358
Number of Beds: 39
Lead Reviewer Code: 122

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.05 Gang Identification: Notification of Law Enforcement	
5.10 Vehicles and Maintenance	