STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Youth Environmental Services
AMIkids Inc.
(Contract Provider)
4337 Saffold Road
Wimauma, Florida 33598

Review Date(s): September 11-14, 2018

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:

Paul Sheffer, Office of Program Accountability, Lead Reviewer (Standard 1)
Brenda Comadore, Office of Program Accountability, Regional Monitor (Shadowed Lead)
Felicia Goldstein, Office of Program Accountability, Regional Monitor (Standard 2)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 3)
Vernon Pryer, Office of Program Accountability, Regional Monitor (Standard 5)
Vanessa Speight, TrueCore Behavioral Solutions, Lead Regional Health Services Administrator, North Region (Standard 4)
Bonita Williams, Office of Program Accountability, Regional Monitor (Interviews & Standard 2)
Sherri Wilson, Office of Technical Assistance, Technical Assistance Specialist (SPEP)

Program Name: Youth Environmental Services
Provider Name: AMIkids Inc.
Location: Hillsborough County / Circuit 13
Review Date(s): September 11-14, 2018

MQI Program Code: 388
Contract Number: 10172
Number of Beds: 32
Lead Reviewer Code: 118

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **1** # Case Managers
- **2** # Clinical Staff
- **1** # Food Service Personnel
- **2** # Healthcare Staff
- **1** # Maintenance Personnel
- **2** # Program Supervisors
- **5** # Staff
- **5** # Youth
- **3** # Other (listed by title): **Lead Teacher,National Director Compliance, Program Compliance Specialist**

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
- **8** # Health Records
- **8** # MH/SA Records
- **7** # Personnel Records
- **10** # Training Records/CORE
- **3** # Youth Records (Closed)
- **8** # Youth Records (Open)
- _____ # Other: _____

Surveys

- **5** # Youth
- **5** # Direct Care Staff
- _____ # 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	Limited
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Limited
2.11	Performance Summaries and Transmittals	Limited
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)	Limited
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	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	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Failed
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Strengths and Innovative Approaches

- The program has seven youth who have worked at McDonald's since February 2018. This was through a partnership with Casper's Corporation. The youth learned skills in culinary arts and customer service. The program also has four youth who have worked at Dollar Tree since February 2018. These youth were able to gain skills in shipping, receiving, stocking shelves, and customer service.

- The program had thirteen youth participate in informational tours at the Sun City Home Depot. This allowed the youth to see the inner-workings of a large store, and to think about job opportunities for the future.

- Nine of the program's youth took part in several speaking opportunities. These included the AMIkids Annual Legislative Day in Tallahassee, Florida, the Sun City Center Chamber of Commerce Morning Coffee, the Sun City Center Chapter of the Military Order of the World Wars (MOWW), the AMIkids Corporate Office Video Conference Speech, the AMIkids YES Board Meetings, the AMIkids Annual Chairman's Conference, and at the Apple Store in Tampa.

- The program took youth to local high school football games as a motivation to stay on track once they graduate from the program.

- The program has youth participating in on-site visual arts classes provided by Very Special Arts (VSA). VSA is an organization through the University of South Florida. VSA has assigned a professional artist to the programs who conducts hands-on groups on how to make sculptures, paintings, and drawings.

Standard 1: Management Accountability

Overview

Youth Environmental Services is operated through a contract between the Department and AMIkids, Inc. It is a thirty-two bed, non-secure residential program for male youth located in Wimauma, Florida. Males served by this program are provided rehabilitation efforts through academic education, a variety of vocational and life-skills training, mental health overlay services, and behavioral health services. The program is performance-based, stresses academic achievement, appropriate behavior, a positive attitude, and excellence in performance. The program provides individual, family, and group therapy, in addition to case management services. Each youth admitted to the program is evaluated by a psychiatrist for medication management, with monthly follow-up evaluations thereafter, when applicable. The primary services used by the program are Cannabis Youth Treatment (CYT), which is an evidence-based practice, and Aggression Replacement Therapy (ART), which is a promising practice. Additionally, the program offers Impact of Crime (IOC), which is a promising practice, and the Council, which is a practice with demonstrated effectiveness. The program had five direct care staff and one recreational therapist position vacancies at the time of the annual compliance review.

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 has a written policy and procedures to conduct background screenings for all staff, volunteers, and interns in accordance with Department requirements. There were eleven newly hired staff applicable for an initial background screening. All staff received an initial background screening prior to their date of hire or start, and none required any type of exemption as a result of their screening. There were no volunteers, mentors, or interns who required background screening during this annual compliance review period. The program was able to show documentation reflecting each of the staff hired during this annual compliance review period completed the program's pre-employment screening prior to hire. The reviewed information indicated each of these staff achieved a passing score on the Diana Screen. The program submitted their Annual Affidavit of Compliance with Level Two Screening Standards to the Department's Background Screening Unit (BSU) on December 12, 2017, meeting the annual requirement. The teachers at the program work for the provider; therefore, a separate educational Annual Affidavit of Compliance with Level Two Screening Standards was not required.

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 for conducting five-year rescreening for all staff, volunteers, and interns in accordance with Department requirements. The program had two staff who met the requirements for five-year background rescreening. Each applicable staff had a rescreening completed prior to their five-year anniversary date, with the information submitted to the Department's Background Screening Unit at least ten days prior to their anniversary date. There were no volunteers, mentors, or interns who were applicable for five-year rescreening.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *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.*	

The program has a written policy and procedures requiring staff to abide by a code of conduct prohibiting any type of abuse and holding them to high standards of professional and ethical conduct. A form acknowledging receipt of the employee handbook, which includes the code of conduct, is signed by each staff during orientation. This was present in each of the seven reviewed staff personnel records. Phone numbers for the Florida Abuse Hotline and Central Communications Center (CCC) are posted in each of the youth dorms and in various locations throughout the facility. There were two incidents reported to the CCC alleging abuse or staff misconduct since the last annual compliance review. Both incidents were investigated by the program at the time of the annual compliance review. In each situation, the program reacted quickly and terminated each of the staff. Five youth were interviewed, and each indicated they felt safe in the program, and none of the interviewed youth reported ever having wanted to call the Florida Abuse Hotline. Each of the youth also indicated staff are respectful when speaking to them and other youth. Four of the youth indicated they have never heard staff use curse words,

and one indicated they heard staff curse frequently. They reported this was usually out of frustration, and staff would usually use the words “damn” or “hell.” Interviews were conducted with five staff, and none reported ever having seen a co-worker stop a youth from calling the Florida Abuse Hotline. All five staff also indicated they had never heard a co-worker use profanity, threats, intimidation, or humiliation when interacting with youth. The program’s policy provides for unhindered access for youth to call the Florida Abuse Hotline. The program’s practice is to inform the supervisor when a youth wishes to make an abuse call, and the supervisor will then have the youth make the call to the Florida Abuse Hotline in the small conference room located in administration. This practice is in place because staff in the dorms do not have immediate access to a phone, and they cannot leave the other youth unattended. This practice was confirmed through the five staff interviews, and an interview with the executive director. During an interview with the executive director, he indicated physical abuse, threats, or profanity towards the youth are not allowed and is included in the code of conduct. He indicated they used incidents which have occurred in the program to train staff to prevent future incidents.

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

The program has a written policy and procedures regarding management response to allegations**.** A review was conducted on the two personnel records for staff who were alleged to have committed acts during the annual compliance review period which would constitute abuse or neglect towards a youth. Each reviewed record contained documentation reflecting immediate action was taken when the program was made aware of each situation. Staff were immediately removed from youth contact, pending the completion of an investigation by the program and other entities. Both of the staff were terminated following an investigation by the program. A review of internal incident reports found no other situations which were related to physical, psychological, or emotional abuse. An interview with the executive director confirmed the program’s practice of immediately initiating an internal investigation once an allegation is made. Program staff also confirmed there were no other staff who were alleged to have committed an act of abuse or neglect during this annual compliance review period. The interview with the facility administrator and a review of ten staff training records confirmed staff receive training on abuse reporting guidelines during pre-service training. The review of five youth case management records confirmed the youth receive information during their orientation to the program on how 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.	

The program has a written policy and procedures for reporting incidents to the Department’s Central Communications Center (CCC) within two-hours of an incident. There were ten incidents reported to the CCC during the annual compliance review period, and five were reviewed. All five of the incidences were reported to the CCC within two hours of the program gaining knowledge of the incident. A review of the youth grievance information and other documentation found no additional incidents requiring a report to the CCC during the annual

compliance review. An interview with the executive director and a review of ten training records, confirmed all staff received training on CCC reporting requirements. It was explained information is usually brought to the attention of the executive director or director of operations if they are on-site to address the situation. If not, supervisory staff will ensure the needed information is reported to the CCC within the two-hour timeframe. This information is then documented in the program logbook. A review of the program logbook found each of the reviewed reports was documented, as required.

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

The program has a written policy and procedures for the use of Protective Action Response (PAR) by staff. The program had four PAR reports during the annual compliance review period. All four of the reports were completed by the end of the staff member's workday and included all required written statements by each staff involved in the incident. Two of the written statements were not signed by the staff member completing the statement; however, after reviewing each of the statements, members of the annual compliance review team were able to surmise who had written each. All required reviews were conducted and documented by the supervisor on-duty at the time of the incident, and by a PAR-certified supervisory staff member within the required timeframes. All four PAR reports were reviewed within seventy-two hours of the incident by the executive director (ED) or designee. Each report reflected a post-PAR interview was conducted with each of the youth within thirty-minutes of the incident by the executive director (ED) or /designee to assess the need for further medical review. One did not have the box checked to indicate this had been done; however, each of the PAR reports had a detailed narrative in this section to describe the conversation the ED or designee had with each youth. One of the youth had a minor injury, and they were taken to the program's nurse, who conducted a PAR Medical Review. All four reviewed PAR reports were reviewed by the ED or designee within seventy-two hours of the incident. The program has a PAR plan which was submitted and approved by the Department's Office of Staff Development and Training. Reviewed documentation validated the completion of a monthly PAR reports which were submitted to the central region office of residential services by the fifteenth of the month. The program's PAR rate during the last quarter was .72, which is below the statewide residential PAR rate of 1.29.

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.	

The program has a written policy and procedures regarding pre-service training. The Department's Learning Management System (SkillPro) and five staff training records were reviewed for pre-service training. Three of the five staff completed the required 120 hours of training within 180-days of hire. Each of these three records indicated staff received training in cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), child abuse reporting, first aid, Protective Action Response (PAR), suicide prevention, emergency procedures, Prison Rape Elimination Act (PREA), and professionalism and ethics. All other

training topics required by their contract were also completed, as confirmed through the review of training records and SkillPro. Reviewed documentation also confirmed all instructors were qualified to deliver the provided training. The remaining two staff are still within their 180 days of their hire dates. The program's pre-service training plan for the year 2018 was approved by the Department's Office of Staff Development and Training on January 9, 2018. The program provided a list of staff who are considered in their ratio. They may use case management, clinicians, and kitchen staff to assist with supervision at times, as all have the required trainings.

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.*	

The program has a written policy and procedures regarding in-service training. The Department's Learning Management System (SkillPro) and five staff training records were reviewed for in-service training. Reviewed documentation confirmed staff completed annual training, in excess, of the required twenty-four hours of annual in-service training. The trainings included all topics, with one exception. One of the reviewed staff members did not take the refresher training on the intended and safe use of tools. This exception was a result of this staff member being on leave due a workman's compensation incident, which prevented staff member from completing all training sessions in the calendar year 2017. The staff has not been cleared for full-duty as of the time of the annual compliance review. The training hours for each of the five reviewed staff members were seventy-one, fifty-five, eighty, eighty-three, and seventy-four hours respectively. Two of the reviewed records were for supervisory staff and each of the staff was found to have completed at least eight hours of training in management and leadership. All three licensed nurses were also found to have current certifications in cardiopulmonary resuscitation (CPR), as well as automated external defibrillator training. The program's in-service training plan for the year 2018 was approved by the Department's Office of Staff Development and Training on December 29, 2017. The program provided a list of staff who are considered in their ratio. They may use case managers, clinicians, kitchen staff, teachers, and the business manager to assist with supervision at times, as all have the required trainings.

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

The program has a written policy and procedures outlining the grievance process for youth to address complaints regarding conditions, treatment, services, the actions of the program, and/or violations of basic rights. All youth shall be afforded an opportunity to grieve the actions of staff or youth they perceive as unfair or a violation of their rights. The program believes it is healthy to have a positive means to resolve issues in a non-confrontational manner. The grievance process includes three phases: informal, formal, and appeal. Staff are trained on the process during their pre-service training and annually thereafter. A review of five staff training records

confirmed staff were trained on the grievance process during their pre-service training, and five staff were provided a follow-up grievance training annually during the year 2017. The informal and formal grievance forms were found to be available in the youth dormitory areas. The program uses “411” forms as their informal process. Youth submit these to discuss any concerns they may have, while also indicating who they would like to speak with. The program does their best to handle these the same day as submission, or early the following day. The program requires formal grievances, which they refer to as “youth complaints,” to be processed by administrative staff within seventy-two hours of submission. The final, or appeal, phase will be addressed by the executive director, the director of operations, or a designee within six days of submission. Twenty grievances were submitted during the annual compliance review period. All grievances for the past year were maintained within a binder, separated by month. Five grievances were reviewed. None of the grievances indicated whether the youth used the informal phase prior to using the formal step; however, each was addressed within seventy-two hours by the executive director or director of operations. In each of the situations, the complaint was resolved at this step. A review of all twenty grievances found none reached the appeal phase. Interviews with five youth confirmed the forms can be found at different places in the program. The youth shared they will place the completed form in the grievance box, and then a supervisor will talk to them regarding the concern. All five youth indicated they can ask for help filling out a grievance form. Five staff were also interviewed regarding the grievance process. Each of the staff were very clear about where the forms are placed, and they all knew a supervisor would address them once submitted. Three staff reported youth could ask for assistance in filling out the form, and three also knew there were three phases to the process. Their comments all reflected understanding of the forms being placed in the grievance box to be handled. An interview with the executive director confirmed the grievance process. He indicated youth place completed forms in the grievance box which is just outside of the youth dorms. This box is checked each day by the director of operations. They will then attempt to address with the staff member or youth who caused the concern in order to resolve the issue as quickly as possible.

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.	

The program utilizes Impact of Crime (IOC), Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), and The Council as the delinquency intervention curricula. According to the Department’s Sourcebook of Delinquency Interventions, CYT is listed as an evidence-based intervention, ART and IOC are listed as promising practices, and The Council is listed as a practice with demonstrated effectiveness. CYT and ART are the programs primary services offered to youth. A review of group sign-in sheets confirmed youth identified with priority needs were assigned to these curriculums or will be in one of the upcoming groups. The reviewed documentation also confirmed IOC groups are held with youth selected for this intervention, including youth identified as having gang affiliation. The review of training documentation found each of these staff were trained, by a qualified trainer, to deliver the respective curriculums. IOC and The Council are being facilitated by direct care staff who have over three years of experience working with juvenile offenders. The executive director further indicated they were selected due to their maturity, creativity, knowledge of proper boundaries, their ability to relate to the youth, and past group facilitation experience. ART has been facilitated by the program’s

designated mental health clinician authority (DMHCA) who is also a licensed mental health clinician (LMHC), and CYT is facilitated by a licensed marriage and family therapist (MFT). A review of sign-in sheets, observations of program activities, and a review of the program schedule, found the program is providing structured, planned programming and activities for at least sixty percent of the time youth are awake. An interview with the facility administrator confirmed these services are being provided to address the needs of their youth, as identified through screenings conducted during admission. A review of five youth records found four of the five youth participated in at least one of the delinquency interventions. The other youth had been in the program for approximately a month and will begin a delinquency intervention within the next few weeks.

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 has a policy and procedures in place regarding life skills training provided to the youth. The program provides a wide variety of interventions focusing on the development of life and social skills in youth. The clinical staff facilitate The Prepare Curriculum, Anger Management for Substance Abuse and Mental Health Clients, an Adolescent Coping with Depression Course, Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), and other psychosocial groups. Qualified staff present The Council to youth. A review of staff training records found all group facilitators were trained to deliver their respective curricula. The groups address skills streaming, communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, critical thinking, and problem solving. The reviewed group sign-in sheets confirmed the clinical mental health overlay services groups are held seven days a week, as required by contract. Interviews with five youth confirmed they are attending groups such as CRT, ART, and other social skills groups which have helped them learn anger management and other skills. The youth stated they learned new skills on changing the way they think. They also indicated they role play during the group activities to work on the new skills learned. During an interview, the director of compliance confirmed youth complete roleplaying weekly and are given immediate feedback. A review of five youth case management and mental health records confirmed each youth received services, as outlined in their performance and treatment plans. The reviewed group sign-in sheets also reflected each of these groups had no more than ten youth in any of the sessions, except for CYT, which is allowed to have up to fifteen youth in each session.

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

The program has a written policy and procedures regarding restorative justice awareness for youth. The program provides the Impact of Crime (IOC) curriculum, in addition to community service projects, which helps to increase awareness, and empathy for, crime victims and survivors. The program indicated youth who are identified with gang affiliation are prioritized to participate in IOC before they are discharged. A review of group sign-in sheets confirmed the curriculum was delivered appropriately. A review of training documentation found IOC facilitators were trained by a qualified trainer to deliver the curriculum. The facility administrator

indicated each group of youth who completes IOC are provided the opportunity to complete a community service trip, allowing the youth to give back in the local community. Additional community service projects are completed with local partnerships. The program's compliance manager was able to provide documentation validating a speaker came to talk with program youth about their life experiences. He spoke about his time as a teenager and victimized, and how this affected his life. They also provided information indicating HIV-positive speakers were invited by Metro Wellness to share their personal histories of victimization which led to them getting to this point in their life. At the time of the annual compliance review, two youth were working at McDonald's and another youth was working at the Dollar Tree. These experiences are allowing them to learn important employment skills, while also earning money they can use to pay restitution to make their victim's whole.

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

The program has a written policy and procedures regarding gender-specific programming. The program provides The Council as their gender-specific curriculum, as required by their contract. This curriculum is a strengths-based group approach which promotes boys' and young men's safe and healthy passage through pre-teen and adolescent years. The program utilizes "Living a Legacy: A Rite of Passage," which is a ten-week course for young men ages fourteen to eighteen. These curriculums were facilitated by two staff during this annual compliance review period. A review of each of their training records confirmed each of the staff was certified as a facilitator for The Council. A review of sign-in sheet documentation, in addition to a review of the daily activity schedule, confirmed is the group was offered on a regular basis. The nursing staff also present health education topics to the youth on testicular self-examinations and how their body adjusts through adolescence. During his interview, the executive director confirmed the program's use of The Council as their gender-specific programming, which is offered to all youth.

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

The program has a written policy and procedures addressing the internal alert system and alerts entered into the Department's Juvenile Justice Information System (JJIS). A review of five youth individual health care records, five mental health and substance abuse records, and five youth case management records indicated all youth with applicable alerts relating to mental health, suicide risk, medications, special diet, allergies, no strenuous activity, and gang member/gang association were entered into JJIS, with one exception. One youth required a sports restriction alert to be entered into both the internal alert system and JJIS; however, the alert was only

entered into the internal alert system. An interview with the executive director, and a review of the program's policy and procedures, found clinical staff downgrade suicide risk or other mental health alerts, medical staff downgrade health conditions or situations which no longer exist after verification, and administration or the on-site supervisor downgrade security alerts.

The program has a policy regarding the implementation and use of an internal alert system. The policy indicates, "Information concerning the youth, staff, and public safety will be communicated to the staff using a continually updated internal alert system which is easily accessible to program staff and keeps them alerted about youth who are security or safety risks." The alert system includes one white-board, which is maintained in the conference room where shift briefings are conducted. The whiteboard was found to contain key alert information, including youth who are a security or safety risk, youth with health-related concerns, youth with food allergies or special diets, and youth with suicide or mental health alerts. The alert board is updated when a youth enters the program and immediately, whenever any changes happen during a youth's stay. A review of five youth healthcare records, five mental health and substance abuse records, and five case management records indicated all applicable youth alerts were placed on the program's internal alert board. The program also maintains a full alert list and an allergy list in a binder, in the conference room. The alert boards and binder information are reviewed at each shift briefing. Reviewed documentation and observations reflected the internal alert information is shared with all staff at each shift briefing. Five staff were interviewed and each reported youth alert information is shared at shift briefings, where they review the alert binder and they review the white-board. An interview with the executive director confirmed the practices which were observed during the annual compliance review. Applicable alert information, and changes when appropriate, were found during a review of the program logbooks.

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

The program has a written policy and procedures regarding the maintenance of youth records. The program maintains an individual healthcare record, an individual mental health/substance abuse record, and an individual case management record for each youth in the program. The reviewed records for five youth were marked as "confidential" and secured in locked file cabinets also marked "confidential," inside offices, which were locked when not occupied. The tabs on each youth management record included the youth's name, Department identification number (DJJID), date of birth, county of residence, and committing offense. Each case management record was divided into five sections with separate tabs for legal, demographics, correspondence, case management, and miscellaneous.

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

The program has a written policy and procedures regarding youth input. The program provides many avenues for the youth to provide input about the program. The program utilizes weekly community meetings for each dorm, which are run by the dorm's youth mayor and youth assistant mayor. In these meetings, the youth voice concerns regarding the program, as well as

make suggestions for things they would like to see happen in their "community." The program also has a youth advisory board which consists of the youth mayor and youth assistant mayor from each of the three dorms. They meet each month with the assistant facility administrator and the social skills coordinator. A review of the meeting minutes and sign-in documentation reflected the youth advisory board has met monthly for the past six months. The reviewed documentation reflected the youth provide input regarding what types of items are offered as rewards, different incentives which should be offered for youth, and sharing ideas about different types of off-campus activities. The youth can also use the "conference request" forms to address concerns they have with specific program staff at any time. Each of the five interviewed youth indicated the program has a process for them to provide input about what happens in the program. Each specifically mentioned the monthly advisory board meetings. The facility administrator was also interviewed. He spoke of the weekly community meetings on each dorm and the youth advisory board which allows for the youth to voice their concerns about the program and make suggestions on how to improve the program.

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 written policy and procedures regarding the advisory board. A review of documentation found the program held quarterly advisory board meetings on February 8, 2018, May 10, 2018, and August 11, 2018. A review of the sign-in sheets and meeting minutes confirmed the advisory board included members from the business community and school board, community partners, and a victim advocate. The program was able to provide documentation reflecting recruitment of a faith community member, a member of the judiciary, the parent/guardian of a former resident, and a member of law enforcement for the board. They hope to have a former Judge and the parent/guardian of a former resident become official members at the next board meeting. An interview was conducted with the chair of the advisory board who indicated they are very involved and shared what the board has worked on at the program. He indicated, since the last annual compliance review period, the board has implemented a new vocational program in small engine repair. He also stated they implemented a new initiative called "Red Day." "Red Day" is a partnership with local organizations and companies, who donate time and services to the program. The most recent result of a "Red Day" was the fresh update of the exterior of the program buildings with paint, which was provided by the local Sherwin Williams.

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

The program has a written policy and procedures regarding program planning. The program holds monthly staff meetings, where information from surveys and reports are shared. Reports shared at these meetings included the previous annual compliance report and the most recent Comprehensive Accountability Report. The surveys and statistical information are used to guide trainings and program direction to improve upon the services offered, and in how to better respond to youth. Reviewed documentation found the program presents anniversary awards, provides tuition assistance, and staff incentives for exemplary performance in an effort to minimize staff turnover. The program also holds weekly management meetings. Information and changes which arise from these meetings are presented to staff during monthly staff meetings. Five staff were interviewed. One staff said the sharing of information is very good, three said it

was good, and one said it was fair. The comments from staff indicated communication could improve. Staff indicated things are shared at shift briefings and staff meetings and they are able to provide feedback and give input at these times. The executive director indicated they go over scenarios related to specific situations to work together better as a team. He also stated they use the information gained from surveys and Department reports to motivate staff and highlight how they compare statewide with other similar programs.

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

The program has a written policy and procedures regarding staff performance. Staff are given a ninety-day evaluation after hire and annually thereafter. A review of performance evaluations found they were completed annually for each staff during July or August. The performance standards were reviewed for six different positions which were found to match the job duties found in the respective position descriptions. The program has position descriptions for all contractually required positions. When a staff member facilitated a group curriculum, this was included in their annual evaluation, to include an evaluation of the facilitator skills and abilities. The facility administrator indicated they attempt to complete all evaluations to coincide with their fiscal calendar, which runs from July 1-June 30. Three of the five interviewed staff confirmed they receive an evaluation annually. The remaining two staff had not been there for an entire year; however, both indicated they received an evaluation after being there for ninety days.

Standard 2: Assessment and Performance Plan

Overview

Youth Environmental Services has two case managers who are responsible for providing case management services to all program youth. Services provided by the case manager include initial contact with the parent/guardian, orientation of the youth to the program, and notification to the court of the youth's admission to the program. Other responsibilities include completion of the Youth Needs Assessment Summary (YNAS), Residential Positive Achievement Change Tool (R-PACT), reassessments, development of the performance plan, facilitating formal and informal treatment team meetings, completing performance summaries, and transition planning. The case manager is a member of the program's multidisciplinary treatment team and serves as the treatment team leader. The team meets formally and informally once a month to discuss each youth's progress in the program. The program also has a career coordinator, with funding from the Department of Education, who assists with building business partnerships in the local community for program youth to obtain employment. The program also employs a transition case manager who oversees the youth's completion of goals and objectives during the transition phase prior to release.

2.01 Initial Contacts to Parent/Guardian and Court Notification	Satisfactory Compliance
The program notifies the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, by written notification within forty-eight hours of admission, and notify the youth's committing court, assigned juvenile probation officer (JPO) and post residential services counselor (if applicable) in writing within five working days of any admission.	

The program has a policy and procedures to address initial contacts to parent/guardian and committing court when a youth is admitted to the program. Five case management records were reviewed. In all five records, the youth's parent/guardian, committing court, juvenile probation officer, and post-residential counselor were notified by telephone and in writing, within twenty-four hours of admission. One of the five youth had involvement with the Department of Children's and Families (DCF) and notification was sent to the assigned counselor on the same day 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.	

The program has a policy and procedures to address the orientation of youth to the program upon admission. The procedures outline all required orientation topics and describes how each youth receives the information/materials. Five case management records were reviewed and each record contained a copy of the Student Orientation Acknowledgement Form signed by the youth and staff on the day of admission. The list indicates twenty-six topics which were discussed with and explained to the youth. The youth initialed a line next to each topic indicating they received the information. The list does not indicate the community access process was explained to the youth; however, it does state the youth handbook, which describes this process, is provided to the youth. Observations of the orientation process during the annual compliance review found a high-ranking youth in the program's behavior management system

was selected to sit with the new youth and case manager during the orientation process to review every page of the youth handbook and answer questions from a youth's perspective. In accordance with their policy, the youth's admission was documented in the logbook and the youth's case record. Five interviewed youth stated orientation to the program began on the same day of admission and they were able to provide examples of topics reviewed during this process.

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

The program has a policy and procedures to describe the process of obtaining written consent of any youth eighteen years of age or older before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment. Five case management records were reviewed and two were applicable to this indicator. The program provided two additional records for review. Each of the four youth were admitted to the program at the age of eighteen and all records contained a signed consent, signed on the day of admission, to release case management, medical, and mental health information to a parent/guardian.

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 has a policy and procedures for the classification of youth and their reassessment/reclassification when warranted. The system promotes safety and security, as well as effective delivery of treatment services based on each youth's individual needs and risk factors. After each department (mental health, medical, security, and case management) complete their admission process/screening(s) of the youth, results are provided to the case manager and a Placement Evaluation Admission Classification (PEAC) form is completed. The program has two open-bay living units. They try to avoid putting more than one new youth in the same living unit, and new youth will always be assigned a bunk bed in one of the most visible areas of the unit available. Five case management records were reviewed. All records contained a PEAC form which addressed all required factors and the results of initial screenings. Two of the five forms did not include past or present legal offense information and two did not indicate if there was a need for the executive director to review the youth's admission packet information. One form did not reflect results of the youth's Vulnerability to Victimization and Sexually Aggressive Behavior screening. The policy indicates youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or

instruments which may be used as potential weapons or means of escape, or participation in an off-campus activity. Three of the five youth records in this sample were applicable for risk reassessment/reclassification. All three youth had an increase in privileges, and participation in work projects or off-campus activities. All of the records contained a reassessment of risk form which showed which activity the youth was approved for by the treatment team. The program's alert board is in the administration building's conference room. This board is continually updated and accessible to all program staff. Upon observation, the alert board correctly matched all alerts in the reviewed records. An interview with the executive director validated the program's practice.

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.	

The program has a policy and procedures to address the notification to law enforcement for all youth with suspected criminal gang activity. A gang affiliation questionnaire is administered to each youth on the day of admission to assess their level of gang affiliation. Information gained through this questionnaire will be used in the classification process and shared with staff to include education. If the youth does not have a previous alert in the Department's Juvenile Justice Information System (JJIS) for gang affiliation/membership, then the information will be sent to the juvenile probation officer (JPO), local law enforcement, and the youth's hometown law enforcement office. None of the five case management records reviewed were applicable for gang activity. The program provided an additional three records for review. All three youth were identified as having suspected gang affiliation post-admission. The program mailed a letter to each youth's home county law enforcement agency and a letter to the local Hillsborough County Sheriff's Office. During routine contraband searches, one youth was found in possession of gang related graffiti/drawings. The drawings were sent to the local sheriff's office and an officer verified to the case manager the drawings were gang related. Gang notification for one youth was made within a week and a half after the youth was admitted to the program.
The alert in JJIS was entered two days after the identification was made. One youth was admitted to the program on June 28, 2018. The notification to law enforcement and the alert in JJIS was not completed until September 9, 2018, three months later. There was a second youth who was admitted to the program on February 22, 2018. The alert in JJIS was completed on May 18, 2018; however, the notification to law enforcement was not sent until September 9, 2018. The notification to law enforcement was sent four months after the youth was identified as having gang affiliation. All three notifications sent to law enforcement occurred five days or less prior to the annual compliance review taking place. Two notifications were sent on September 6, 2018, and the third notification was sent on September 9, 2018. The intent of Florida Administrative Code 63E-7.013(8) is not met when JJIS alerts and law enforcement notifications are completed several months after a youth had been identified as having gang involvement. All records verified information on the youth's gang status was shared with the educational provider, the JPO, and the post-residential counselor, if applicable.

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

The program has a policy and procedures to address the gang prevention and intervention strategies when youth are identified with gang affiliation. The policy indicates identification of youth to participate in gang prevention or intervention activities shall be based on information obtained through the program's screening, assessment and classification processes, as well as observed behaviors while in the program. The case manager administers a gang affiliation assessment/questionnaire to each youth at admission to identify the youth's level of gang affiliation/membership. The policy and procedures indicate the Impact of Crime (IOC) curriculum is used as a prevention strategy within the program. If a youth is identified as a gang member or as having an affiliation with gangs, the program must provide some type of intervention such as gang court, intervention classes, or guest speakers. Additionally, the youth's individual performance plan (IPP) should include a goal and objectives relating to their interventions, which must be completed prior to their release. None of the five reviewed records were applicable for this indicator; therefore, the program provided three additional records for review. All three youth had a goal on their IPP which indicated they would refrain from gang activity while in the program. One of the three youth completed IOC and the other two are scheduled to participate in the next IOC cohort. The program provided documentation of intervention strategies conducted by Determined to Learn and Develop (DLD) Enterprises. DLD provided a guest speaker to facilitate group sessions from the Altitude of Greatness (AOG) curriculum at least nine times since the last annual compliance review. Part of this curriculum's objective is to provide instruction to youth on life without gangs. This curriculum is used as part of the program's intervention strategies.

The program's policy indicates a local gang liaison will provide a gang class to identified/suspected gang members quarterly. According to the program these classes do not occur under the advisement of the program's local gang liaison with the Hillsborough County Sheriff's Office (HCSO). Two HCSO deputies came to the program in November 2017 and gave basic gang awareness training to staff at their all-campus meeting. So far this year, the program has thirty-eight staff who have completed gang awareness training in the Department's Learning Management System (SkillPro). The program provided documentation to show their attempts to schedule another training with HCSO in 2018; however, a time/day has not been set.

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

The program has a policy and procedures to ensure each youth receives an initial Residential Positive Achievement Change Tool (R-PACT) Assessment within thirty-days of admission and a reassessment every ninety-days thereafter. Five case management records were reviewed. An initial R-PACT Assessment was completed within thirty days in all five records, with one

exception. One youth's assessment was completed five days late. Four of the five youth were applicable for reassessment(s). Each of the youth had one reassessment completed within this annual compliance review period and all four were completed beyond the ninety-day required timeframe. The assessments were completed two, three, five, and eleven days late. All assessments and reassessments were completed in the Department's Juvenile Justice Information System (JJIS) and copies were maintained in the youth's record.

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

The program has a policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed for each youth within thirty-days of a youth's admission. Five case management records were reviewed, and each record had a YNAS which was completed within thirty days of the youth's admission, with one exception. One YNAS was completed six days late and was not signed by the case manager. Each YNAS was documented 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.*	

The program has a policy and procedures requiring the intervention and multidisciplinary treatment team to develop each youth's individualized performance plan (IPP) within thirty days of admission. Five case management records were reviewed, and each IPP was developed by the treatment team within thirty days of admission, with one exception. One youth's IPP was completed six days late and was not signed by the living unit representative. All IPPs were based on findings of the initial assessments. Each youth's plan was developed by the treatment team and included individualized and measurable goals for the youth to achieve prior to release from the program. All goals are based upon the prioritized needs reflecting the risk and protective factors identified in the Youth Needs Assessment Summary. The five IPPs contained target dates for completion of each goal, the youth's responsibility to accomplish the goal, and the program's responsibilities to help the youth achieve the goal. All five plans included goals which target the youth's top three criminogenic risk factors identified by the Residential Positive Achievement Change Tool (R-PACT). None of the four plans were signed by the parent/guardian. A letter was mailed out at admission asking for their input in the event they would not be able to attend the scheduled meeting. Within ten days of completion, a copy of each youth's IPP was mailed to the committing court, the youth's juvenile probation officer,

Department of Children's and Families (DCF) Counselor, if applicable, and the parent/guardian. Each plan was mailed to the parent/guardian and DCF counselor with a request to sign and send back the signature page. Five interviewed youth confirmed they participated in the development of their IPP. Each verified they received a copy of their plan, and four were aware of the goals they are currently working on.

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

The program has a policy and procedures to address revisions to a youth's individualized performance plan (IPP) when determined necessary by the intervention and treatment team. Revisions are to occur when new criminogenic needs are identified during the Residential Positive Achievement Change Tool (R-PACT) reassessment, when the youth demonstrates progress or lack of progress toward completing a goal, or when new information is acquired or revealed. Five case management records were reviewed. Four of the five youth were eligible for IPP updates due to progress/lack of progress, completion of goals, and/or changes in goal target completion dates. This was discovered through a review of incident reports, and other documentation which had been submitted to the treatment team. None of the four plans required updates based on R-PACT reassessment results. There was no documentation in any of the records to show the IPPs were updated in the Department's Juvenile Justice Information System (JJIS) when goals were completed, added, or continued; however, the lead case manager was able to show where she was entering notes on JJIS in an alternate location.

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

The program has a policy and procedures which address the requirements for completion of performance summaries every ninety days, beginning from the signing of the youth's performance plan, or at shorter intervals when requested by the committing court. Additionally, the treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program. The performance summary is a vehicle to inform the youth, parent/guardian, juvenile probation officer (JPO), and other parties of the status of each performance goal and describe the youth's overall adjustment to and performance in the program. Three of the five active case management records were applicable for the completion of performance summaries and transmittals. The readiness to change or level of motivation was not clear in one of three summaries reviewed. Two of the three summaries did not mention significant positive/negative events which occurred over the review period. Each of the three summaries provided a brief statement in each category/section. None of the summaries listed the youth's performance in each educational class subject, to include grades. Each reviewed performance summary was completed within ninety days and contained the youth's comments

and all required signatures. The original summary was filed in each of the reviewed records. All of the summaries were mailed to the required parties within ten days of completion.

Three closed case management records were reviewed for release summaries. All three records contained a copy of the summary, with the original sent to the JPO. All three Pre-Release Notifications (PRN) and summaries were sent to the JPO at least forty-five days prior to the youth's anticipated release date. All three summaries had clear documentation for justification for release. The program notified the parent/guardian, in writing, the youth's release was approved in two of the three records. In the remaining record, the parent was not notified in writing due to the last-minute PRN approval provided by the committing court. Documentation in each youth's record did not indicate youth received a copy of their performance summary. Five youth were interviewed, and two of the three applicable youth indicated they did not receive a copy of their performance summary.

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

The program has a policy and procedures requiring the program to make every effort to include parents/guardians in the case management process. On the day of admission, the case manager mails each parent/guardian a welcome letter which includes the date and time of their youth's entry meeting. This meeting is to discuss the needs assessment and create the individualized performance plan (IPP). Five case management records were reviewed, and two youth were over the age of eighteen and not applicable for parent/guardian involvement. In all three applicable records, documentation revealed attempts were made to include parents/guardians in the formal treatment teams and transition planning. Two of the three records did not document attempts to include the parent/guardian in the development of the IPP. Treatment team meetings for four youth were observed during the annual compliance review and an attempt was made in each meeting to contact the youth's parent/guardian by phone; only one parent was available to participate. In his interview, the executive director indicated the program reaches out to parents/guardians at admission and notifies them of the needs assessment meeting to determine goals for the program. Parents/Guardians are also encouraged to visit their child monthly during visitation, in addition to participating in the monthly treatment team meetings. Three closed youth records were reviewed, and all records documented parent/guardian participation in the transition planning process.

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

The program has a policy and procedures to address the members of treatment team. Case managers are identified by the program to be the treatment team leader. The program's multidisciplinary treatment team members consist of the case manager/treatment team leader, youth, representatives from program administration and the youth's living unit, mental health treatment staff, education staff, medical staff, and, when applicable, the career coordinator and transition case manager. When applicable, the team also includes the youth's parent/guardian, the Department of Children and Families (DCF) counselor, and the juvenile probation officer (JPO). Five case management records and fifteen formal treatment team review forms were

reviewed. All of the review forms documented the participation of required treatment team members and all attempts to contact the JPO, DCF counselor, and/or parent/guardian were documented in the few occasions when each was not able to participate by phone. Treatment team meetings for four youth were observed during the annual compliance review and an attempt was made in each meeting to contact the youth's JPO and parent/guardian by phone. The JPO participated in three of the four meetings and parents/guardians participated in one of the four meetings. A representative from the youth's living unit was not present during any of the meetings; however, the director of operations was able to report on the required information, although he was attending the meeting as a representative of program administration.

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 reviewed case management records documented the incorporation of the youth's treatment and education plans into the individualized performance plan (IPP). One youth record was applicable for involvement with the Department of Children's and Families (DCF); however, there is no indication of a case plan needing to be referenced or incorporated. None of the records were applicable for current behavior support plans or case plans through the Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Limited 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.*	

The program has a policy and procedures requiring the intervention and multidisciplinary treatment team to meet every thirty days to formally review each youth's performance, to include Residential Positive Achievement Change Tool (R-PACT) reassessment results, progress on individualized performance and treatment plan goals (IPP), positive and negative behavior, including behavior which resulted in physical interventions. Additionally, the case manager/treatment team leader will conduct bi-weekly informal reviews of each youth's performance. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed. In the four applicable records reviewed, documentation revealed a total of thirty-one formal and informal treatment teams were completed, with one exception. One youth's record was missing an informal treatment team form for the month of August. Each reviewed performance plan included the youth's name, date of review, reports from treatment team members, and reassessment results. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were encouraged to participate, and were notified in advance. In all instances of when the youth's JPO, parent/guardian, or other pertinent parties were unable to participate in person, they were invited to participate by telephone or provide written input. Reviewed documentation confirmed treatment team meeting attendees consisted of the youth, case manager, therapist, education,

nurse, and representatives from program administration and the youth's living unit. When applicable, Department of Children and Families (DCF) staff attended treatment team meetings by telephone. Progress review statements for goals on each review form were almost identical from month to month. There was little variation in the reports of progress on goals from month to month, even if the goal being reviewed in the month was different. Objectives for goals sometimes have "continued" written on the form; however, there is no documented/reviewed reason for a goal being continued nor was the new projected target completion date provided. None of the reviews documented negative events or behaviors. One youth's review form did not mention a fight he had earlier in the month and another youth's review form did not indicate his failing grades or negative school behavior as reported by education staff. Four formal treatment review/team meetings were observed during the annual compliance review. The treatment team asked the youth what goals he was currently working on and what examples he could give to show he has made progress. The youth then asked each treatment team member for their input on his progress. The treatment team was very supportive with each youth and emphasized the positive aspects of the youth's behavior and treatment progress. Five youth were interviewed, and four indicated they have been given the opportunity to demonstrate learned skills at treatment team meetings. One youth indicated he had not had a treatment team meeting yet.

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

This program provides career education programming which includes communication, interpersonal, and decision-making skills. This program is a Type 2 program offering English, Math, Science, Social Studies, and one elective course. The elective course offers vocational training opportunities to youth. Youth can participate in vocational training programs funded through the Department of Education. Prior to July 1, 2018, the program was funded by the Department of Labor. To be eligible for vocational programming, each youth must maintain passing grades in all classes, display appropriate behavior, and actively participate in classroom projects.

During an interview, the lead teacher stated each youth's workplace readiness is assessed through the completion of learning style inventories, interest profiles, and assessment plans. Assessments offered to youth include the STAR Renaissance testing for reading and math, Worldwide Interactive Network Inc. (WIN) Common Assessment, and the My Career Shines career interest inventory. Career education services offered to youth include: Safe Staff Food Handler Certification and the National Center for Construction Education and Research (NCCER) Core Carpentry Certification. Youth who qualify can move past the NCCER Core curriculum class and participate in the hands-on carpentry vocational program. The program has a career coordinator to prepare youth for job readiness and employment opportunities within the program and after release. The program has agreements with the local Dollar Tree store and McDonalds to employ qualified program youth while they are in the program. While the youth work off-site at one of these locations, a staff member is always there to provide sight and sound supervision. Each working youth receives their paycheck on a debit card, which they are given once they leave the program. Even if the youth does not qualify to work off-site, the career coordinator will work one-on-one with all youth to develop a resume and work on interview skills. The career coordinator maintains all information to include in each youth's exit portfolio. Additionally, there are certifications of youth posted in appropriate/applicable areas. Information is shared with treatment team members through monthly youth treatment team meetings. The program has a transition case manager who is responsible for overseeing

activities to be completed when youth enter the transition phase of the program and prepare for release.

Three closed case management records were reviewed. All youth had a performance plan goal focusing on employability. All records contained samples of completed employment applications, a resume, and appointments with the Career Source Center. Records also included appropriate documents to obtain employment (State of Florida identification card, social security card, and/or vocational certifications) and documentation of the parent/guardian and juvenile probation officer's awareness of the youth's exit, vocational, and/or educational plans. An interview with the executive director validated the program's practice.

2.17 Educational Access	Satisfactory Compliance
The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The program contracts with the Hillsborough County School Board (HCSB) to provide educational services. Educational services are provided on a year-round basis. Instruction to youth is provided five days a week, 250 days a year, and distributed over twelve months. An interview with the lead teacher indicated ten days may be used for teacher training and meetings, if needed. The master program schedule indicates 300 minutes of education instruction is provided each day. The youth are provided with face-to-face instruction and receive credit for mathematics, English, reading, social studies, science, and vocational education. A review of the program's daily schedule and logbooks for six months prior to the annual compliance review indicated educational instruction was rarely interfered with and this was confirmed by the lead teacher. Five youth were interviewed about educational access and they all indicated their education is rarely interrupted.

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.	

The program has a policy and procedures to address the completion of an education transition plan upon entry and address services to be provided during the program stay and services to implemented upon release, including but not limited to, continuing education and/or employment. Three closed case management records were reviewed. All records included a transition plan which was developed at the time of admission and included the youth's post-release goals. Each record contained the recommended educational placement post-release. The plan documented specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services. The lead teacher indicated, if applicable, the education transition plans include referrals for exceptional student education (ESE) services or other interventions necessary to assist youth in their transition post-release.

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

The program has a policy and procedures to ensure the treatment team plans for the youth's successful transition to the community upon release from the program. Two of the five reviewed youth records were applicable for transition planning, conferences, and Community Re-Entry Team (CRT) meetings; therefore, two additional closed records were reviewed. All of the records indicated the transition conference was conducted at least sixty days prior to the youth's release, as required. All required participants were invited to participate by telephone or in person. Reviewed documentation indicated a letter of notification was mailed to all required parties. If participation could not be arranged, the parties were invited to provide verbal or written input prior to the meeting. The reviewed records contained documentation which reflected the youth, case manager/treatment team leader, transition case manager, executive director/designee, mental health and career coordinator, the youth's juvenile probation officer (JPO), parent/guardian, and education staff participated in each transition conference. The treatment team leader obtained all signatures of parties attending and by telephone. A copy of the plan was sent to anyone not in attendance with a request for returned signature on the document. A return e-mail acknowledging the JPO's receipt and review of the transition plan was printed and filed in each record with the plan. Each transition plan included appropriate goals and end dates for the youth's release back into the community. Documentation in both closed records indicated the program received an invitation, by email, to participate in the youth's CRT by phone. The CRT meeting was separate from the transition and exit meetings and all meetings were conducted prior to the youth's release. Participation of both youth in CRT meetings was documented in the program's chronological notes or a copy of the JPO case notes.

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

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed, and each contained an exit portfolio which was discussed and initiated at the youth's transition conference. The exit portfolio contained the following items, as applicable: a social security card, birth certificate, state-issued identification card, copy of the youth's transition plan, vocational certificates earned in the program, educational record/transcripts, a completed job application, résumé, and a calendar with follow-

up appointments in the community to include dates, times, and locations. Reviewed documentation confirmed educational staff forwarded exit portfolio information to the receiving school board and program staff sent a copy to each youth's juvenile probation officer. Documentation indicated all three youth were given a copy of the exit portfolio upon release.

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

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed, and all records revealed an exit conference was conducted at least fourteen days prior to the day of release, as required, and each were conducted after the program notified the juvenile probation officer (JPO) of the youth's projected release. The records documented all participants dated signatures and a summary of pending transition goals. Documentation revealed exit conference participation, with minor exception, by the intervention and treatment team leader, parent/guardian, educational representative, JPO, youth, and other pertinent parties, in person or by telephone. In one youth's conference, the parent/guardian and JPO were not able to participate; however, documentation shows both parties were invited to the conference ahead of time. The case manager contacted both participants after the meeting to provide a review. For each youth, the date of admission and date of release matched the dates entered into the Department's Juvenile Justice Information System (JJIS).

Standard 3: Mental Health and Substance Abuse Services

Overview

The program provides mental health and substance abuse services to the youth at the program with a focus on mental health overlay services, which ensures each youth receives mental health services daily. The program's clinical team consists of a designated mental health clinician (DMHCA), a licensed mental health counselor, and three non-licensed clinicians. The program's clinicians provide mental health groups, substance abuse groups, individual counseling, family counseling, behavioral therapy, psychosocial skills, supportive counseling, admission screenings, and comprehensive evaluations, as well as suicide services to the youth at the program. As part of the program's contractual requirements, the program provides the youth with the opportunity to participate in off-site Alcoholics Anonymous and Narcotics Anonymous (AA/NA) meetings once a month. The program contracts with a licensed psychiatrist to provide psychiatric services to the youth at the program and to conduct initial psychiatric evaluations, monthly medication monitoring, and follow-up psychiatric evaluations. The psychiatrist is on-site bi-weekly to provide the above listed services to the youth at the program and is available twenty-four hours a day, seven days a week for consultation.

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

The program has a policy and procedures in place indicating the program shall have a designated mental health clinician authority (DMHCA) or a clinical coordinator who is required to be on-site weekly. The policy also indicates the program's DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. The program has identified a licensed mental health clinician (LMHC) as the program's DMHCA. The DMHCA has a back-up LMHC who covers when the DMHCA is on leave. A review of the Florida Department of Health Medical Quality Assurance Search website indicated the DMHCA has a clear and active license in the state of Florida. An interview with the DMHCA indicated they are on-site weekly and they review and sign weekly progress notes completed by the three non-licensed clinicians, conduct treatment planning, assessments of suicide risk (ASR), follow-up ASRs, quarterly reviews of treatment records, and conduct weekly supervision with non-licensed staff. The DMHCA also indicated they maintain a caseload and currently have two youth on their caseload. The DMHCA reported they provide groups, individualized treatment, family therapy, and meets with the psychiatrist twice a month to provide updates on youth receiving psychiatric services. A review of the DMHCA's sign-in log for the six months prior to the annual compliance review confirmed the DMHCA or the back-up LMHC were on-site weekly, as required by the contract.

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

The program has a policy and procedures in place addressing the program's contractual requirement to have at least one licensed professional on-site five days a week. The program has one additional licensed mental health clinician (LMHC) other than the designated mental health clinician authority (DMHCA) who is contracted to provide coverage for the other DMHCA. A review of the Florida Department of Health Medical Quality Assurance Search website indicated the LMHC has a clear and active license in the state of Florida. The program also contracts with a licensed psychiatrist. A review of the Florida Department of Health website revealed the psychiatrist's license is also clear and active in the state of Florida.

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

The program has a policy and procedures in place indicating 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 policy further indicates all non-licensed staff shall receive direct supervision from a licensed professional on a weekly basis and master's-level staff who perform assessments of suicide risk (ASR) shall have twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The program holds a regular license in accordance with Chapter 397, Florida statutes to provide substance abuse services to the children and adolescents for outpatient treatment. The license is valid through February 28, 2019.

The program has three non-licensed clinicians who provide regular mental health and substance abuse services to the youth in the program. A review of each clinician's personnel records revealed one of the clinicians has a Master of Science in a human services field and is a certified prevention professional (CPP), and the other two clinicians have master's degrees, majoring in marriage and family therapy. A review of each non-licensed clinician's training record revealed they each had twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training also included the administration of at least five ASRs conducted under the supervision of a licensed professional.

A review of the program's clinical supervision binder for the six months prior to the annual compliance review indicated all three non-licensed clinicians received weekly supervision, when they provided services to the youth, from the designated mental health clinician authority, who is a licensed mental health clinician. Weekly documentation included the date the supervision was held, time and hours the supervision was provided, names of clinicians in attendance, signatures of the attendees, and the signature of the licensed professional who provided the supervision. The weekly supervision documentation also contained a summary of the

supervision sessions, instructions and directions to the clinicians, and a review of sample treatment or summary notes.

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

The program has a policy and procedures in place indicating each youth will receive a mental health and substance abuse screening upon admission to the program. The needs of the youth are identified through a comprehensive screening process and referrals are made when youth have identified mental health and substance abuse needs or a possible suicide risk is identified. The program uses the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and a comprehensive review of each youth's commitment packet, which includes a review of prior suicide alerts, completed Positive Achievement Change Tool (PACT) assessments, PACT Mental Health and Substance Abuse Screening and Referral form (PACT MHSA), previously completed comprehensive assessments, Suicide Risk Screening Instrument, and probation pre-disposition report, as their primary screening tools. If a youth is identified as having an alert for suicide ideations, prior suicide threats or attempts, hits on the MAYSI-2 or PACT MHSA form, recent losses, or a resent psychiatric disturbance, they are immediately referred for an Assessment of Suicide Risk (ASR). All youth admitted to the program are referred for a new comprehensive evaluation which is to be completed by a clinician with thirty days of their admission.

A review of five youth mental health and substance abuse records revealed all youth had a MAYSI-2 completed on the day of their admission by a trained clinician. All records also contained documentation the clinician conducted a comprehensive review of each youth's commitment packet. All five youth had a program intake screening form for suicide risk and three of the forms indicated the applicable youth had prior alerts for suicide and each youth required an ASR. All five reviewed records documented each youth was referred for a new comprehensive evaluation to be completed within thirty days of the youth's admission.

An interview with the executive director indicated the program uses the MAYSI-2 during the admission process, as well as an ASR, as necessary. The executive director further confirmed the program completes a comprehensive evaluation on each youth within thirty days of their admission.

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

The program has a policy and procedures in place outlining the program's process for the completion of a mental health and substance abuse evaluation. The program's policy indicates each youth receives a new evaluation within thirty days of their admission, as required.

A review of five youth mental health and substance abuse records indicated each youth received a new mental health and substance abuse evaluation completed by a non-licensed

clinician within thirty days of their admission. All five reviewed evaluations were reviewed and signed by a licensed professional within ten days of completion. Each of the evaluations contained the youth's demographic information, relevant background information, behavioral observations, mental status examinations, findings, interviews administered, diagnostic impressions, recommendations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drugs on major life areas, and risk factors of continued abuse of alcohol and drugs. Four of the five evaluations documented the reason for each youth's referral for a mental health and substance abuse evaluation. The program acknowledged the one youth's comprehensive evaluation did not have the reason for the referral documented on the evaluation. All five records contained a signed consent for substance abuse services and a signed consent for release of substance abuse information. One youth record also contained a court order requiring the youth to participate in all mental health assessments.

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

The program has a policy and procedures in place outlining the program's mental health and substance abuse treatment services. The program's policy indicates each youth is assigned to a multi-disciplinary treatment team and the program's clinical staff provides youth with mental health groups, substance abuse groups, individual counseling, family counseling, behavioral therapy, psychosocial skills, and supportive counseling, as necessary.

A review of five youth mental health and substance records revealed all youth were assigned to a multi-disciplinary treatment team upon admission to the program. The documentation reviewed supported each youth's treatment team was comprised of individuals from program's administration, residential living unit representative, mental health, case manager, medical staff, education staff, juvenile probation officer (JPO), the youth, and their parent/guardian.

A review of the five youth comprehensive evaluations indicated all youth had a substance abuse and mental health diagnosis and were receiving substance abuse and mental health treatment services. Each of the records contained a properly executed Authorization for Evaluation and Treatment (AET), a signed Youth Consent for Substance Abuse Treatment form, and a Youth Consent for Release of Substance Abuse Treatment Records form. All five records contained documentation each youth was receiving services from a trained clinician working under the direct supervision of a licensed professional. The clinicians were using a program form entitled Counseling/Therapy Progress Note, which contained all required elements of Department MHSA form 018. A review of all five youth's counseling/therapy progress notes, as well as group sign-in sheets validated mental health groups had no more than ten youth in a group and substance abuse groups had no more than fifteen youth in a group. During the annual compliance review, observations of a mental health group also found there were no more than ten youth in the group. Further review of each of the five youth's progress notes indicated each youth received individual counseling and psychosocial skills training.

An interview with the designated mental health clinician authority (DMHCA) confirmed the program provides mental health groups, substance abuse groups, family counseling, and individual counseling. The DMHCA also indicated the program provides the youth with Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), Impact of Crime (IOC) groups, and Boys Council groups. Five interviewed youth indicated they were each participating in group treatment. One of the five youth indicated they are currently attending ART and another youth indicated they are attending substance abuse groups. Five interviewed staff indicated they do not facilitate mental health or substance abuse groups.

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

The program has a policy and procedures in place outlining the program's treatment and discharge planning process. A review of five youth mental health and substance abuse records revealed all youth had an initial mental health and substance abuse treatment plan developed, signed, and approved by all treatment team members on the day of their admission. All initial treatment plans were completed by a non-licensed clinician and were approved by a licensed professional within ten days of completion. All reviewed treatment plans were mailed to the parent/guardian for signature, and the parent/guardian sent back a signed copy of the plan. Two of the five initial treatment plans included documentation the youth would be seen by the psychiatrist within fourteen days of their admission for an initial psychiatric evaluation.

All five reviewed youth records contained an individualized treatment plan developed with all members of the treatment team except for the youth's assigned juvenile probation officer (JPO). All individualized treatment plans were completed by non-licensed clinicians and were reviewed and approved by the designated mental health clinician authority (DMHCA) with ten days of completion. All master treatment plans were signed by the members of the treatment team, except for the JPO. The parent/guardian participated in the development of the plan by telephone, and this was denoted on the signature line instead of a signature. None of the five reviewed treatment plans indicated the youth required psychiatric medications or services. All five treatment plans documented the prescribed services recommended by the clinician, such as individualized counseling, group counseling, mental health overlay services, family counseling, psychosocial skills counseling, and substance abuse counseling.

A review of all five youth's individualized progress therapy notes indicated all services were provided to each youth as stated in their treatment plans. A review of five individualized treatment plans indicated four were applicable for treatment plan reviews. The four applicable records required a total of sixteen treatment plan reviews which were completed every thirty days following the development of the individualized treatment plan. There was one treatment plan review which was completed in August 2018; however, the date on the top of the review

was dated as July 2018, but all signatures and the counseling progress note indicated the review occurred in August 2018.

Three closed records were reviewed for the completion of mental health and substance abuse discharge plans. All three records contained a completed mental health and substance abuse discharge treatment plan completed on Department MHSA form 011. Each of these plans were completed prior to the youth's exit conference, and reviewed documentation reflected they were discussed during each exit conference. None of the three youth were released on suicide precautions or had an open suicide risk alert at the time of their discharge. All three treatment discharge summaries documented services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by the youth during treatment.

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

The program has policy and procedures in place indicating the program is designated as a mental health overlay services (MHOS) program and provide evidence-based services such as Aggression Replacement Therapy (ART) and Cannabis Youth Treatment (CYT) services. A review of five youth mental health and substance abuse records revealed each youth received services every day they were present at the program. The reviewed records indicated each youth received individual therapy, group mental health and substance abuse services, family counseling, psychosocial skills therapy, and psychiatric services, when necessary. Two of the reviewed records revealed the youth participated in CYT groups and the remaining three youth records indicated the youth participated in ART groups. An interview with the designated mental health clinician authority and the executive director confirmed the program provides MHOS services to the youth at the program.

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

The program has a policy and procedures in place for the provisions of psychiatric services. The program contracts with a licensed psychiatrist who is board certified in child and adolescent psychiatry and forensic psychiatry. A review of the Florida Health's Medical Quality Assurance Search website indicated the psychiatrist has a clear and active license in the state of Florida. The program's policy was reviewed, approved, and signed by the program's designated mental health clinician authority (DMHCA) on August 27, 2018 and the psychiatrist on August 28, 2018. A review of the psychiatrist's contract revealed they are required to be on-site bi-weekly which was confirmed based on a review of sign-in and sign-out logs for the six months prior to the annual compliance review. The contract also specifies the psychiatrist shall be available twenty-four hours a day, seven days a week. An interview with the psychiatrist confirms they are available twenty-four hours a day, seven days a week and is on-site bi-weekly. The interview with the psychiatrist indicated they are responsible for the coordination and implementation of psychiatric services at the program and they specifically conduct initial psychiatric evaluations,

follow-up assessments, referrals for additional services (as necessary), monthly medication monitoring, and twenty-four hour consultations.

A review of five mental health substance abuse records revealed one youth was referred for an initial psychiatric evaluation. The program provided three additional applicable records for review. All four applicable records revealed each youth received an initial psychiatric evaluation within fourteen days of their admission. Three of the four reviewed records indicated the youth were continued on the medications they entered the program on and the fourth youth was not prescribed any medications as a result on the evaluation. All initial psychiatric evaluations contained the youth's medical, mental health and substance abuse history, a mental status examination, a diagnosis based on the Diagnostic and Statistical Manual of Mental Disorders (DSM) - V, and treatment recommendations. Three of the four records documented the medications the youth was prescribed, an explanation of the need for the psychotropic medication, the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, frequency of medication monitoring, and risk and benefits of taking the medications. All four initial evaluations were completed on the Department form entitled Clinical Psychotropic Progress Note (CPPN) and had all required pages. Two of the four initial evaluations clearly identified the evaluation was the initial diagnostic psychiatric interviews. The remaining two initial evaluations indicated in the narratives the psychiatrist was conducting a follow-up assessment; however, the documentation in each youth's record revealed it was the initial evaluation.

Three of the four initial psychiatric evaluations indicated the youth were continued on the medications they were taking upon admission and one of the youth received an additional psychiatric medication from the completion of the evaluation. There was documentation in the youth's record indicating the parent/guardian was contacted for consent for the youth to take the newly prescribed medication. All three reviewed records where the youth were taking medications required the youth to be seen by the psychiatrist for medication management at a minimum of every thirty days. A review of the three applicable records revealed there should have been ten instances of medication management for the applicable youth. There was documentation in each of the youth's records the psychiatrist completed medication management reviews with each youth every thirty days. One of the ten instances indicated a youth's medication was increased and the third page of the CPPN documented the youth's parent/guardian consented to the medication change and the parental consent was witnessed by two program staff. An interview with the psychiatrist and the DMHCA confirmed the program does not have any standing orders for psychotropic medications or emergency treatment orders for psychotropic medications.

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 comprehensive plan for mental health and substance abuse services, suicide prevention, crisis intervention, and emergency care. The purpose of the plan is to ensure all youth receive efficient and effective services while admitted to the program. The plan also indicates it is imperative each youth's need for mental health and substance abuse services, ranging from moderate to acute emotional distress, chronic mental illness, or substance abuse impairment, are met. The program's suicide prevention plan includes all required components, as required. The suicide plan specifically addresses identification and

assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. The plan was last reviewed and approved by the program's executive director and designated mental health clinician authority on July 3, 2018.

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

The program has a policy and procedures in place outlining the program's suicide precautions and the methods used for supervising, observing, monitoring, and housing for youth identified through screenings, review of available information, or staff observations as having suicide risk factors.

A review of five mental health and substance abuse records indicated three of the youth were applicable for suicide prevention services. All three youth were applicable for suicide prevention services during their initial admission screening. One of the three youth received additional suicide prevention services upon their return to the program after a stay in a juvenile detention center for two days for a court hearing; therefore, there were four total instances of suicide prevention services.

A review of the four instances of youth being at risk for suicide included documentation all youth were placed on precautionary observations (PO) and were referred for an Assessment of Suicide Risk (ASR). Each of the instances contained documentation the PO logs were completed accurately, with no lapses in observation times. All POs were authorized, and staff provided supportive services until an ASR could be completed. All four ASRs were completed by a non-licensed clinician, who found the youth to not be at risk for suicide and suggested the youth be discontinued from PO and placed on standard supervision. All four reviewed ASRs documented the non-licensed clinician conferred with the designated mental health clinician authority (DMHCA) and director of operations prior to placing the youth on standard supervision. All ASRs contained the signatures of the DMHCA and the director of operations. All ASRs were reviewed for accurate completion and signed by the DMHCA. There was documentation indicating each youth's parent/guardian and juvenile probation officer (JPO) were notified of the youth's potential for suicide risk, precautionary observation, completion of the ASR, and reduction of supervision to standard supervision.

The program documented all four instances of suicide precautionary observations in the Department's Juvenile Justice Information System alert database and the alerts were closed when the youth was released to standard supervision. There was also documentation of the all four youth's placements on PO in the program's logbook, as well as documentation to show the youth's release back to standard supervision. None of the four instances required a follow-up ASR.

The program does not use secure observations and a review of the five mental health and substance abuse records confirmed there were no instances of secure observation. The program has two suicide response kits; one is located in the administration area in a lock box and the other is in the medical clinic. The review team observed both kits contained a knife-for-life, wire cutters, needle nose pliers, and basic first aid supplies. The program's suicide prevention plan indicates the program will complete a review of all serious suicide attempts or self-injurious behavior. During the annual compliance review period, the program did not have any instances of these behaviors, but the plan does indicate the management team would review the circumstances surrounding the event and discuss possible changes to the program's policy and procedures.

Five staff were interviewed regarding their responsibilities if a youth expressed suicidal ideations to them. All five staff indicated they would notify mental health, place the youth on sight and sound supervision, and document the youth's behaviors. One of the five interviewed staff indicated they would also fill out a referral form, and another staff indicated they would notify administrative personnel. All five interviewed staff indicated the program maintains two suicide response kits and they are in administration and medical. Four of the five staff also indicated the shift supervisor carries a knife for life on their person during the shift. This was addressed during a daily debriefing, and the executive director (ED) and other program staff, indicated this practice had recently been changed. The ED indicated he would include this topic at the next monthly staff meeting.

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

The program has a policy and procedures in place outlining the program's process for suicide precaution observation logs. A review of five youth mental health and substance abuse records revealed there were three youth who received suicide prevention services and placed on precautionary observations (PO). A review of the three applicable records revealed there were four PO logs applicable for review. The program uses the Department's Suicide Precaution Observation Log, MHSA form 006. Each log designated the appropriate supervision level (constant supervision) and observations of the youth were made in real time and did not exceed thirty minute intervals for the duration of each youth's placement on PO. None of the four observation logs indicated the youth displayed any warning signs which needed to be reported to the executive director or the designated mental health clinician authority (DMHCA). All four PO logs were reviewed and signed by a shift supervisor, as well as by mental health staff. All four PO logs listed safe housing areas within the program where the youth could be while they were on precautionary observations.

Interviews with the three youth who were placed on precautionary observations revealed while the youth were on suicide precautions, a staff member was always with them and never left them alone.

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

The program has a policy and procedures in place indicating all staff will receive a minimum of six hours of training in suicide prevention and implementation of suicide precautions. A review of five pre-service and five in-service staff training records revealed all staff received more than the six hours of required suicide prevention training. The program's suicide prevention training included mock suicide drills, which were held quarterly on each shift. A review of five in-service staff training records revealed all five staff participated in quarterly mock drills conducted in the six months prior to the annual compliance review.

A review of the drill documentation indicated the program conducted thirteen mock drills in the third and fourth quarter of fiscal year 2017/2018 to ensure all staff participated in a drill during each quarter. The reviewed drill documentation supported all staff participated in at least one drill each quarter. The drill documentation supported a mock suicide scenario was used and the program staff demonstrated the use of the knife-for-life and life saving measures during each drill.

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 comprehensive plan for mental health and substance abuse services, suicide prevention, crisis intervention, and emergency care. The program's plan addresses how staff 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 program. The plan is reviewed on an annual basis and was last reviewed by the executive director and designated mental health clinician authority on July 3, 2018. The program's mental health crisis intervention services plan includes all required components, as required. The plan specifically addresses notification and alert system, means of referral, to include self-referral, communication, supervision, documentation, and a review process.

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

The program has a policy and procedures in place which indicates the program completes a crisis assessment on youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage). During the annual compliance review period, the program did not have any youth who required the completion of a crisis assessment. The program's designated mental health clinician authority indicated the program would use the Department's MHSA form 02, entitled Crisis Assessment in the event a youth was in psychological distress.

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

The program has a comprehensive plan for mental health and substance abuse services, suicide prevention, crisis intervention, and emergency care. The program's emergency care plan incorporates all of the required elements. The emergency care portion of the comprehensive plan includes immediate staff response, notifications, communication, supervision, authorization to transport for mental health and substance abuse evaluations, documentation, training, and a review process. The executive director and designated mental health clinician authority conducted a yearly review and approval of the plan on July 3, 2018.

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

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

Standard 4: Health Services

Overview

Youth Environmental Services is contracted to provide comprehensive on-site medical services to each youth admitted to the program. The program has a contract with a licensed physician, who serves as the program's designated health authority (DHA), providing oversight of all physical health and medical services, including the provision of clinical direction and approval of policies and protocols for provided health services. The DHA is on-site weekly for two hours and is available by cell phone for emergencies twenty-four hours a day, seven days a week. The program has two advanced registered nurse practitioners (ARNP) providing back-up coverage in the absence of the DHA. The program provides nursing coverage seven days a week, with two registered nurses (RN). The nursing staff and a local provider present health education to youth during their stay. The program has a modified Class II Type B pharmacy permit. The program utilizes South Bay Hospital in Sun City Center, Florida, for emergency services and maintains agreements with a dentist and ophthalmologist for consultation and youth treatment. The program maintains a contract with a psychiatrist who provides medication management services and conducts an initial psychiatric evaluation for applicable youth to determine if a need is warranted for psychotropic medication.

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

The program has a written policy and procedures identifying a designated health authority (DHA) as being clinically responsible for the youths' medical care at the program. The program has a contract with a licensed physician who specializes in Pediatrics and holds an unrestricted license which meets all requirements for independent and unsupervised practice in Florida. There is a coverage plan in place with two advanced registered nurse practitioners (ARNPs) for scheduled absences or vacations. The program maintains a copy of a collaborative practice protocol for both ARNPs who also hold unrestricted licenses to practice in the State of Florida. There is evidence of the DHA being on-site for at least two hours weekly for the past six months, as documented on the sign-in/out logs. The ARNP assisted with coverage three out of the past twenty-eight weeks. The DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site medical care. Current licensure for all three registered nurses employed by the program was validated through the Florida Department of Health website.

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

The program has written policies in place for all health-related procedures and protocols utilized at the program. There was documentation to support the facility operating procedures were approved and signed by the executive director on August 13, 2018 and the designated health authority (DHA) on August 11, 2018. The DHA signed and dated all of their respective written treatment protocols on July 7, 2018. Evidence supports all health care staff reviewed, signed, and dated a cover page for nursing protocols between July 3, 2018 and July 7, 2018. There is

evidence of an orientation conducted for a newly hired registered nurse. There were no blanket facility operating procedures.

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

The program has a policy and procedures in place for reviewing the Authority for Evaluation and Treatment (AET) for each youth. A review of five youth records confirmed two of five youth contained a valid copy of the AET signed by the parent/guardian. Both AETs were stamped "copy." Two youth were eighteen years of age and both records contained a signed AET for youth over the age of eighteen years old. There is a valid court order for one youth authorizing treatment for routine medical, mental health screenings, and ordinary care for minor illness or injury. There are copies and originals of completed parental notifications which are maintained behind the AET in each individual health care record.

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 procedures in place to inform the parent/guardian of significant changes in a youth's condition and obtains consent when new medication and treatment is initiated. Two of the five reviewed youth records contained parental notifications confirming over-the-counter medication and vaccination administration according to nursing protocol and physician's orders. There is documentation of witnessed verbal consent located in the chronological progress notes. Each verbal notification was followed by mailing written parental notifications utilizing the Parental Notification of Health-Related Care: Medication Management (Form HS 021) and the Parental Notification of Health-Related Care: Vaccination/Immunization (Form HS 022). Additional parental notifications for over-the-counter medications were signed by one youth who was eighteen-years-old.

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 written policy and procedures to inform the parent/guardian to obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments. None of the five reviewed records were applicable for psychotropic medications; therefore, three additional youth records were reviewed. Each of the three applicable records indicated the program informed the parent/guardian and obtained witnessed verbal consent when new psychotropic medication was initially prescribed, discontinued, or a significant dosage adjustment was made. Each record contained documentation to show the Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN) form and the CPPN page three were mailed to the parent/guardian. Completed parental notifications were filed in the individual health care record (IHCR) behind the Authority for Evaluation and Treatment (AET).

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 written policy and procedures to ensure a youth's immunization status is verified to meet state and Department requirements. A review of five youth records indicated each youth's immunization history and status were reviewed and verified within thirty days of admission to the program. Immunization records are obtained from either school records or the Florida Shots website. The physician reviews each record and orders necessary immunizations during the completion of the Comprehensive Physical Assessment (CPA). One youth was applicable for receiving immunizations during this annual compliance review period. The youth was eighteen years old and consented to receiving tetanus, diphtheria, and pertussis (TDAP), and Varicella vaccines which were administered off-site at the designated health authority's (DHA) private practice. The Department of Health (DOH) Vaccination Information Statement (VIS) form, which provides information pertaining to the vaccine, was reviewed by the youth. The Department's immunization tracker was updated subsequent to vaccination administration. There was no documentation to indicate a religious exemption immunization status form was completed by a parent/guardian.

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 written policy and procedures to ensure all youth are screened upon admission in order to determine health care concerns which may warrant a referral for further assessment by healthcare staff. A review of five youth records confirmed each youth received an initial medical screening utilizing the Facility Entry Physical Health Screening (FEPHS) form. All five reviewed records indicated the screening was completed by the registered nurse on the same day of 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 maintains an internal alert system which identifies medical issues which may affect safety and security of youth at the program. The program maintains alerts on a white board posted in the administrative conference room. Internal alerts are also maintained in a binder which is reviewed by staff during shift debriefings. All youth with allergies, chronic medical conditions, visual impairments, and medication side effects were confirmed on the alert board and binder. None of the five records reviewed were applicable for medical alerts; therefore, three additional records were provided by the program for review. Each applicable internal alert matched information contained in the youth's individual healthcare record (IHCR). Healthcare staff are responsible for updating and verifying all medical alerts in the internal alert system. Confidentiality is maintained for all alerts. Interviews with five staff confirmed they review the alert board and alert binder each day to review current alert information.

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 policy and procedures in place to ensure all youth receive an orientation regarding the healthcare services provided by the program. Orientation topics include access to medical care, access to sick call, what constitutes an emergency, medication process and side effect monitoring, the right to refuse care, what to do if sexually assaulted, and the non-disciplinary role of health care providers. A review of five individual healthcare records indicated all youth received an orientation to the program's healthcare services on the same day of their admission to the program, which was signed by both the youth and the registered nurse. Each record contained an orientation packet reflecting an overview of all required topics, including communicable diseases, which are completed by the health care staff. During an interview with the clinical nurse manager, she verbalized all youth are told who the program's designated health authority (DHA) and psychiatrist are upon admission to the program.

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 written policy and procedures to address designated health authority (DHA) notification when a youth is admitted to the program with a medical condition or when requiring emergency care. A review of five youth records indicated the DHA was notified of all admissions regardless of whether or not the youth was identified with a chronic health condition. The reviewed documentation in the admission progress notes confirmed DHA notifications were made by telephone by the registered nurse on the same day of admission. The reviewed documentation also indicated there were no youth in need of emergency care during the admission process.

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

The program has a written policy and procedures to ensure a healthcare admission rescreening is completed each time the physical custody of a youth changes. One of the five reviewed youth records indicated a need for rescreening due a change in physical custody. There were no additional records for review. Documentation indicated an all new Facility Entry Physical Health Screening (FEPHS) form 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 in place which addresses the completion of the Health-Related History (HRH) form. A review of five youth records indicated each contained a completed HRH form which was completed by the registered nurse at the time of admission, prior to completion of the CPA. All five reviewed individual healthcare records contained a

review by the DHA during completion of the CPA. This was accomplished by checking a box on the CPA and signing the bottom of each HRH form.

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 written policy and procedures to address the completion of a Comprehensive Physical Assessment (CPA) for each youth by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP). All five reviewed individual health care records contained a new CPA which was completed by the DHA within seven days of the youth's admission on the Department's CPA form. All fields of the physical examination were completed as required, including the BMI, visual acuity field, tanner stage, scalp/head, cardiovascular, medical grade, and tuberculin skin test (TST). Documentation confirmed a portion of the exam for all five reviewed records were "Deferred by Clinician." The Department's Problem List was subsequently updated upon completion of the CPA.

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 written policy and procedures in place to ensure all youth receive a Tier I Tuberculosis (TB) screening within seventy-two hours of admission to the program. All five reviewed youth records contained documentation of a current tuberculin skin test (TST) within the last year. The TST results were documented on the Comprehensive Physical Assessment (CPA), the Infectious and Communicable Disease (ICD) form, and outside jacket of each youth's record. One of five reviewed records required an annual TST, which was administered subsequent to physician orders. One additional youth required an annual tuberculosis screening which the registered nurse conducted through interview and assessment. The program documents this screening on the TB screening questionnaire. The program has not had any youth admitted to the program with signs or symptoms of tuberculosis since the last annual compliance review.

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 written policy and procedures in place to ensure all youth are screened and evaluated for sexually transmitted infections (STI). Documentation of each screening is reflected on the Department's STI screening form. A review of five youth records indicated the youth were screened upon admission and referred to the physician, as needed. One of the five reviewed youth records indicated a need for STI testing, which also resulted in a designated health

authority (DHA) referral for follow-up. Two additional records were reviewed which required STI testing. All STI testing was completed, as ordered, by the DHA. The screening results were documented on the Infectious and Communicable Disease form (ICD) for each youth. All laboratory results were reviewed and signed by the DHA and filed in the lab section of the individual health care record.

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 routinely offers counseling, testing, and referrals for treatment to all youth at risk for human immunodeficiency virus (HIV) infection. There is evidence in each of the individual health care record (IHCR) reviewed to support all five youth were offered counseling and testing for HIV by a certified HIV counselor through Metro Health Wellness. Three of the five youth records indicated the youth received HIV testing following written consent documented in the IHCR. All three youth records reviewed provided documentation on the Individual Health Education Record indicating pre-test and post-test counseling was completed, as required. All HIV results were sealed in an envelope, marked “confidential,” and filed in the lab section of each youth’s IHCR. There was no evidence of a youth’s status on the internal alert system. All five interviewed youth indicated they were offered an HIV test.

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

The program has a written policy and procedures in place to address youth sick call requests and to ensure youth are seen in a timely manner. The youth receive information regarding the sick call process during orientation on the same day of admission. A review of five youth records found multiple sick call encounters; however, none of the records presented with the same complaint three or more times within a two-week period. Each record contained documentation indicating the youth was assessed by a registered nurse within twenty-four hours; one youth required a referral to the designated health authority (DHA) as a result of the sick call request. All completed sick call forms were filed with the chronological progress notes in each individual health care record. Sick call hours are visibly posted throughout the program and were observed on the master schedule. Youth have access to sick call forms which are maintained in staff binders on the units. Youth place completed sick call forms in the sick call box. The sick call box is located outside of the health services department and is frequently checked by the registered nurse when on-site. An interview with staff confirmed when there is no licensed nurse on-site, the shift supervisor reviews the sick call requests at regular intervals, no longer than four hours after the sick call was submitted. If it is determined a higher level of service is needed than they can provide, they will contact the DHA and document the referral on the Report of On-Site Health Care by Non-Healthcare Staff form (HS Form 049). Additional notifications include the clinical nurse manager and director of operations.

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 written policy and procedures in place to ensure youth receive timely medical care through the sick call process. The program's policy requires youth privacy to be ensured during all sick call encounters. All five reviewed youth records had multiple sick call encounters; each sick call was conducted by a registered nurse. All encounters were documented on the sick call index and the programs sick call referral log. Documentation was in subjective, objective, assessment, and plan (SOAP) format and in accordance with Health Services Rule; each sick call contained vital signs, treatment, education, and follow-up care, if needed. One sick call encounter for a youth did not contain vital signs. Each of the reviewed sick call forms was signed by the youth to reflect they had been seen for the encounter. Observations of a sick call during the annual compliance review found it was conducted by the registered nurse in the health services department for one youth who had a sick call complaint. A complete set of vital signs were taken and there was educational instruction provided to the youth regarding treatment, follow-up, and hand washing. The youth acknowledged his understanding of treatment by signing the individual sick call form. During the sick call observation, staff was positioned near the door inside the health services department. Privacy from other youth was maintained during the encounter. All staff interviews indicated sick call encounters are conducted by the licensed nurse.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program's policy and procedures state they do not use restricted housing or confinement; therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures to address episodic and first aid care. Two of the five reviewed youth records were applicable for episodic care; therefore, an additional record was reviewed. All three youth records contained documentation in subjective, objective, assessment, and plan (SOAP) format, including referrals and follow up care. Documentation of episodic care was filed in the chronological section of each youth's individual health care record (IHCR). Each episodic encounter was documented on the episodic care log. There was one instance of episodic care rendered by non-healthcare staff on August 3, 2018 for dental pain. There was evidence of follow up care by the registered nurse on August 4, 2018 in the chronological section of the IHCR; however, the encounter was not documented on the episodic care log. The program has first aid kits located in the administrative building, kitchen, and the health services department. The first aid kits are fully stocked and sealed with a breakaway tag. Each kit contained contents which were not expired and were approved by the designated health authority (DHA). The program has procedures in place for periodic monitoring of first aid kits and emergency equipment. The first aid kits and AED are checked monthly by the registered nurse and replenished, as 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 written policy and procedures to ensure all youth receive appropriate emergency care, monitoring, and follow-up. All five interviewed staff reported being able to call 9-1-1 when a youth is identified with a medical emergency. There was evidence in the staff training records to support all staff had current cardio-pulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid certifications. One youth record indicated the need for emergency transportation. All documentation and follow-up care requirements were met. The program maintains one AED located outside the door of the administrative area which is easily accessible by staff. The AED procedures were located behind the AED unit. The AED pads were installed on July 2, 2017 and expires on July 31, 2019.The AED battery was installed on June 19, 2016 and expires on June 30, 2020. Monthly emergency equipment checks are completed by the registered nurse. There is a list of emergency phone numbers, including Poison Control, located throughout the program in designated binders located in the administrative office area, the conference room used for shift debriefings, and the health services department. A review of medical drills indicated a drill was conducted on each shift, on a quarterly basis, using various scenarios simulating the use of first aid and/or administration of CPR. Each drill was conducted by the registered nurse and signed by each program staff indicating their participation. Documentation of each drill is reflected on the emergency medical drill form and program log book. There is evidence of Epi-Pen training for staff was conducted by the registered nurse during medication administration training.

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 written policy and procedures in place to provide timely referrals and coordination of medical services. One of the five reviewed records indicated off-site medical care was provided for vaccination administration; therefore, one additional record was reviewed. The additional record reviewed was referred by the DHA for routine off-site treatment. The off-site consultation form was completed for all three off-site instances and all were reviewed and signed by the designated health authority (DHA), as required. Parental notification of each off-site encounter was mailed to the parent/guardian, with the exception of the one youth who was eighteen years of age. There is evidence referrals were tracked and of appropriate follow-up treatment utilizing the program's outlook calendar, as needed.

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.	

There is a written policy and procedures in place to ensure youth who have chronic illnesses receive regularly scheduled evaluations and follow-up care as necessary. The program has a system in place for monitoring youth who have chronic illnesses. Youth are tracked by utilizing a medical tracking form. Five youth records were reviewed for chronic illness, of which none were applicable; therefore, three additional youth records were selected for review. Documentation

indicated youth were evaluated by the physician prior to the renewal of prescription medication. Periodic evaluations are to be conducted every ninety days and as necessary. The one exception identified in the three applicable records was for a youth who required a periodic evaluation for an elevated body mass index (BMI). The youth was evaluated by the designated health authority (DHA) on May 19, 2018 and was not re-evaluated until September 8, 2018. Each record contained a specialized treatment plan. The Department's Problem List was updated, as necessary.

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

The program has a written policy and procedures in place to ensure a youth's medication is verified upon admission. None of the five records reviewed were applicable for medication management; therefore, three additional youth records were reviewed. All of the applicable records included a Facility Entry Physical Health Screenings (FEPHS) form which confirmed each youth's medication regimen was verified upon admission to the program. Each record contained documentation in the chronological progress notes indicating the designated health authority (DHA) and/or the psychiatrist were notified of each youth's admission. The DHA is notified by telephone of all admissions regardless of medical condition.

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 written policy and procedures in place to ensure all youth medications are current and patient-specific. None of the five records reviewed were applicable for medication management; therefore, three additional youth records were reviewed. Each of the applicable records contained a current, valid order for prescription medication. Each prescription was given pursuant to a current practitioner's order. Each individual health care record (IHCR) contained orders on a physician order form indicating the medication was continued upon admission to the program. There is evidence on the Clinical Psychotropic Progress Note (CPPN) page three for each youth on psychotropic medication indicating treatment plan/orders by the psychiatrist. There was one youth which received over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET) being administered. They were administered in accordance with approved protocols. Parental notification and consent were obtained for each instance.

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 a written policy and procedures in place to ensure all medications are stored in a locked and secure area. Observations of medication indicated the medications were stored in a locked medication cart located in the health services department. All non-controlled medications were stored separately and inaccessible to youth. Oral medications were not stored with injectable or topical medications. The program has a secured refrigerator used for medications only. All syringes and sharps were secured in the health services department in a locked cabinet behind an additional locked door. The medication cart was clean and organized; stock items are maintained separately from youth-specific medications. The program maintains

a bulk supply of over-the-counter medications in a locked room located in the health services department. The program has a pharmacy consultant who assists with the disposal and destruction of controlled and non-controlled medications when they have expired or been discontinued.

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

There is a written policy and procedures regarding medication and sharps inventory based on Department requirements. The program conducted weekly inventory counts for over-the-counter medications and sharps for the past six months. There were no discrepancies noted. Inventories were reviewed for three sharps, three over-the-counter medications, and three youth prescriptions and found they were consistent with the program's inventory records. There is a perpetual inventory with running balances of all prescribed medications administered to the youth, to include all over-the-counter (OTC) medications. They also conduct weekly inventories for all back-up OTC medications. The program has written procedures in place for inventory discrepancies.

4.29 Medication Management – Controlled Medications	Failed 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 in place for all controlled medications to be inventoried, stored, and documented, as per the Board of Pharmacy. Three controlled medications were counted and were consistent with the controlled substance inventory record. Although there is documentation to support all controlled medications are counted three times daily by the individual licensed nurse, during the past six months, there was no evidence or documentation in any of the reviewed records to support shift-to-shift inventories for controlled medications were verified and/or witnessed by a secondary staff. The program could not provide any examples to reflect this practice had been conducted. The program's own policy indicates shift-to-shift inventories are to be conducted by a nurse and verified/witness by the executive director, director of operations, or shift supervisor. After this was brought to the program's attention, they immediately changed their practice, and now have the shift supervisor observe the shift-to-shift inventories as they are conducted. Observations during the annual compliance review found all controlled medications were stored in a locked area inside the locked medication cart.

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.	

There is a written policy and procedures to ensure a Medication Administration Record (MAR) is maintained for each youth. The program utilizes pre-printed Medication Administration Records (MARs) issued by Diamond Pharmacy. None of the five records reviewed were applicable for a MAR; therefore, three additional youth MARs were reviewed. Each MAR contained a current, valid medication order. The youth's photo was attached to the MAR and contained all elements required. The MARs indicated each youth received medication, as ordered, and documented

start and stop dates for the medications. Staff and youth initialed the MAR each time medication was administered to the youth. Nursing staff documented daily side effect monitoring on the MAR. There was one instance of a medication error as a result of a missed dose, which was reported to the Central Communications Center (CCC) on April 17, 2018. There was documentation confirming a review of this incident during the quarterly pharmacy meeting on July 5, 2018. The medication process for youth transported off-site was addressed by management. Over-the-counter medication administration was documented on the back of each youth's MAR, as necessary. A review of the nursing progress notes and the Clinical Psychotropic Progress Notes (CPPN) for three applicable youth found one youth had a medication change. This adjustment to their psychotropic medication was documented appropriately in the physician orders and was witnessed by two staff on the CPPN.

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.	

There is a written policy and procedures regarding medication administration by licensed healthcare staff. Medication administration is conducted by the registered nurse, as scheduled, and takes place at the half door between the health services department and the large group room. Observations of afternoon medication pass was conducted; youth approached the medication cart individually to receive their prescribed medication. Secondary staff was positioned at the door providing supervision while also monitoring the medication process. The Five Rights of Medication Administration were followed prior to administering the youth's medication. The nurse and youth both initialed the Medication Administration Record, acknowledging administration of medication. The youth was asked to sweep around their mouth and cough. Secondary staff performed an additional mouth check. The working space is clean and organized. Sick call was not conducted during medication pass. The program had medication refusals during this annual compliance review period.

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 written policy and procedures which indicate trained non-healthcare staff may administer over-the-counter and prescribed medications, as necessary, and will include the director of operations and team leaders/shift supervisors. This responsibility is only delegated to staff following completion of the program's training curriculum conducted by the registered nurse. The program maintains a list of non-licensed staff who completed the training curriculum. There was one instance of a youth receiving over-the-counter medication for tooth pain on August 3, 2018 which was administered by non-licensed staff. There was documentation of treatment rendered by non-licensed staff on The Report of On-Site Healthcare by Non-Healthcare staff (form HS 049) and the youth's MAR. Documentation indicated the non-licensed healthcare staff consulted with the nurse by phone. There was evidence of a review in the IHCR by the registered nurse on August 4, 2018. The reviewed documentation reflected initials were made by both the staff and youth to reflect this medication being given. None of the five interviewed youth reported taking any medications. Five staff were also interviewed. All five

reported medications are given by the nursing staff, and three also indicated supervisory staff can assist with medications in the absence of nurses.

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 written policy and procedures in place for periodic monitoring of psychotropic medications. None of the five records reviewed were applicable for psychotropic medication monitoring; therefore, three additional youth records were reviewed. The designated health authority and psychiatrist were notified of each youth's admission. The medications were continued until the completion of the initial diagnostic psychiatric evaluation which was completed within fourteen days of each youth's admission. All three records confirmed each youth received medication management every thirty days, as necessary. Each psychiatric evaluation reviewed contained all of the required elements. There were no standing or pro re nata (PRN) 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 written infection control procedures which include prevention, containment, treatment, and reporting requirements based on the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. Infection control procedures address all required types and categories of diseases including common infectious diseases, contagious illnesses, bacterial infectious diseases, tuberculosis, hepatitis, pediculosis, scabies, Methicillin-resistant Staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorist agents, and chemical exposures in the workplace. Documentation supports universal precautions are included in the program's education and prevention program for staff and youth. A review of staff training records indicated the required trainings were completed. The program staff are offered Hepatitis B vaccination series at no charge at an off-site provider, as necessary and upon request. There were no instances which required notification to the local health department, CDC, or Central Communications Center (CCC).

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 written comprehensive infection control education plan which outlines pre-service and in-service training for all staff and youth. A review of five youth records indicated each youth received infection control education upon admission during the orientation process including the prevention of communicable diseases and bloodborne pathogens. Each record contained evidence of documented education on the Individual Health Education Record form.

A review of staff training records indicated staff received pre-service and in-service training on infection control practices.

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

The program has an exposure control plan (ECP) written in accordance with Occupational Safety and Health Administration (OSHA) standards. All staff have access to review the ECP. The plan is reviewed annually by the executive director and designated health authority. The last review was conducted on September 4, 2018. There were no instances which required notification to the local health department, Center for Disease Control and Prevention (CDC), or Central Communications Center (CCC).

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

Overview

Youth Environmental Services (YES) is a non-secure residential program equipped with a thirty-nine camera system, which is able to store recording for thirty-days. The director of operations and executive director are responsible for the safety and security of the program. The program does not operate a master control. The program grounds consist of several detached single-story buildings situated on a spacious, grassy lot. There is no perimeter fencing surrounding the program. Behind the main administration building are four other buildings arranged in a parallel manner creating a large courtyard area suitable to accommodate various group and recreational activities. There is a small closed-in building just beyond the courtyard which is utilized for weight training. The two front buildings house classrooms and meeting rooms and the case management department, as well as a laundry area. The back buildings house the two large housing units and across from the units is the kitchen/cafeteria building. Thirty-nine cameras provide the program twenty four-hour surveillance of the property. In addition to the director of operations, who works during the day, shift supervisors conduct most of the safety and security inspections. While touring the program, there was no observed hazardous conditions. The housing units were clean and well-maintained with no potential danger observed.

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

The program has a policy and procedures regarding supervision of youth in custody. Additionally, the staff-to-youth ratio during off-campus activities, and with work projects with tools is one staff to five youth. The policy requires staff to observe youth at least every ten minutes while they are in their sleeping room, either during the sleep period or at other times, such as during illness. A review of the shift log for the past six months contained evidence of the program conducting informal and formal head counts. Three different program staff were randomly selected each day of the annual compliance review and questioned as to how many youth they were supervising daily, and if they knew the policy and procedures on youth supervision including ratio requirements, reconciling the count, the use of radios, and communication with medical and mental health staff when youth are not located. Staff were able to provide answers which matched the program's policy. All staff interviewed were able to explain the procedures they would follow when the count cannot be reconciled. Each of the staff was also aware of how many youth were in their care when questioned. Observations conducted throughout the annual compliance review found the daily schedule was posted/available to youth in each living unit, and was followed. There were multiple movements of youth throughout the school day, and staff were observed reinforcing the youth's positive behavior and redirecting any negative behavior in accordance with their behavior management system.

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.*	

The program has a detailed written description of its behavioral management strategies which are consistent with the principals of learning theory. A review of the program's behavior management system (BMS) found guidelines for youth such as their conduct, positive and negative consequences for behavior, including while in the classroom. Observations conducted during a tour of program found written descriptions of the BMS posted conspicuously throughout the program. A review of five youth case management records found verification each youth received a youth handbook containing a written description of the rules governing conduct and positive and negative consequences for behavior. The program ensures each youth receives orientation on the BMS within twenty-four hours of his admission. BMS utilized by the program contains guidelines for maintaining order, protecting, and promoting youth rights. It also identifies constructive disciplinary actions/non-punitive punishments, opportunities for positive behavior, recognition of accomplishments, and promotes socially acceptable means for youth to meet their needs. Further review of the BMS verified the program uses a token economy system, which uses a wide variety of incentives/rewards which outnumber consequences in its effort to promote positive behavior. The BMS also contains specific appropriate consequences and sanctions, which are applied immediately and matched to the severity of the behavior. Youth are reminded throughout the day of the consequences of their behavior. Staff monitor the youth's behavior through a point card process. Negative and positive behavior are documented on the points card. Points are never taken away; they are simply not earned. The BMS is also monitored daily by the program's management team and the case management department. Management monitors rewards and consequences daily with each youth point card. The director of operations tracks all consequences and documents them in a three-ring binder. A review of five staff training records verified each staff received training in the program's BMS. An interview with the executive director validated the practice. The program has consistently utilized the current BMS with no changes for the past three years. Interviews with five staff reflected they were aware of the consequences and rewards available to program youth. They also indicated only privileges can be taken away from youth as a consequence. Interviews with the five youth indicated they knew the program level system and were all aware of the rewards and consequences in the program.

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

The program has a policy and procedures in place regarding the behavior management system (BMS) which defines infractions and system monitoring. The program's BMS has a variety of rewards used by the program, in addition to appropriate consequences and sanctions. Furthermore, consequences are applied immediately with clarity and are matched to the severity of the behavior. The program's BMS rewards outnumber the appropriate consequences. The program strives to use seven positive rewards to one negative consequence. Newly hired staff are trained on the program's BMS during their pre-service training and annually thereafter. A review of three staff position descriptions found all position descriptions specified the required qualifications of staff whose job functions includes implementation of the program's BMS. Staff performance evaluations include assessment of use of rewards and punishers and understanding of the BMS. An interview with the program's executive director validated the practice of supervisors monitoring staff use of the BMS, while also providing feedback to staff. The program maintains a policy which states it does not use room restriction. Interviews with five staff indicated behaviors are reviewed with youth when they don't earn a point on their card. At this time, they have the ability to explain their behavior. The staff also indicated their supervisor will usually give them feedback in a one-on-one discussion. They also indicated this could be addressed on their annual evaluation. Interviews with the five youth indicated they knew the program level system and were aware of the rewards and consequences in the program. Each of the youth indicated they were not allowed to punish other youth. They also reported staff were consistent in how they give out the program rewards. When asked to rate the program's behavior management system, all five youth indicated it is fair.

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 maintains a policy and procedures regarding ten-minute checks while youth are in their sleeping quarters, or at other times, such as during an illness. The policy requires staff to document real time observations manually on a head count sheet or a program log. Documentation shall include initials of the staff conducting the check. Although the program is equipped with a thirty-nine camera system, none of the cameras are placed in the youth housing areas. A review of the past six months of ten-minute checks documented on the program's night log was conducted. The review found the checks were documented every ten-minutes in real time, without exception. None of the reviewed log sheets contained preprinted

times. The program dorms are open bay sleeping units with eight bunks each. All youth were visible from the front of each housing unit. Staff are required to ensure youth are present in their bunk by visually confirming the actual body skin is present. Interviews with five staff reflected the program practice is to complete their checks for youth every eight minutes while they are sleeping.

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 policy and procedures addressing program census, counts, and tracking. The program's policy requires formal head counts to occur at the beginning of each shift, after each outdoor activity, and during emergency situations (i.e., escapes, riots). The program tracks daily census information, including, at a minimum, the total daily census count, new admission, release or direct discharges, transfers, and youth temporarily away from the program. The supervisor confirms the program census, stating the location of all youth (recreation, on-site, education, treatment team) and reconciles the count, while documenting this in the logbook. Numerous informal counts are logged throughout the day. Additionally, a review of the program's logbook found documented entries occurring consistently when any youth was temporarily away from the program, discharged, or admitted into the program. Also documented were head counts on a regular basis to include emergency counts. Head counts were also conducted as each youth entered or left any area of the program. This was confirmed through interviews with five staff. Respondents also indicated knowledge of what the program would do if a head count was not accurate. Observations during the annual compliance review confirmed the program practice of completing headcounts during the day.

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

The program has an established policy and procedures regarding logbook entries and shift report reviews. The policy guidelines require each logbook to be bound with numbered pages. Each reviewed logbook contained entries regarding youth temporarily away from the program, special instructions for supervision and monitoring of youth, and population counts at the

beginning and end of each shift and any other population counts conducted during the shift. The policy further requires any youth transports away from the program to be documented, including the names of staff and youth involved and the destination. Information relating to escape or attempted escape incidents is also required in the logbook. Also required are admissions and releases, including the name, date and time of anticipated arrival or departure, and mode of transportation, and perimeter checks, and other security checks conducted by direct care staff.

The program's practice is to have the supervisor or lead staff maintain the logbook while on duty. A review of three logbooks from the past six months found all entries were made in ink and easy to read. None of the entries were removed or obliterated. All errors were struck through with a single line and dated and initialed by the staff correcting the error. There was evidence the program documented all Central Communications Center (CCC) reports and all Florida Abuse Hotline calls. Each logbook contained evidence of weekly management reviews providing follow-up and recommendations. In both housing units, the annual compliance review team observed shift reports for the past forty-eight hours. Each reviewed shift report contained a summary of events, incidents, and activities also documented in the programs central logbook; each also contained the dates and signatures of staff, confirming he/she reviewed the shift report.

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 regarding key control. The program's policy contains procedures for key assignment and usage, including restrictions on usage, the inventory and tracking of keys, secure storage of keys, procedures addressing missing and lost keys, and replacing and reporting damaged keys. The policy requires all visitors and staff to turn in their keys and receive either a visitor tag identifying the peg their key was secured on or a program key to allow movement throughout the program. An interview with the director of operations (DO) found he was responsible for key control at the program. The DO articulated the key control process and provided a demonstration which included a tour of reception area where keys are secured. Keys to the program key box, private property storage, youth records, staff records medical and mental health areas are issued to specific personnel. An inventory was conducted and compared to the program's key supply. No discrepancies were identified, and all staff key rings were secured where keys could not be removed or added, and all key rings were tagged with a control number which match the program's written inventory.

Supervisors are responsible for collecting and distributing keys. The program maintains an assignment sheet which contains the date, key ring assigned, and signature of staff providing keys and receiving keys. A review of three logbooks for the past six months found a review of the key cabinet is documented on each shift consistently. The DO reported the program has not any lost or missing keys during the annual compliance review period. This was confirmed through a review of reports to the Central Communications Center (CCC). Observations conducted by the members of the annual compliance review team found when staff arrive to

begin their shift, their personal keys are exchanged for program keys. Upon the end of the shift, the exchange occurs in reverse. This exchange occurs at the reception area, where program keys are secured, and youth do not have access. Observations also found a consistent process for the collection of visitor and staff keys upon entry of the program. This area is connected to the main entrance by a window which keys are exchanged through. Three randomly selected staff, at various times of the day, were checked for personal keys during the annual compliance review. None of the selected staff were in possession of their personal keys. Interviews with five staff confirmed their knowledge of the program's key system. The respondents were also able to explain what processes they will follow if they have a broken or missing key.

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 policy and procedures regarding preventing the introduction of contraband into the program. The program' s policy is compliant with the Department's recommended guidelines for contraband. The program ensures all youth receive a student handbook during orientation upon admission into the program. The program also provides each parent/guardian with a with a parent/guardian handbook. Both the youth and parent/guardian handbooks contain a list of identified contraband items. The list includes personal cell phones and or equipment and /or electronic devices capable of taking pictures and or/audio/video recordings. The list further identifies other items which would present a security risk such as weapons, tools, dangerous chemicals, drugs, alcohol, tobacco, money, and lighters. Also, during orientation youth are informed of the consequences for breaking the rules, searches of mail, the physical plant and grounds, several types of youth searches, and procedures for the disposition of contraband. Youth receive an orientation upon arrival at the program; the orientation checklist includes a review of program policy on contraband, including consequences. Five youth records were reviewed and each contained a completed orientation checklist. Each checklist was signed by the youth and the staff providing the orientation. Each record contained documentation of the receipt of a student handbook. Staff search the program grounds and shared areas regularly. Program vehicles are searched before and after youth transports. Also, the program routinely conducted searches of the youth and program prior to and after visitation. A review of documentation for the past six months regarding searches found searches were conducted on a routine basis; the forms documented if the youth had unauthorized items in their property or on their person, such as extra clothes and towels, ink pens, and snacks. Furthermore, the form identified the reason for confiscation, manner of disposition, and staff signature. An interview of

the executive director found youth may be interviewed to determine how the contraband was admitted into the program. Any occurrences will be discussed in management meetings and used for training purposes.

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

The program maintains a policy and procedures regarding searches and full body visual searches. The policy requires searches to be conducted on the youth during the intake process, prior to and upon return from off-campus activities, and other times, as needed. The searches consist of full body visual searches at admission, and pat-down searches following activities. During the annual compliance review, two youth were admitted to the program. Observations of the search process found two staff of the same sex conducted the search, in a secluded area of the program. The staff continuously provided directives to the youth while following the guidelines of a full body visual search. Also, during the annual compliance review, members of the review team observed youth transitioning from one activity to another who were searched in a respectful manner, by a staff member of the same gender. The information regarding the full body visual search, including the name of the staff conducting the search, was documented on the intake chronological sheet. Five case management records were reviewed; there was documentation in all five records, indicating all full body visual searches were completed by two staff of the same gender as the youth when they entered the program. Interviews with five staff indicated they conduct searches of youth prior to each movement. This was also confirmed through the interviews of five youth.

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

The program has a policy and procedures regarding vehicle maintenance. The program maintains three vehicles which are used for transporting youth. There was documentation to support each vehicle received an annual maintenance check in April 2018. There was also documentation of on-going maintenance service provided, when required. Each vehicle was observed during the annual compliance review and each had all of the required items, including a fire extinguisher, seat belt cutter, window punch, and road hazard indicator. The program stores the vehicle's first aid kits in medical and staff check them out prior to each transport. Each vehicle had working seat belts for all seats. The program provided supportive documentation verifying a program administrator performed a weekly vehicle inspection on all vehicles which transport youth.

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.	

The program has three vehicles, one truck and two vans, which are used to transport youth. These vehicles are always secured when not in use, and the keys are maintained in a locked box located in administration. The policy requires program staff operating a program vehicle to have and maintain a current driver's license. The program's business manager conducts driver's license checks on all staff, twice a year. Documents were provided showing all approved transport staff are up-to-date on their driver's license checks. The policy provides program youth are not to be transported in personal vehicles and are not permitted to drive program or staff vehicles. Additionally, the policy states youth shall not be left unsupervised in a vehicle, and staff must utilize working communication equipment. Mechanical restraints are also utilized, and staff and youth are required to use seat belts during transportation. The policy also requires a minimum of two staff, with one being the same sex as the youth being transported, during transports. A random check of staff personal vehicles did not find any unsecured. The number of staff transporting youth was documented in the program's primary control logbook. All program vehicles were inspected and observed to have the appropriate number of seat belts. All seat belts appeared to be in working order. A fire extinguisher was located within reach of the driver in all vehicles. Additionally, a window punch and a seat belt cutter were attached to the key ring for each vehicle. First aid kits are stored in the medical department and issued to the vehicle driver prior to each departure. Prior to all transports, transportation staff must complete a vehicle inspection check list, retrieve all necessary documents pertaining to youth, and medications and precautionary observations logs, if needed, for transport. Interviews with five staff indicated they will be provided with a program cell phone for all transports.

5.12 Weekly Safety and Security Audits	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.	

The program has a policy and procedures regarding weekly safety and security audits. The policy meets Florida Administrative Code 63E-7.013(5) requirements. The program's compliance specialist has been designated as the responsible party to conduct weekly security audits and safety inspections. The policy requires development and implementation of corrective actions warranted because of safety and security deficiencies found during any internal or external review, audit, or inspection. A review of a safety and security audits for past six months confirmed inspections occurred weekly and were submitted to the central region residential office and the program's corporate office. The inspections contained identification of the deficiency and estimated repair completion. An interview of the executive director confirmed the practice.

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

The program has a policy and procedures to address issuance, inventory, and control of tools. The maintenance staff is responsible for the secure storage and inventory of all tools used at the program. Only brooms, dustpans, and mops were observed throughout the program in

secure areas. The program maintains a storage area for all maintenance tools in a secure room accessible by the director of operations and maintenance staff. No youth or unauthorized staff have access to the secure maintenance tool area. A daily inventory of tools is conducted in both the maintenance area and the broom closets are maintained. All tools are marked with an identifier and inventoried by the maintenance staff except on days the area is not accessed. All daily inventory sheets are signed and placed in a central file. Copies of tool inventory sheets are provided to the executive director for review. All tools are located on a pegboard and highlighted. Upon observation, tools were found to be present and properly labeled. Tools which contain a sharp edge or point, which can be utilized as weapons, are secured in a locked cabinet inside the secured maintenance area and inventoried daily. The tool inventory and inspection logs were reviewed and coincided with the tools in the secure room. A review of five program staff training records verified program staff were trained on tool usage.

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 maintains a policy and procedures regarding youth handling of tool and the accountability of tools and the required level of staff supervision needed during the tool usage by the youth. The policy requires youth to be trained on using tools appropriately and safely. Staff are required to maintain direct sight and sound supervision of youth using tools during program clean up. The program conducts risk assessments on each youth to determine a youth's level of risk to harm himself or others, before the youth can use a broom, mop, or scrub brush. During treatment team meetings, the risk assessments are updated, as needed.
A review of five youth records containing risk assessments indicated all five youth could participate in work projects and off-campus activities. The program's policy further states youth are not allowed to handle kitchen tools. Youth who have earned their certifications and can pass a risk assessment help serve food in the kitchen area. After each youth leaves an area where class A tools are utilized, they receive a full body visual search by direct care staff for contraband. Five youth were interviewed and all of the youth were aware of the need to pass a risk assessment before being able to use class A tools in the carpentry area. All five staff interviewed indicated youth can use mops and brooms if they pass their risk assessment.

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 to address all outside contractors who enter the program. The policy requires outside contractors to sign a notification form which provides guidelines outside contractors must follow while working in the program. If any contractors refuse to sign the written notification contractor agreement, they will not be allowed access within the secured program; therefore, the program's maintenance staff inventories the tools and escorts the contractor to the area where the work is being done in and remains with them until the project is completed. All contractors, while on-duty, are in the supervision of the program's maintenance worker. Contractors must sign-in and out of the program and list all tool items brought on-site if tools are utilized by contractors. The program restricts tools to those which are necessary. Program youth are not authorized around work areas where contractors are present. Areas where contractors worked are searched after work is completed. The maintenance worker signs and verifies all contractor provider forms are signed and the

inventory of tools is documented. A review of the program project invoices and twenty-six contractor forms found no discrepancies.

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

The program has a policy and procedures in place for fire, safety, and evacuation drills. The program performs monthly fire drills on all shifts with various scenarios which are consistent with the Continuity of Operations Plan (COOP). The program conducts safety and evacuation drills quarterly. All drills are documented on fire drill safety forms and maintained in the drill logbook secured in administration area. Management staff also document fire, safety, and evacuation drills under emergency drills in the program logbook. The program's emergency drill log was reviewed from April 2018 through September 2018, along with the program's logbook. Both reflected the program conducted fire drills monthly on each shift, as required. Documentation of fire drills included the type of drill, date, time of drill, completion time, staff present, and the supervisor's review. The program provided documentation of two COOP drills, one emergency response drill, and two escape drills, all of which were conducted during this annual compliance review period. The program's egress plan showed the location of all first aid kits and fire extinguishers. The director of operations was interviewed and reported the program conducts monthly fire drills on each shift. All five interviewed youth stated they were instructed on what to do in case of a fire, and also indicated drills are done several times a month. All five interviewed staff reported they have participated in fire drills and escape drills.

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

The program's policy and procedures detail all aspects of the Continuity of Operations Plan (COOP). The plan provides for the continuation of basic care and custody of youth in the event of an emergency or disaster while ensuring safety for all youth and staff. The reviewed COOP addresses four phases of emergency management including preparedness, response, recovery, and mitigation while stipulating staff responsibilities in dealing with the disaster/emergency on-site or in the event of an evacuation. An interview of the director of operations found the COOP is posted and available in the executive director's office and staff break area. Documentation indicates drills were conducted quarterly. The drills were documented in the logbook and were reviewed and approved by all required parties. The program's COOP was signed by the executive director on May 1, 2018 and submitted for approval to the Department's residential regional director. The regional director provided his signature, indicating approval, on May 12, 2018.

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

The program has a policy and procedures regarding known flammable, poisonous, and toxic material which requires them to be maintained in the maintenance building along with current safety data sheets and to always be kept current. All hazardous materials are to be properly labeled and never processed by youth. The policy dictates proper biohazard guidelines are required to be followed, and at no time shall they be disposed of by pouring them on the ground. The labels for hazardous materials should contain the chemicals identity, appropriate hazard warnings, and the name of the manufacturer. The program maintains five chemicals used for cleaning supplies in a secure room wherein materials are stored. The secured room contains current safety data sheets (SDS) for all chemicals stored within. A comparison of what is in storage and what is documented on the inventory sheet shows there is an accurate account for what is stored in each area and confirmed an inventory is conducted daily.

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 maintains a written policy and procedures which does not allow for youth to handle any flammable, poisonous or toxic items, or materials. The policy permits youth to clean under strict staff supervision. The staff are required to spray the cleaner on the surface and the youth to wipe down the surface. Five youth were asked if they handle any chemicals or toxic items. All five interviewed youth stated only staff handle the chemical bottle. All five interviewed youth indicated they are allowed to help clean; however, staff will apply/spray the chemicals to the area being cleaned.

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

The program has a policy and procedures regarding the disposal of flammable, poisonous, and toxic materials. The policy requires the disposal of such items to be in accordance with the Occupational Safety and Health Administration (OSHA) standards. The procedures also indicate the program will dispose of all flammable, toxic, caustic, and poisonous items which can be disposed on-site per Safety Data Sheet (SDS). This would also be documented on the applicable disposal form. The programs management staff, specifically the maintenance staff, is responsible for the disposal of any toxic items. These items are inaccessible to youth. The program employs an outside contractor to service the grease traps, and a review of invoices indicated servicing is conducted on a regular basis.

An interview with the program's plant maintenance worker verified the program maintains five chemicals used for cleaning purposes, and any excess is flushed down the drain and empty containers are disposed in the trash. The process for chemical spills is found in the program's continuity of operations plan (COOP). There have not been any incidents of a chemical spill at the program within the last six months. An interview with the director of operations confirmed the program's practice.

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

The program's schedule, observations during the annual compliance review, and interviews with youth indicated recreational and leisure activities are provided appropriately and afford the youth with both the required large muscle activity and the opportunity to explore a variety of interests. The program's policy states activities are planned to expose youth to a variety of recreational and leisure choices, exploration of interests, constructive use of leisure time, and social and cognitive skill development, as well as to promote creativity, teamwork, healthy competition, mental stimulation, and physical fitness. The program maintains a monthly recreation activity calendar and ensures the youth are provided with a wide array of supervised and structured recreation and leisure activities which include basketball, football, weight lifting, lunges, kickball, reading, and letter/journal writing. The program has full-time recreational therapist position; however, at this time, the position is vacant. The program indicated this position has only been vacant since August 11, 2018. The program also reported they have a candidate selected who is currently going through the screening process.

Youth participating in outdoor activities were observed to be supervised with staff members taking precautionary measures to prevent over-exertion, heat stress, dehydration, and physical injury. A review of the logbook confirmed recreation and leisure activities took place as outlined in the program's daily schedule. All five interviewed youth stated they are provided activities which explore their interests, make constructive use of time, and create a feeling of teamwork and healthy competition. All staff interviews verified the youth are provided at least one hour of large muscle activity each day.

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

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

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

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

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

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

The program has a comprehensive water safety plan which addresses safety issues, emergency procedures, and rules to be followed to ensure supervision and youth safety during water-related activities. A review of the program's water safety plan found it to be compliant with the Florida Administrative Code 63E-7.013 (22). Furthermore, the plan required a ratio of one certified lifeguard instructor to eight youth when youth are participating in water activities; however, the program adheres to a ratio of one certified lifeguard to five youth which enhances the safety of the youth participating in all water-related activities. The program only recognizes lifeguard certifications from the Red Cross and the Young Man's Christian Association (YMCA).

A review of five youth records found evidence of each youth completing an assessment of their swimming abilities. The test was completed in a local pool. All youth tested were identified as swimmers and were able to participate in water activities. Each of the youth was tested by the program's certified life guards. Each swim assessment included water activities designed to assess the youth's swimming ability and took into consideration a variety of non-skill related factors including age, maturity level, any special needs, physical stature, and overall physical conditioning to determine a swimming level. Review of staff training records found both certified lifeguards received proper training and certification for water involved activities. None of the five interviewed youth had participated in any water activities. The water activities completed by the program are done on special trips which do not take place at the program.

5.23 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program has a policy and procedures in place which provide youth with opportunities to re-establish and maintain family and community ties and to be involved in the first-person communication with attorneys, and their agents, approved law enforcement, court, and Department personnel. The program policy further indicates the program shall make every effort to assist the youth in maintaining and strengthening positive family and community ties in an environment which unobtrusively monitors and controls the movement of visitors within the program. Youth at the program are eligible for visitation immediately after admission. A review of five youth case management records revealed each record contained a telephone logs of phone contacts, which indicated weekly phone calls to approved family members. Each record also contained a record of mail received and sent by the youth. The list of authorized visitors is listed in each youth's case management record and is limited to those on their Department of Juvenile Justice Information System (JJIS) face sheet, unless approved by the administrative staff. The case managers are responsible for maintaining the list of approved visitors prior to visitation and supplying the list to direct care staff and administration, to ensure only authorized individuals can visit with the youth. If necessary, the program considers requests for alternative visitation arrangements when the youth's family is unable to visit during regular visitation days. The program's multi-purpose room is the designated area for visitation. Visitation rules are posted on the exterior door of the program and next to the entry door into the program's secure lobby. Also, each youth's parent/guardian receive a copy of the program's visitation policy and guidelines in their parent handbook mailed out to them shortly after the youth's arrival at the program. All five interviewed youth stated they were given the opportunity to communicate with family members by mail, visitation, or telephone.

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

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

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

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

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

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

Program Name: Youth Environmental Services
Provider Name: AMIkids Inc.
Location: Hillsborough County / Circuit 13
Review Date(s): September 11-14, 2018

MQI Program Code: 388
Contract Number: 10172
Number of Beds: 32
Lead Reviewer Code: 118

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	4.29 Medication - Controlled Medications
2.07 R-PACT Assessment and Reassessments	
2.10 Performance Plan Revisions	
2.11 Performance Summaries and Transmittals	
2.15 Treatment Team Meetings (Formal and Informal Reviews)	