STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Youth Environmental Services

AMIkids In.
(Contract Provider)
4377 Saffold Road
Wimauma, Florida 33598

Review Date(s): August 6-9, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Program Accountability, Lead Reviewer (Standard 1)
Tamara MahlAdkins, Office of Program Accountability, Regional Monitor (Standard 2)
Amanda Nelson, Office of Program Accountability, Regional Monitor (Standard 3 and Interviews)
Kamille Payne, Office of Program Accountability, Regional Monitor (Standard 3)
Shawna Sweney, TrueCore Behavioral Solutions, Lead Regional Health Services Administrator (Standard 4)
Canitha Taylor, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Youth Environmental Services
Provider Name: AMIkids Inc.
Location: Hillsborough County / Circuit 13
Review Date(s): August 6-9, 2019

MQI Program Code: 388
Contract Number: 10172
Number of Beds: 32
Lead Reviewer Code: 173

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.12 Parent/Guardian Involvement in Case Management Services	
2.13 Members of Treatment Team	
4.01 Designated Health Authority/Designee *	

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
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Non-Applicable
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	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 *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Youth Environmental Services is a thirty-two bed program, for fourteen to eighteen year old males located in Wimauma, Florida. The program is operated by AMIkids, Inc., through a contract with the Department. The program provides the following services: 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) and Aggression Replacement Therapy (ART). Additionally, the program offers Impact of Crime (IOC) and the Council. Program administration is comprised of an executive director, business manager, and director of treatment. Case management services are provided by two case managers who are responsible for providing case management services to all program youth.

The program has a designated mental health clinician authority (DMHCA) who is required to be on-site weekly. 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 DMHCA when out on leave. The program also contracts with a licensed psychiatrist. 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 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 program has two advanced registered nurse practitioners (ARNP). The program provides nursing coverage seven days a week, with two registered nurses (RN).

The layout of the program includes: six buildings, one is administrative, two are classrooms and two are living units. There is one building for the kitchen and dining hall. The program has thirty-nine operating security cameras providing coverage. At the time of the annual compliance review, the program had three vacant positions; one recreational therapist, one case manager, and one shift supervisor.

Strengths and Innovative Approaches

- The program has a vocation program in which youth are able to earn industry recognized certifications in the following areas: SafeStaff (Food handler Certification); The National Center for Construction Education and Research (NCCER) Core Carpentry and NCCER Carpentry Level 1; and small electric motor repairs.

- Youth have the opportunity to become first aid/cardiopulmonary resuscitation (CPR) certified.

- Mote Marine Laboratories provides on-campus marine biology lessons for students to learn about caring for marine life

- Youth have the ability to participate in AMIkids, Inc. bi-annual Summer (South Carolina State University campus) and Winter Challenge (Hudson, Florida) events, where they compete against other AMIkids programs from ten states across the country. Events include track and field, academic brain-bowl, first-aid, swimming, marlinspike, creative writing, and science fair. Additionally, the teams are judged on sportsmanship, excellence, and leadership.

Standard 1: Management Accountability

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

The program has a written policy and procedures for initial background screening. The program had twenty newly hired staff and four new volunteers since the last annual compliance review who required an initial background screening. A review of twenty staff records supported background screenings were completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each staff's date of hire and/or contact with youth or access to confidential information. Each newly hired staff's criminal history, Florida Department of Law Enforcement (FDLE), FDLE Automated Training Management System and the Department's Central Communications Center (CCC) Person Involvement Report were reviewed by the program's human resources manager prior to each date of hire. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on January 10, 2019, meeting the annual requirement. Reviewed documentation supported the teachers are employed by AMIkids and received an annual background screening on January 23, 2019. A review of four volunteer background screenings found they were each completed prior to contact with youth. The program had twenty direct care staff who required a pre-employment assessment. Reviewed documentation found a pre-employment assessment was completed by each newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record.

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 addressing the rescreening process for staff every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resources manager to determine when a five-year rescreening is required. The program had one five-year rescreen required since the last annual compliance review and documentation supported it was completed, as required.

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

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

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

The program has a policy and procedures which addresses a code of conduct. Five applicable staff personnel records were reviewed, and each contained the signed acknowledgement, receipt, and review of the program's code of conduct. Observations of the physical plant during the annual compliance review found the telephone numbers for the Department's Central Communications Center (CCC) and the Florida Abuse Hotline posted throughout the program. The executive director (ED) stated youth have unimpeded access to the Florida Abuse Hotline and the CCC for youth who are eighteen years of age. If a youth requests to call the Florida Abuse Hotline, the youth care worker radios for a team leader, and the youth is then taken to a telephone where they may make the call in private. Five interviewed staff confirmed this practice. There were two applicable incidents during the annual review period which involved complaints against staff, of which both were reviewed. Each reviewed internal incident report and reports made to the Department's CCC reflected both incidents were reported to the CCC and the Florida Abuse Hotline, as required. One of these incidents was substantiated and the staff was terminated, the second incident was found to be unsubstantiated. The ED stated once an allegation against staff is made, the staff is immediately removed from youth contact and an internal investigation is conducted. Action may include verbal warnings, written disciplinary action, suspension, and/or termination. Five interviewed youth reported feeling safe in the program and were not deprived of basic needs at any time. In an interview, four of the five youth reported staff are respectful when speaking to them, none of the five youth reported being stopped from calling the CCC or the Florida Abuse Hotline, when requested, and none reported hearing staff curse. Five interviewed staff reported never hearing a co-worker use profanity towards a youth or telling a youth they could not call the Florida Abuse Hotline. All five staff interviewed could state the procedures for calling the CCC and Florida Abuse Hotline.

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 maintains a written policy and procedures which addresses management's response to allegations. A review of incidents since the last annual compliance review found the program had two incidents concerning allegations against staff for incidents of physical, psychological, and emotional abuse, of which both were reviewed. Documentation for each incident supported management immediately initiated an internal investigation and removed each staff from youth contact. One incident was substantiated for use of excessive use of force, and the staff involved was terminated. The remaining incident was unsubstantiated, and the staff returned to duty. In an interview, the executive director (ED) reported staff are made aware of the abuse reporting protocols during pre-service and annual in-service training. The ED further stated the telephone numbers to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) are posted throughout the program for easy reference. The ED stated once an allegation against staff is made, the staff is immediately removed from youth contact and an internal investigation is conducted. Action may include verbal warnings, written disciplinary action, suspension, and/or termination. Five staff interviews indicated they will give a phone call to any youth requesting to call the Florida Abuse Hotline or CCC.

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

The program has a written policy and procedures regarding reports to the Department's Central Communications Center (CCC). The program had fifteen incidents reported to the CCC during the annual compliance review period, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour timeframe and in accordance with CCC reporting procedures. The program maintains a master binder for containing reports to the CCC. A review of shift reports for the past six months supported all reports were documented. A review of internal incidents for the past six months determined there were no incidents which should have been reported to the CCC but were not. All five interviewed youth indicated they never have been stopped from reporting abuse since they have been in the program.

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 addressing Protective Action Response (PAR). The program has a PAR plan approved by the Department's Office of Staff Development

and Training on January 2019 and May 2019 for the new executive director (ED). The program had six PAR reports completed in the past six months and five reports were reviewed. Documentation found each report included a review by a PAR certified instructor and documented a post-PAR interview conducted within thirty minutes after the incident. A review of the PAR incident reports found each included comments by the ED or designee within seventy-two hours of the incident. None of the reviewed reports required a PAR medical review. Documentation confirmed each report was reviewed within the timeframe and processed by a team leader and a PAR instructor to determine if use of force was consistent with policy in PAR report. None of the reviewed reports required a report to the Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks were reviewed, and documentation did not reveal any additional PAR incidents occurred. In an interview with the ED, it was indicated PAR reports are reviewed during morning management meetings to ensure staff compliance with PAR protocols. Any incident of excessive or unnecessary force is immediately investigated by the program. The program experienced a decrease of PAR incidents since the last annual compliance review. The program's PAR rate during the annual compliance review period was .73, which is lower than the statewide Residential PAR rate of 1.59.

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

The program has a written policy and procedures addressing pre-service training. The program maintains a pre-service training plan and calendar for all new staff which was submitted to the Department's Office of Staff Development and Training on January 1, 2019 and approved on April 1, 2019. Pre-service training requires 120 of training, including one week of Proactive Action Response (PAR) training with certified staff, is conducted through web-based and instructor-led courses. Six staff training records were reviewed for pre-service training as they were the only new staff hired during the annual compliance review period. Six reviewed records found each staff completed the certification process within 180 days of hire. Reviewed documentation supported all six staff completed all required trainings inclusive of PAR, first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, emergency procedures, child abuse reporting, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. All six of the reviewed training records supported each staff completed the required suicide prevention training prior to contact with youth. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro). The training coordinator confirmed staff performing in all positions receive the same pre-service training, apart from the nursing staff. The contract requires Emotional and Behavioral Development training to be conducted on all pre-service trainees within the 180 days and it was found to be completed, as required, in all six records reviewed.

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

The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 1, 2019 and approved on April 1, 2019. Five applicable staff training records, including two team leader's training records, were reviewed for in-service training. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training, as required. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, including standards of conduct and active shooter training. Five staff completed training in suicide prevention inclusive of two hours web-based and four hours instructor-led. Two team leader training records were reviewed for completion of eight hours of management and team leader training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation supported each team leader exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). The program's contract was reviewed and confirmed there were no additional training requirements.

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 to address the grievance process. Youth are provided a handbook upon admission which outlines the youth grievance process. The program uses a three-tier level grievance process consisting of informal, formal, and appeal phases. The program uses the "411" forms for completing an informal grievance. Observations during the annual compliance review found grievance forms and "411" forms are in each dormitory. If a youth does wish to file a grievance, the youth completes the grievance form and places it in the grievance box located outside of each dormitory. The team leader who gathers the forms once a day has seventy-two hours to respond to the youth in writing. Should the youth feel the initial response from staff does not adequately address the youth's concerns, the issue is presented to the next level of management staff. The final level is the executive director (ED) and/or designee who will then provide their written response to the youth within seventy-two hours for the appeal level of the grievance process. An interview with the ED confirmed this practice. A review of the program's grievance binder reflected three grievances were filed within the past six months, of which all three were reviewed. Documentation found all three grievances were resolved in the formal phase. No grievance was appealed and had to be resolved by the ED or designee within the required timeframe. The team leader responded the same day the grievance was filed in all three samples. The first phase of the grievance process is the youth

completes the “411” form as an alternative to filing a formal grievance form, and the second phase is for the youth to meet with the shift team leader, once completing the formal grievance form. The final phase includes a review by the ED or designee if the youth is not satisfied with the resolution proposed by the shift team leader. The program maintains a grievance binder with all the grievances and “411” forms filed for a year. Five interviewed staff were able to describe the program’s grievance process. Five youth were interviewed, and each knew how to file a grievance and stated they could ask for assistance in completing the form, if necessary. A review of five in-service training records found all five receive the grievance training update annually. A review of five pre-services training records found all five received grievance training during their pre-service training.

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

The program provides delinquency interventions through evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. The evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Impact of Crime (IOC), Aggression Replacement Therapy (ART), Cannabis Youth Treatment (CYT), and The Council for Boys and Young Men 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 for Boys and Young Men is listed as a practice with demonstrated effectiveness. CYT and ART are the program’s primary services offered to youth, with each youth placed in groups according to their identified individual needs. This practice was confirmed by the executive director (ED). An interview with the ED confirmed delinquency interventions are delivered by trained staff. A review of each of the designated staff’s training records reflected all staff had the appropriate education and qualifications to be hired in their respective positions and completed the required training to facilitate the delinquency intervention groups. The program’s daily schedule reflects delinquency intervention groups are conducted seven days a week, pursuant to the program’s contract, and reviewed sign-in sheets confirmed this practice, it is noted at least sixty percent of the time youth are awake, services are provided. A review of five youth individual performance plans supported each youth had at least one delinquency intervention goal addressing an identified priority need, and reviewed group sign-in sheets validated ten youth were participating in IOC groups. An IOC group was observed during the annual compliance review week which validated the group was delivered as designed. In an interview, the ED reported youth are matched with staff, therapists, and case managers based on their individual assessments.

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

The program has a written policy and procedures which provides interventions and instruction focusing on developing life and social skill competencies to youth through classroom and group instruction, hands-on experiences, and role model by program staff. The program's activity schedule allows for scheduled interventions for youth to receive life skills training pursuant to the contract. The clinical staff facilitate The Prepare Curriculum. Qualified staff present The Council for Boys and Young Men to youth. A review of five youth individual performance plans and sign-in sheets validated the youth are participating in life skill training for anger management, communication, critical thinking, interpersonal relationships, and communication, as indicated in each youth's identified priority needs, seven days a week by group facilitators trained to deliver their respective curricula. Reviewed documentation in each staff's training record confirmed each has received the required training to deliver the curricula. In an interview, the executive director stated all youth in the program participate in life skills groups. Five youth were interviewed and all five stated they attend groups daily. All five interviewed youth reported learning new skills such as anger management, decision making skills, and how to process grief. In addition, each of the five-youth stated they practice the new skills during group and individually during their daily routines.

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 provides delinquency interventions through evidence-based principles and practices of restorative justice. The evidenced-based interventions are those designed to reduce the influence of risk factors related to re-offending behavior. The program utilizes Impact of Crime (IOC) as the delinquency intervention model of restorative justice with each youth placed in groups according to their identified individual needs. This practice was confirmed by the executive director (ED). IOC is a closed group and at the time of the annual compliance review, there was one group running as scheduled. An interview with the program's ED confirmed delinquency interventions are delivered by staff with the required education and qualifications to be hired in their respective positions. It was noted in staff training records staff facilitating IOC received the required training. The program invites guest speakers who are also victims to speak to the youth in conjunction with victim videos provided with the IOC curriculum. A review of five youth individual performance plans and random group sign-in sheets validated they are each participating in IOC groups. An IOC group was observed during the annual compliance review week which validated the curriculum was delivered as designed.

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

The program has a written policy and procedures which addresses gender-specific programming for a male population as required by the contract. The program identified The Council as their gender-specific curriculum. The curriculum was facilitated by four staff during the annual compliance review period. A review of each of their training records confirmed each staff was certified as a facilitator for The Council for Boys and Young Men. The daily activity schedule allows for the Council for Boys and Young Men to be offered on a regular basis. The executive director (ED) indicated in an interview all youth will participate in the evidenced-based groups, which addresses many aspects of the characteristics of the program's population. During the annual compliance review week, a group was unable to be observed due to none being held at the time of the annual compliance review.

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 regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. An interview with the program's executive director (ED) confirmed the alert reports and internal alerts are distributed and reviewed by shift supervisors and administration, daily. Upon review of the alert board and list, the supervisors discuss the alerts with all working direct care staff, at each shift briefing. The internal 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 current alert list is issued to team leaders and reviewed with living unit staff, kitchen staff, and the medical clinic. This list is maintained in the conference room in a binder, which is updated daily. A review of shift reports confirmed alerts are a standing agenda item. The medical and mental health and substance abuse staff, as well as the case managers, and administration enter and update any applicable or critical alerts in the JJIS alert system and the program's internal alert system. If a youth with an alert is admitted to the program after a shift's briefing, the appropriate department staff updates the internal alert list, white board, and the JJIS alert system and immediately distributes the new list to the team leaders, administration, and kitchen staff, at which time the information is verbally

communicated to direct care staff. A review of five youth records found each was applicable to have an alert entered into the program's internal alert system and the JJIS alert system. Reviewed documentation supported each had the appropriate alert entered into the internal alert system. Five interviewed staff confirmed staff are notified of alerts during each shift's briefing, are required to review the alert book and sign the logbook under alert review.

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

The program maintains separate hardbound binders for case management, healthcare, and mental health and substance abuse records, all of which are maintained by the respective departments. Observations of the records found each marked "confidential" and secured in assigned offices when not in use. Reviewed records contained all of the most recent information in chronological order. Within each reviewed record, information was separated into clearly labeled designated sections for legal, demographic, case management with treatment plan and interventions, and correspondence, along with a miscellaneous tab.

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

The program has established a youth advisory board which allows an avenue for youth to discuss issues, concerns, and suggestions for possible changes in practice. The youth dormitory representatives are chosen by the treatment team, rewarding youth who have demonstrated positive behaviors and compliance with treatment goals. The youth advisory board meets quarterly to discuss issues such as food service including special monthly meals, behavior incentives, specialized programming, holiday and community service activities, abuse protocols, healthcare, along with an open floor forum. Youth advisory board members are the liaisons between the youth and program administration. An interview with the executive director (ED) and reviewed sign-in sheets validated meetings were held quarterly. Representatives of the program's management team and the recreation therapist monitored the meetings and offered advice from the management perspective. In an interview, the ED reported the youth advisory board helps youth feel a part of the process with valued opinions and input. In addition to the youth advisory board, all youth participate in weekly community meetings to discuss any presenting issues they may have during their day. In addition, youth also complete quarterly surveys and the results are compiled by the compliance department and discussed during all staff meetings. Youth are also encouraged to utilize "conference request" forms as an avenue to convey suggests or complaints. Five interviewed youth validated the program conducts weekly community meetings and the use of "conference request" forms and they can take their issues to the advisory board members.

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

The program maintains a written policy and procedures establishing a community advisory board titled “Board of Trustees.” The community partnerships have been developed to connect the local community with the goals and objectives of the program’s design. The partnerships have been established with the local school system, religious groups, the Police Department, victim advocacy services, a judge, and a local business. A youth from the Youth Advisory Board is present at all meetings. 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, a member of law enforcement, and a member of the LGBTQ community for the board. They are still trying to find a parent/guardian and LGBTQ representative to agree but were successful in filling the other membership positions. An interview was conducted with the chair of the Board of Trustees who indicated they are very involved with the program and improving the youth’s lives. Meetings were held on November 8, 2018, February 7, 2019, May 9, 2019, and August 8, 2019. A copy of the agenda, sign-in sheets, and minutes from the previous community meetings were available for review. An annual compliance review team member was able to sit in on the meeting held August 8, 2019. There were fourteen members in attendance. The board reviewed meeting minutes from the meeting held in May 2019. Open positions were discussed and ides for hiring a recreational therapist were discussed. The board discusses starting a family campaign where every board member to local families. They discussed recruitment of new board members to meet the board requirements.

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

The program maintains a written policy and procedures regarding the program’s planning process and to ensure provisions for adequate staffing and open lines of communication among staff. The program conducts daily debriefings each day on each shift, additionally the program holds weekly management meetings. The program conducts all-staff meetings monthly. A variety of topics are discussed including the program’s policy and procedures, as well as the parent/guardian and youth survey results and the Comprehensive Accountability Reports (CAR). A review of sign-in sheets from the all-staff meetings for the past six months indicated staff meetings were held monthly. The meeting’s agendas and minutes reflected staff were informed about multiple subject areas from operations, risk management, and case management, while allowing each specific department the opportunity to present their concerns. An interview with the executive director (ED) indicated staff are kept informed through shift briefings and monthly staff meetings. Active recruiting is ongoing to address staff vacancies. To increase staff retention and employee morale, the program identifies an employee of the month and year, as well as conducts various employee appreciation events and tuition assistance. Youth and parent/guardian surveys are conducted during visitation and upon the youth’s release from the program. An interview with the ED indicated the outcome data used by the program are the parent/guardian surveys, feedback during treatment team, and feedback during individual and family sessions. Random review of surveys included feedback for case management, mental health, food, and medical services. The information is then shared during manager’s, and all staff meetings and incorporated into the program’s planning process. Four of five interviewed staff reported communication in the program was either good or very good. One of

five staff stated communication is fair. Each staff validated information is conveyed during shift briefings and all staff meetings.

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

The program has a policy and procedures addressing the evaluation of staff performance. Performance evaluation measures are completed annually for in-service staff and at the initial ninety-day probationary period for pre-service staff, addressing areas including basic job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. The evaluation process also includes best practice elements adapted by the program. Evaluations are unique for the specific types of staff positions at the program. Staff who facilitate groups are evaluated for their skills at facilitating a delinquency intervention, and all staff are evaluated on the implementation of the program's behavior management system. Once reviewed by staff, they are given the opportunity to provide their signature on the evaluation form along with any comments. The employee performance evaluation practice was confirmed in an interview with the executive director (ED). Five personnel records were reviewed to include, youth care workers, a supervisor, a case manager, and a therapist, and each included the job description for the applicable specific position, applicable performance evaluations, education records and degrees, and a copy of the acknowledgement for the program's code of conduct. Five staff were interviewed and two stated they receive a performance evaluation annually, two stated they receive a performance evaluation every six month, while one response was every month.

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

The program has a written policy and procedures regarding recreation and leisure opportunities for youth. The program employed a recreation therapist who held a bachelor's degree in Sports Management with two years related experience working in a residential program, as required by contract, during the annual compliance review period until July 12, 2019. The program's activity schedule outlines a block of time for daily large muscle activity for youth, as well as group time. A separate recreation therapy schedule was found from December 2018 through March 2019; however, calendars for April through July 2019 were not able to be recovered from the recreation therapist's computer after their resignation. In addition, the program has dorm time which is time allotted for youth to engage in their chosen leisure activities such as letter writing, television viewing, and board games. Youth are encouraged through recreation, leisure, and recreation therapy to explore interests and engage in constructive leisure activities. During the program tour, a covered pavilion was observed and was constructed as a sheltered location for the youth to have an outdoor gym to help protect them from potentially hazardous weather while allowing youth opportunities for outdoor large muscle activity. Each youth's treatment plan included weekly recreation therapy and high-risk youth were prescribed additional recreation therapy. The recreation therapist conducted recreation groups until July 11, 2019 after which the recreation therapist resigned. The recreation groups held during the annual compliance review period covered a variety of topics including meditation and guided imagery, art therapy, Jenga, origami, brain teasers, exploration of leisure activities, health education, and movies. The groups focused on teaching and improving cognitive skill development, flexibility and change,

problem solving, relationship building, teamwork, and communication. Youth who have earned opportunities to go off-campus have been able to participate in recreation trips to fish, set up for community events, play laser tag, attend a movie, and other community activities. The program reported they are actively recruiting to replace the recreation therapist. During the vacancy, the youth are still receiving art therapy from an outside provider and in the interim all August treatment plans are being amended to remove recreation therapy as a prescribed service for the youth until a new recreation therapist is hired. The program utilizes a quarterly student advisory board to allow youth the opportunity to provide feedback into programming; however, there was no meeting held in the quarter for October through December 2018. Five youth were interviewed, and each reported they receive varied opportunities throughout the day for mental and physical exertion. Each youth further reported they received at least an hour of physical activity a day and engaged in activities such as basketball, football, lifting weights, watching television, board games, and reading. Five staff were interviewed and each confirmed the youth receive recreation each day and are offered a variety of opportunities.

Standard 2: Assessment and Performance Plan

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

In all five case management records reviewed, documentation indicated the program notified the youth's parent/guardian by telephone within twenty-four hours and in writing within forty-eight hours of admission. In all five records, documentation showed the court and juvenile probation officer (JPO) were notified within five working days of the youth's 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.	

In four of five records reviewed, documentation indicated the program provided each youth an orientation to begin on the day of admission. In the remaining one record, the program placed a note into the youth's case management record on August 2, 2019 indicating the orientation checklist was missing from the record, but staff had interviewed the youth who stated he received the orientation during intake; the original orientation was also documented in the chronological notes on the date of admission. In all five records, documentation showed the orientation included services available, daily schedule conspicuously posted to allow easy access for youth, expectations and responsibilities of youth, written behavioral management system, including rules governing conduct and positive and negative consequences for behavior, availability of and access to medical and mental health services, and access to the Florida Abuse Hotline or the Central Communications Center (CCC). The orientation also contained the program's zero tolerance policy regarding sexual misconduct, including how to report incidents or suspicions of sexual misconduct, availability of special accommodations to ensure all written information about sexual misconduct policies, including how to report sexual misconduct, is conveyed verbally to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled, right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures. The items considered contraband including illegal contraband, possession of which may result in the youth being prosecuted, performance planning process involving the development of goals for each youth to achieve, dress code and hygiene practices, procedures on visitation, mail and use of the telephone, expectations for release from the program, including the youth's successful completion of individual performance plan goals, recommendation to the court for release based on the youth's performance in the program, and the court's decision to release, as well as community access, grievance procedures, emergency procedures, including procedures for fire drills and building evacuation, facility tour and general layout of the facility, focusing upon those areas which are and are not accessible to youth, assignment to a living unit and room, treatment team, and a staff advisor or youth group and medical topics were part of the orientation. A youth admission could not be observed since the program was on an admission freeze during the annual compliance review. Five youth interviews indicated the orientation began within twenty-four hours of admission to the program and it included the program rules; three said they were informed of the schedule and received

the handbook, four stated they were introduced to the staff and one indicated receiving information on the behavior management system.

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.	

None of the five records reviewed were applicable for youth eighteen years of age or older; therefore, three additional applicable records were requested and reviewed. In all three of the applicable records, the program obtained written consent for youth eighteen or older before providing or discussing with the parent/guardian information related to physical or mental health screening, assessment, or treatment.

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

The program has a policy and procedures regarding the classification process, which includes a classification system promoting safety and security, as well as effective delivery of treatment services and when reassessments are warranted. The program has an internal alert log which is updated on a daily basis and is signed by all staff at the beginning of their shift to acknowledge a review of all alerts. In all five records reviewed, documentation revealed the initial classification factors included physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. All of the youth had a new Victimization and Sexually Aggressive Behavior (VSAB) screening completed and entered into the Department's Juvenile Justice Information System (JJIS) prior to each youth's room/bunk assignment. The classification also included identified or suspected risk factors, including suicide risk, medical risk, escape risk, and security risk. In all five records, the youth was classified for purposes of assignment to a living area and youth group. The JJIS alert list was reviewed for any issues affecting classification in all five records. All of the medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process were immediately entered into the program's internal alert system and JJIS, where applicable. Reassessments were completed prior to considering an increase in the youth's 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, and participation in off-campus activities. An interview with the executive director indicated all youth have a pre-classification meeting, and classification meeting, wherein a classification document is completed which factors mental health status, physical health status, cognitive performance, age, and prior victimization into a youth being assigned a bunk in a dorm.

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

One of the five reviewed records was applicable for youth with gang associations. Two more records were requested and reviewed. In the three applicable youth records reviewed, documentation indicated the local law enforcement, as well as law enforcement in the youth's home county were notified of suspected gang activity by the program, upon receiving notification at the time of admission. In all three records, information on the youth's gang status was shared with the educational provider, and the youth's juvenile probation officer (JPO). In one of the records, the notification occurred fifty days after the youth's admission following an audit by the compliance specialist who discovered notification had not yet been completed.

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.	

One of the five reviewed youth records was applicable for youth with gang associations; therefore, two additional records were requested and reviewed. In the three applicable youth records reviewed, the youth had been identified as a gang member or affiliated gang member. All three youth records documented the youth participated in gang prevention and intervention strategies. The three youth performance plans included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program provides Impact of Crime (IOC) to the youth focusing heavily on empathy development as an intervention strategy. All youth receive the Prepare curriculum which is a psycho-educational group session to work on gang prevention and awareness.

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

In all five records the Residential Positive Achievement Change Tool (R-PACT)/Residential Assessment for Youth (RAY) was completed within thirty days of admission and the initial assessment was maintained in the Department's Juvenile Justice Information System (JJIS). In all five records, the R-PACT/RAY Re-Assessments were completed within ninety days after completion of the initial R-PACT/RAY. In three of the five records, updates and reassessments were completed, when deemed necessary, by the intervention and treatment team to effectively manage each youth's case and the program maintained all reassessment documentation in each youth's official record. The other two records were not applicable for re-assessments.

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

In all five records reviewed, the Youth Needs Assessment Summary (YNAS) was completed within thirty days of admission and 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.*	

In all five records reviewed, the individualized performance plan was developed within thirty days of the youth's admission and after the initial assessment was completed. In each of the reviewed records, the intervention and treatment team, consisting of the treatment leader, youth, administrative representative, treatment staff, living unit representative, and educational staff, were present during the development of the individualized performance plan. All five performance plans were signed by the youth, intervention and treatment team leader, and all parties who had significant responsibilities in goal completion, besides the living unit representative, who did not sign any of the plans. The living unit representative signed the mental health treatment plans, which were conducted on the same date in conjunction with the performance plans. The parent/guardian signature sheets were mailed to the parents/guardians; however, none of them were returned to the program. In the five records reviewed, the performance plans included the elements of individualized goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, the three top criminogenic needs were addressed, specific delinquency interventions, with measurable outcomes which will decrease the criminogenic risk factors and promote strengths, skills, and supports to reduce the likelihood of the youth reoffending, transition activities targeted for the last sixty days of the youth's anticipated stay, youth's responsibilities to accomplish goals, program staff responsibilities to enable youth to complete goals, and target dates for goal completion. In three of the five records, within ten working days of the plan being completed, transmittal letters and copies of the plans were sent to the committing courts, juvenile probation officers (JPO) and parents/guardians. In one remaining record, the plan was sent out one day late to the committing court, JPO, and parent/guardian, and in the last remaining record, a transmittal letter could not be located. One of five youth interviews indicated the case manager created the performance plan and the youth did not get to choose any of the goals, two said the goals created involved expressing feelings in a positive way, one had identifying triggers, another to identify likes and dislikes about school and anger control. All five youth indicated

they, the case manager, parents/guardians, therapists, and JPOs helped in developing their plan. One said he has monthly treatment team meetings. All five stated they received a copy of their performance plan.

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

Three of the five reviewed youth records were applicable for performance plan revisions. In one record, performance plan revisions were completed based on newly acquired/revealed information which warranted such. In the two remaining applicable records, the youth's demonstrated progress toward completing their goals; therefore, a revision was completed.

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

In three of five records reviewed, the performance summary was completed every ninety calendar days following signing of the performance plan. In one of the three applicable records, a performance summary was prepared prior to the youth's release from the program. In all three records, the summary included youth's status on each performance plan goal, youth's overall treatment, the youth's academic status and credits earned in the program, including performance and behavior in school, youth's behavior, level of motivation/readiness to change, interaction with peers and staff, overall behavior adjustment to the program, significant positive and negative events. In one applicable record, the justification for release was included. Each of the applicable records contained the original performance summaries, the youth were able to read and add comments prior to signing, and were provided a copy. All of performance summaries were signed and dated by the treatment team leader, staff member preparing the summary, executive director or designee, as well as the youth. A copy of the summary was sent/provided within ten days to the committing court, youth's juvenile probation officer (JPO), youth, and parent/guardian, in the three applicable records.

A review of three closed records, as well as one applicable open record, found the original release summary, along with justification for release was sent with the Pre-Release Notification (PRN) to the JPO within forty-five days prior to the planned release and the signed copy was retained in the records. The court did not object to the release of any of the youth. In the three closed records, once approved, the program provided written notification to the youth's parent/guardian of the planned release and completed a Residential Assessment for Youth (RAY)/Residential Positive Achievement Change Tool (R-PACT) exit assessment. All five youth interviews indicated the youth received a copy of their performance summary.

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

The program encourages and facilitates involvement of the youth's parent/guardian in the case management process including assessment process, participation in the development of the youth's performance plan, progress reviews, transition planning, and allows the parent/guardian to participate in meetings telephonically, with video conference or to provide verbal/written input prior to the meeting. In twelve of sixteen treatment team meetings held for all five youth, as well as two additional records addressing youth in the care of the Department of Children and Families (DCF), the program did not notify the parent/guardian prior to the meetings. The compliance manager provided a training memo wherein the case manager was told to utilize a letter to provide to the parent/guardian, juvenile probation officer (JPO), and other pertinent parties notifying them of all treatment team meetings; the memo was signed July 26, 2019 and at the time of the annual compliance review, the new notification process had not been initiated. The program staff indicated they facilitate parent/guardian involvement through initial contacts, verbally or in writing, requesting input for assessment and goal planning, as well as notification of formal treatment team meetings, family counseling sessions, family festivals, and weekly phone calls. All five interviewed youth indicated their parents/guardians were involved in case management services, participating in treatment team meetings, as well as the creation of the treatment plans. The executive director interview indicated the case manager sends out enrollment information upon the youth's arrival which invites the parent/guardian to the first treatment team meeting. During orientation, the case manager starts dialogue with the parent/guardian telephonically to discuss their involvement while the youth is within the program.

2.13 Members of Treatment Team	Limited 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.	

A treatment team review of five open records, as well as two additional records addressing youth in the care of the Department of Children and Families (DCF), indicated out of twenty-eight total treatment team meetings reviewed, the treatment team leader, youth, administrative representative, treatment staff, educational staff, and where applicable, the transition coordinator were present at every formal treatment team. Twenty-four of twenty-eight treatment team meetings, the living unit representative was present. Out of twenty-eight meetings, only one did not have documentation indicating if the juvenile probation officer (JPO) had been called during the meeting and in six others a voicemail was left. In eight of sixteen applicable meetings, a voicemail had to be left for the parent/guardian. In seven out of twelve applicable treatment team meetings, a voicemail had been left for the DCF worker. In one of two applicable meetings, the gang prevention specialist was not present. In four of sixteen treatment team meetings held for all five youth, as well as two additional records addressing youth in the care of the Department of Children and Families (DCF), the program notified the parent/guardian prior to the meetings The program did not have any documentation, beyond the first treatment team meeting, of the youth's JPO, parent/guardian, and where applicable, the DCF worker being invited. The program did invite all other pertinent parties.

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.	

In all five records, as well as two additional records addressing youth in the care of the Department of Children and Families (DCF), the Individualized Performance Plan (IPP) incorporated academic, performance, or safety plans, as well as mental health treatment, where applicable. The staff indicated the youth in the care of DCF did not have a case plan to incorporate into the performance plan.

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

In four of the five reviewed records, documentation indicated all formal reviews were completed at least every thirty days and included the youth's name, date of review, any comments from treatment team members or others, a brief synopsis of the youth's progress in the program, progress on performance plan goals, positive and negative behaviors, youth demonstrating skills acquired in the program, and treatment progress. In one record, one of the formal treatment team meetings was conducted one day late.

The bi-weekly informal reviews included youth's name, date of review, meeting attendees, progress on performance plan goals, and the youth demonstrating skills acquired in the program. In three of the five records, the informal reviews were conducted bi-weekly each month. In one of the remaining records, there were two months of missing reviews, and in the other record, one month of missing informal reviews. Observations of four treatment team meetings found all required staff were present, including the treatment team lead, youth, administration staff, living unit representative, treatment staff, educational staff, transition coordinator, nurse, and vocational representative. In three meetings, the juvenile probation officer (JPO) and parent/guardian participated by telephone, in one a voicemail was left. In all four meetings, the performance plan goals, positive and negative behaviors, and treatment progress were discussed. In all four meetings, the youth was given the opportunity to demonstrate skills learned and all treatment team members participated actively in the meeting. All five youth interviews indicated the youth are given an opportunity during treatment team meetings to demonstrate skills they have learned in the program, as well as staff reviewing performance plan goals, positive and negative behavior and treatment progress with them.

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

The program provides type 2 career education programming which provides an orientation to a broad scope of career choices, based on personal abilities, aptitudes, and interests. The program provides vocational programming appropriate for the youth, their education abilities and goals, and the typical length of stay in the program. An interview with the lead teacher revealed the program utilizes education services and assessments to include My Career Shines, Worldwide Interactive Network Inc. (WIN) Common Assessment, and STAR

Renaissance. An interview with the executive director (ED) was conducted. The ED stated the program offers culinary education (food handler certifications-SafeStaff and ServSafe), National Center for Construction Education and Research (NCCER) certifications, small motor repair, and career readiness courses. The program utilizes the AMIkids Career Readiness curriculum career which includes communication, interpersonal, and decision-making skills. Youth in the program can gain vocational certification in food handling (SafeStaff/ServSafe) and NCCER Core Carpentry Certification. Youth who qualify can move beyond the NCCER Core curriculum class and participate in the hands-on carpentry vocational program. Youth who qualify are also offered opportunities to participate in paid internships/employment at local McDonald's and Dollar Tree.

Three closed youth individual case management records were reviewed, and all three youth completed an employment application and a résumé. In two of the three records reviewed, youth were provided general information about CareerSource but did not have specific information on their local CareerSource center. An interview with the compliance specialist revealed the program determined in June 2019 during an internal audit, case management was not providing local specific information for CareerSource and this has since been corrected. One of the three records reviewed did have local CareerSource location and business hours information provided to the youth as this youth was discharged in July 2019. In two of three of the records reviewed, a copy of a Florida identification card and birth certificate was found in the records. The record which did not contain this document did contain documentation showing programs efforts to contact the juvenile probation officer (JPO) to obtain birth certificate so the program could obtain an identification card for this youth. All three reviewed records contained appropriate documents for obtaining Florida employment to include all certification documents the youth completed in the program. All records contained documentation which supported the JPOs were made aware of the vocational plan for each youth. In two out of three records, there was documentation which supported each youth's parent/guardian was made aware of the vocational plan for youth as the parent/guardian participated in the transition and exit conferences. One of the three records reviewed did not contain documentation indicating a parent/guardian participated in the transition or exit conferences (attempts were made by phone). This record documented voicemails were left for parent/guardian by career coordinator before and after youth was discharged from the program notifying parent/guardian of youth's vocational plan.

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

The program integrates educational instruction into the daily schedule in such a way to ensure the integrity of the required instruction time of 250 days is distributed over a twelve-month period with a minimum of twenty-five hours of instruction weekly. Professional development days used for teacher planning are documented on the Department's education program calendar. A review of the daily activity schedule from the program and Department education program schedule verified this practice. A review of the past six months of logbooks supported education is followed in compliance with the daily educational schedule. An interview with the lead educator and five youth confirmed minimal interruptions to education. The lead educator stated youth attend 1500 minutes (twenty-five hours) of classroom instruction a week and the school schedule is 8:00 a.m. to 2:20 p.m. daily.

2.18 Education Transition Plan	Satisfactory Compliance
Upon admission, staff and youth develop an education transition plan which includes 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 admission and address services to be provided during the youth's program stay and services to be implemented upon release, including but not limited to, continuing education and/or employment. Three closed case management records were reviewed. All records included an education 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 continued academic options to include returning to school or pursuing a General Equivalency Diploma (GED) and referrals for exceptional student education (ESE) services, if applicable, or other interventions necessary to assist youth in their transition post-release. Final determination of school placement or academic options is made by the receiving school and is based upon re-entry meeting between student, parent/guardian or caretaker, and school district upon program exit.

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.*	

In the three closed records reviewed, documentation confirmed the transition conference was held at least sixty days prior to the targeted release date and the youth, treatment team leader, executive director or designee, and other team members attended the transition conference. In each record, the youth's juvenile probation officer (JPO), parent/guardian, education staff, and other pertinent parties were notified in advance to participate. During the transition conference, the participants reviewed the transition activities on the youth's performance plan, revised the performance plan were applicable, identified additional activities, target completion dates, persons responsible for completion, and the treatment team leader obtained attendees dated signature, representing their acknowledgement of the transition goals and accountability for completion. In all three closed records, a Community Re-Entry Team (CRT) meeting was conducted prior to the youth's release, the youth and case manager participated, and the program had evidence regarding invitation to the CRT.

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.	

In three closed records reviewed the exit portfolio was discussed and initiated at the transition conference. In two records, the state-issued identification was part of the exit portfolio, in the remaining one the program did not have the required documentation (birth certificate, social security card) to attain the identification, even after attempts to obtain them from the parent/guardian. In two records, the exit portfolio contained a calendar of upcoming community events and providers. Each of the exit portfolios contained educational/vocational certificates obtained while in the program, educational records/school transcripts, resume, and completed employment application. All three had the exit portfolio verified at the exit conference and the information was provided to the juvenile probation officer (JPO) and documented in the case management record.

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.	

In three closed records reviewed, the exit conference was conducted at least fourteen days prior to and after the program notified the juvenile probation officer (JPO) of the youth's release. The exit conference was documented in all three case records and included the date, signatures, and a summary pending transition goals. In the three closed records the date of admission and the date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS) data. All three exit conferences reviewed the status of transition activities established at the transition conference and finalized plans for the youth's release and the intervention and treatment team leader, parent/guardian, educational representative, JPO, youth and other pertinent parties participated in the meetings. In all three the exit conference was conducted separate from the transition and the Community Re-Entry Team meeting.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time licensed clinical social worker (LCSW) serving as the designated mental health clinician authority (DMHCA) and the clinical director. The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2021. The DMHCA is on-site five days a week and on-call twenty-four hours a day, seven days a week and is responsible for the coordination and implementation of mental health, substance abuse, and specialized services at the program. The DMHCA has a back-up licensed mental health counselor (LMHC) who covers when the DMHCA is on leave. The program provides mental health overlay services (MHOS) to all youth in the program. The DMHCA ensures clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. An interview with the DMHCA indicated she provides daily face-to-face clinical support to all clinical staff and meets with the clinical staff weekly to discuss youth-specific clinical issues and ensures documentation deadlines are met. A review of the weekly supervision logbook confirmed this practice. The DMHCA meets twice a month with the psychiatrist regarding each new youth for admissions, for an initial psychiatric evaluation to determine what, if any, psychiatric interventions are needed (i.e. psychotropic medication). The DMHCA communicates psychiatric concerns for each youth on psychotropic medications or refers youth already in the program for newly developed concerns. A review of the DMHCA's position description validated the services provided. The DMHCA indicated they are on-site weekly and they review and sign weekly progress notes completed by the four non-licensed clinicians, conduct treatment planning, Assessments of Suicide Risk (ASR), follow-up ASRs, and quarterly reviews of treatment records. The DMHCA reported they provide groups, individualized treatment, and family therapy. 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)	Non-Applicable
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program's policy, procedures, or contract does not require any other licensed clinical staff other than the individual serving as the designated mental health clinician authority (DMHCA); therefore, this indicator rates as non-applicable.

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

The program has a policy and procedures in place indicating clinical team leaders 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 treatment. The program has four 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 record revealed one of the clinicians has a Master of Science in a human services field and is a certified prevention professional (CPP), one has a master's degree, majoring in marriage and family therapy, and the other two non-licensed clinicians have a Master of Social Work (MSW). 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 four non-licensed clinicians received weekly supervision, when they provided services to the youth, from the designated mental health clinician authority (DMHCA), who is a licensed clinical social worker (LCSW). 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 written policy and procedures regarding the provision of a mental health and substance abuse screening for each youth upon admission. The policy states and an interview with the program director confirmed the program utilizes the Massachusetts Youth Screening Instrument- Version Two (MAYSI-2) as the admission screening. Five youth mental health records were reviewed and each was screened using the MAYSI-2 on the day of admission. Each MAYSI-2 was completed by a staff trained in its administration and was conducted in a confidential manner. Reviewed documentation found the staff reviewed available documentation and completed the MAYSI-2 in full in the Department's Juvenile Justice Information System (JJIS). Each of the youth had hits on the MAYSI-2 which warranted a comprehensive assessment, and all received the assessment as required. All youth receive a comprehensive

assessment as part of the program; therefore, a referral was not required. Four of the five youth required an Assessment of Suicide Risk (ASR) based on supplemental information provided during the admission. The same mental health therapist who completed the MAYSI-2 also immediately administered the ASR; therefore, a referral was not completed or required. Each of the four applicable youth received the ASR immediately after the MAYSI-2 within the required timeframe and documentation was found to support the program director and designated mental health clinical authority (DMHCA) was notified.

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

The program has a written policy and procedures which requires all youth to receive a new comprehensive assessment within thirty days of admission to the program. Five youth mental health records were reviewed and each documented a comprehensive assessment was conducted within the required timeframe. Each assessment was conducted as a combined mental health and substance abuse comprehensive assessment and included all required information. Each assessment was completed by a non-licensed mental health clinical staff and signed and approved by the licensed designated mental health clinical authority (DMHCA) on the same day the assessment was completed.

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.*	

Each youth is assigned to a multidisciplinary treatment team upon admission which was reflected in each of the five reviewed youth mental health records. The treatment teams are composed of the youth, parent/guardian, residential living unit representative, assigned clinician, and other staff responsible for the youth's treatment. Each record and an observation of a treatment team meeting conducted during the annual compliance review confirmed each required treatment team member was involved in the treatment team meetings. Each youth was prescribed mental health and substance abuse services. The program has a Chapter 397 license through the Department of Children and Families to provide substance abuse services to the youth. Each of the five reviewed youth records included a valid Authority for Evaluation and Treatment (AET) and a signed Substance Abuse Consent and Release form to receive prescribed services. Treatment notes were maintained in each youth's mental health record and documented by week on the required Department form. Each youth record included documentation indicating the youth received individual, family, and group therapy. All individual therapy is conducted one-on-one between the youth and clinician. The activity schedule, logbook, and treatment notes indicated the youth participated in group therapy seven days a week. A review of sign-in sheets found all groups included ten or fewer youth, as outlined in the program's contract. The groups addressed psychosocial skills training which addresses specific behaviors and goals outlined in each youth's treatment plan. The skills the youth learned and

practiced are documented in each youth's treatment notes for the group. The designated mental health clinician authority (DMHCA) and non-licensed mental health clinical staff conducted each of the groups and are trained in each modality they facilitate. The DMHCA was interviewed and reported each youth receives group therapy based on their identified goals, which includes Aggression Replacement Therapy (ART), Cannabis Youth Treatment, Living in Balance, and other groups as required. An ART group was observed during the annual compliance review and the youth were engaged in the scheduled lesson plan which was facilitated as outlined in the curriculum. Five youth were interviewed and each youth reported they are involved in group therapy and specified ART. Five staff were interviewed and each confirmed the mental health staff conduct groups for the youth.

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

A review of five youth mental health records found each included an initial treatment plan which was completed on the day of admission to ensure each youth had expedited access to services. The initial treatment plan was documented on a form which included all elements of the required Department form and covered both mental health and substance abuse services. Each initial treatment plan was completed by a non-licensed clinician and signed by the licensed designated mental health clinical authority (DMHCA), as well as other members of the youth's treatment team. Three youth were applicable for psychiatric services upon admission and each of the three initial treatment plans reflected psychiatric services were required.

Each of the five youth mental health records included an individualized treatment plan which was completed within thirty days of each youth's admission. The treatment plans were documented on a form which included all required elements of the Department's form and were completed by a non-licensed clinical staff and signed by the DMHCA within the required timeframe. In addition, all required treatment team members signed the plan. Each record contained documentation indicating the parent/guardian was mailed a copy of the treatment plan, which was subsequently signed and returned in three of the records. The treatment plans outlined the youth's prescribed mental health and substance abuse services, including psychiatric services for the three applicable youth. The five youth required thirteen treatment plan reviews and twelve were completed at intervals no greater than thirty days apart. One review was conducted four days late. A review of each youth's treatment notes in their mental health records reflected each youth received all services as prescribed.

Three closed youth mental health records were reviewed and each included a mental health and substance abuse discharge plan. Each of the three discharge plans was documented on the Department's form and included all required elements. None of the youth were identified as a suicide risk at discharge. There was documentation in each of the records the discharge plan was discussed with the youth, juvenile probation officer (JPO), and parent/guardian. Each

record also reflected the youth, JPO, and parent/guardian were given a copy of the discharge plan.

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

The program provides mental health overlay services (MHOS) as outlined in their contract with the Department. The program provides therapeutic activities and group therapy seven days a week. In addition to MHOS therapeutic groups, all youth also receive substance abuse prevention services, at a minimum, through Living in Balance. Youth with co-occurring substance abuse disorders are prescribed the Cannabis Youth Treatment curriculum. The licensed designated mental health clinician authority (DMHCA) is on-site five days a week and mental health clinical staff coverage is provided seven days a week. Each non-licensed clinician is assigned a caseload of no more than sixteen youth. At the time of the annual compliance review, each clinician had seven youth on their caseload. The program's contracted psychiatrist is on-site every two weeks for at least two hours, as required. The program's contract requires Alcoholics Anonymous and Narcotics Anonymous (AA/NA) to be offered to youth. The program reported they survey youth who have entered transition on whether they are interested in the AA/NA service and if so, are taken to a meeting once a month. Youth trip forms verified youth were taken off-site to AA/NA groups once a month during the annual compliance review period except for the month of June due to a recent youth escape incident. The program director and DMHCA were interviewed and verified the MHOS services are offered daily to youth and include individual, family, and group counseling, and AA/NA groups.

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

The program has a contract with a psychiatrist to provide psychiatric services to youth. The program's psychiatrist is board licensed by the Department of Health with the license expiring January 31, 2020. A review of the psychiatrist's sign-in log found the psychiatrist was at the program every two weeks during the annual compliance review period for at least two hours each week. Five youth mental health records were reviewed and three were applicable for psychiatric services. One of the three youth was admitted to the program with psychotropic medications and was seen by the psychiatrist within the required timeframe. The other two applicable youth were referred to the psychiatrist after admission and each was seen within fourteen days of referral. The initial diagnostic interview for each youth was documented on the Department's Clinical Psychiatric Progress Note (CPPN) and included all required elements. Documentation supported each of the three youth received psychiatric services and medication monitoring for psychotropic medications by the psychiatrist every thirty days. Each psychiatric monitoring was documented on a CPPN, including page three, for each youth which detailed medications. Signatures for the psychiatrist and a witness, indicating the parent/guardian was notified and gave consent, were found any time the youth was prescribed new medication or the

medication was changed. A review of each of the three applicable youth's treatment plans found recommendations from the psychiatrist were incorporated into the plan. An interview with the designated mental health clinician authority (DMHCA) found the DMHCA and nurse observe all psychiatric appointments in order to accurately relay information to each youth's treatment team. In addition to in-person meetings with the DMHCA and nurse, an interview with the psychiatrist revealed the psychiatrist is available by phone to discuss youth needs in treatment team. The psychiatrist also reported they are available twenty-four hours a day for emergency consultation. The psychiatrist is responsible for all psychiatric care at the program and does not utilize an advanced registered nurse practitioner (ARNP).

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 policy and maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The MHSA plan was last updated and approved by the facility administrator and the designated mental health clinician authority (DMHCA) on July 30, 2019. The program's written plan detailed suicide prevention procedures and included all required elements, as outlined in Florida Administrative Code 63N-1. The plan included but was not limited to: identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and recognizing verbal and behavioral cues. Additionally, regardless of screening results, each youth receives a comprehensive evaluation within thirty days of admission. An interview with the executive director indicated the program provides suicide prevention training throughout the year and conducts quarterly mock emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury.

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 suicide prevention plan which outlines their response to youth identified at risk of suicide and includes a review process for serious self-inflicted injuries or mortality which includes all required elements. The program maintains one suicide response kit which was found to include all required items and is kept in administration by the key box. Five youth mental health records were reviewed and four were applicable for suicide prevention services. Each youth was placed and maintained on precautionary observation (PO) upon admission until an Assessment of Suicide Risk (ASR) was completed. The PO was authorized and a mental

health clinician supported the youth. Following an ASR, a conference was held with the clinician, designated mental health clinical authority (DMHCA), and executive director, which was documented on the ASR form. Each of the four youth was stepped to standard supervision as a result of the ASR and conference. None of the four youth had indications of further suicide risk on their ASR; therefore, additional PO or follow-up ASRs were not required. Each ASR was conducted by a non-licensed clinician and signed by the DMHCA. Each non-licensed clinician had documentation of completion of ASR training. Each of the four youth's ASRs were completed immediately following the administration of the admission screening and included notification to the youth's parent/guardian. PO logs documented safe housing areas and staff ensured youth were not restricted in their activities. A review of the program logbook found each youth's PO status was documented, as required. In addition, each youth had an alert appropriately entered and discontinued in the Department's Juvenile Justice Information System (JJIS). The program does not utilize secure observation. Five staff interviews were conducted and each staff reported in the event a youth expresses suicidal thoughts, staff are to notify mental health, the executive director, and team leader and document supervision of the youth. Four staff reported they would place the youth on PO and one additional staff reported they would search the room. Each of the five staff identified the suicide response kit is kept in administration.

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.	

Five youth mental health records were reviewed and four were applicable for placement on precautionary observation (PO). Each of the four applicable youth records included documentation the youth were maintained on PO for the duration of the time they were identified as a suicide risk and the supervision was documented on the Department's form. The youth were maintained on the appropriate level of supervision and checks were completed at no greater than thirty-minute intervals in real time. None of the youth displayed warning signs, which was noted on the back of the PO log. Each log included safe housing requirements and was signed by the shift team leader and the mental health clinician. Three youth interviews were conducted with youth who had been on PO. Each of the three youth reported the staff were with them at all times and they were never left alone while on PO.

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 to ensure all staff who work with youth shall receive six hours of suicide prevention training to include: recognition of verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Five in-service staff training records were reviewed for required suicide prevention training. All five records contained a minimum of two hours of the Department's Learning Management System (SkillPro) training and four hours of instructor-led training. Mock suicide and mental health emergency drills were reviewed for the last four quarters (August 2018-July 2019) and a drill was conducted on each shift in all quarters. The program conducted a total of forty-two drills during this timeframe. Drill participation was reviewed for fourteen random staff (fifty percent of

the total staff who are not on pro re nata status) and the results show all fourteen staff participated in at least one drill each quarter. All staff participate in mock suicide and mental health emergency drills, not just direct care staff. All mock suicide drills contained the use of cardiopulmonary resuscitation (CPR), first-aid, and the use of a suicide response kit. The drills detailed all participants role during the drill and detailed the methods for contacting other program staff, the Central Communications Center (CCC), medical and mental health personnel, and emergency medical services. Documentation reflected staff members who are not present during a quarterly drill were provided with an opportunity to review each drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of suicide attempt or incident of serious self-inflicted injury in the facility. An interview with the executive director confirmed mock suicide and mental health emergency drills are conducted, at a minimum of, once a quarter for all staff on all shifts. Five staff were interviewed about various drills they have participated in within the past twelve months, two out of five staff indicated they had participated in medical and mental health drills quarterly.

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 policy and procedures in place to respond to youth in crisis in the least restrictive method possible to protect the safety of the youth and others while maintaining control and safety of the facility. The program maintains a written crisis intervention plan, reviewed, approved, signed, and dated by the executive director on July 25, 2019 and the designated mental health clinician authority (DMHCA) on July 27, 2019. The plan detailed crisis intervention procedures to include: notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and 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 crisis plan in place to respond to youth determined to be in need of crisis intervention and services. The program did not have any youth in need of a crisis assessment during the annual compliance review period. The program provided documentation of the forms and process they would use in the event a youth was determined to be in need of crisis

intervention. Five staff training records were reviewed and each completed training in suicide prevention and emergency response as required.

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

The program has a written emergency mental health and substance abuse and crisis intervention plan which was reviewed and signed by the executive director on July 25, 2019 and by the designated mental health clinician authority (DMHCA) on July 27, 2019. The plan contains, but is not limited to: immediate staff response, notifications, communications, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 FS (Baker Act), transport for emergency substance assessment and treatment under Chapter 397 (Marchman Act), documentation, training (including mock drills), and review.

3.17 Baker and Marchman Acts (Critical)	Satisfactory Compliance
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 has a written policy and procedures in place which outline the response to youth determined to be in need of emergency mental health or substance abuse services, provided through the Baker or Marchman Act. The program had one youth determined to be in need of Baker Act services on two separate occasions during the annual compliance review period. In the first instance, the youth was immediately placed on one-on-one supervision, assessed by the designated mental health clinical authority through an Assessment of Suicide Risk (ASR), and determined to be in need of Baker Act services. In the second occasion, the youth was initially placed on constant supervision following an ASR; however, when the youth was reassessed the next day, it was determined the youth needed Baker Act services and was placed on one-on-one supervision until transport to the Baker Act facility. Following the youth's return from the Baker Act facility, in both instances, the youth was placed on one-on-one supervision until a follow-up ASR was conducted, at which time each youth was stepped to constant supervision. Each youth was not moved from constant supervision to close supervision until an ASR determined the youth was appropriate for stepping down. Each youth was then placed on close supervision until another follow-up ASR determined the youth was appropriate for standard supervision. All documentation was maintained and supervision was conducted as required for the youth in both instances.

Standard 4: Health Services

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

The program has an independent contractor agreement with a licensed medical doctor (MD). Review of documentation found the MD's license issued by the State of Florida Department of Health (DOH), Division of Medical Quality Assurance is valid through January 31, 2021. The MD's training is in pediatrics. The MD serves as the designated health authority (DHA) for the program and provides on-site services two hours once a week. The program maintains specific sign-in sheets inclusive of the time in and time out. A review of the sign-in sheets validated the DHA was on-site weekly for at least two hours each week except for the weeks of January 2, January 6, and February 12, 2019, when the advanced registered nurse practitioner (ARNP) provided coverage. According to Department Rule 63M-2.0031, the DHA must be on-site at least once a week, with no more than nine days passing between visits. Since January 2019, the ARNP covered for the DHA on four separate occasions (January 2, January 6, January 12, and February 23, 2019). The program's contract requires an MD of equal licensure to provide coverage in the DHA's absence. The DHA's independent contractor agreement requires the DHA to be on-call twenty-four hours a day, seven days a week and assigns responsibility to the DHA for communication with the nursing staff regarding youth medical needs. There is a collaborative practice in place with an advanced nurse ARNP, the ARNP holds an unrestricted license in the State of Florida with an expiration April 30, 2021. An interview with the DHA confirmed they provide weekly on-site services to the program and are available electronically by cell phone twenty-four hours a day, seven days a week. In addition, the DHA reviews nursing protocols and facility policies and procedures. The DHA is responsible for the overall clinical healthcare services provided to youth in the program.

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 maintains a written policy and health-related procedures and protocols. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported the DHA signed all healthcare policies and procedures on July 6, 2019. The program maintains a training requirement for newly employed healthcare personnel to receive a comprehensive clinical orientation to the healthcare policies and procedures, inclusive of Florida Administrative Code 63-M, which was provided by a registered nurse (RN). The program maintains a nursing protocol manual developed and approved by the DHA on July 6, 2019. There is evidence orientation was conducted for all new nursing staff.

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 maintains a written policy and procedures requiring the maintenance of a signed and dated Authority for Evaluation and Treatment (AET) form in each youth's individual

healthcare record (IHCR). The AET form is to be signed by the parent/guardian and serves as informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter medication for which treatment may be rendered by healthcare staff. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the form and to whom the information is released and shared with. A review of five youth individual healthcare records revealed four records contained copies which were clearly stamped “COPY” of an AET and one record contained an original. A review of three additional records for youth who were eighteen years of age or older validated each record contained a release of Information. Two youth were in the custody of the Department of Children and Families (DCF) and each contained the appropriate court orders for treatment. An interview with the nurse indicated they would contact the parent/juvenile probation officer for a current copy of the AET, if needed.

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

The program maintains a written policy and procedures to ensure the parent/guardian is informed of significant changes in the youth’s condition and to obtain consent when new medications and treatments are prescribed. A review of five youth individual healthcare records (IHCR) found no youth required consent for immunizations; two of the five youth on psychotropic medications shows the parent/guardian gave verbal consent to new and changes in medications, along with a note being sent to the parent/guardian. Two of five youth records found the Clinical Psychotropic Progress Note (CPPN 3) was completed by the psychiatrist and witnessed by the registered nurse and sent to the parent/guardian. The parent/guardian, in both records, was contacted and agreed to the treatment. There is evidence the youth did not start psychotropic medication without verbal consent. Two of the five youth required verbal consent for over-the-counter (OTC) medication, not included on the Authority for Evaluation and Treatment (AET) and verbal consent was received, and a written notification was sent to the parent/guardian. Three healthcare records for youth eighteen years of age or older were reviewed in addition to the original five youth records and none required medications or medication changes. Two youth in the care of the Department of Children and Families were reviewed in addition to the original five youth records and none required medication or medication changes. There was no instances off-site emergency care during the annual compliance review period. Nursing progress notes show phone calls to parents/guardians were witnessed at the time of the call, except on one occasion: May 13, 2019 was missing a witness to the call. An interview with the nurse indicated notifications are made electronically, by phone, and/or through mailed documents. The following require parent/guardian notifications to be made according to the nurse interview: OTC medications not covered by the AET, vaccinations/Immunizations not consented for on the AET, significant changes to existing medication (excluding psychotropic medications), changes in condition/medication for youth with chronic conditions, off-site emergency care, notification made by phone and, subsequently, in writing, hospitalizations, surgeries/invasive procedures, non-routine dental procedures, youth presents with same medical complaint three or more times, oral temperature exceeds 102 at two different checks, and whenever a youth is taken off-site for medical treatment.

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

The program maintains a written policy and procedures requiring each youth to receive a routine healthcare screening and evaluation upon admission. A review of five youth individual healthcare records (IHCR) validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening form (FEPHS) on their date of admission. All admission screenings were completed by a registered nurse. An interview with the nurse indicated they see a new youth within two to three days after a youth has been admitted and the FEPHS Screening shall be completed by a registered nurse, licensed practical nurse (LPN), direct care staff, medical doctor, advanced registered nurse practitioner, or other. If completed by direct care staff, it must be reviewed with the youth by LPN or higher within twenty-four hours.

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

The program maintains a written policy and procedures to establish a system for all youth to be oriented to the healthcare system upon admission. A review of five youth individual healthcare records (IHCRs) validated each youth received a healthcare orientation on the day of admission which covered access to medical care, sick call processes, what constitutes an emergency, the medication process, the youth's right to refuse medical care, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare staff. Youth and nursing staff sign the health education packet to acknowledge the training was provided and the youth understood the information provided. In addition to the admission healthcare orientation, youth receive on-going health education which was also documented in the IHCR. Exceptions noted during the review are two youth missing documentation of receiving Hepatitis C education.

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

The program's practice is for the designated health authority (DHA) to be notified by telephone when each youth is admitted. Nursing staff document the notification(s) on the nursing chronological/notification progress note and the DHA notification of admission form. The nurse signs the form and the DHA signs the DHA notification of admission form at the next on-site visit. A review of five youth individual healthcare records validated this practice.

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

The program maintains a written policy and procedures to ensure nursing staff complete the Department's Health Related History (HRH) form prior to the Comprehensive Physical

Assessment (CPA). A review of five youth individual healthcare records found a new HRH form was completed for each youth on the day of admission. The nursing staff and the designated health authority (DHA) each documented their review of the HRH form by signing the form. An interview with the nurse indicated they have seven days to complete the HRH.

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

The program maintains a written policy and procedures to ensure each youth receives or has a current Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority. All sections of the CPA were completed in full utilizing an "O" or an "X." All five reviewed CPAs indicated the youth refused a portion of the examination and each youth documented their signature of refusal on the CPA. Medical grades (MG) were completed on all five youth. Three youth came in as MG 1, one MG 5, and one youth MG 2. A review of the documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. One exception noted was a youth's CPA did not reflect the skin condition/medication the youth was admitted to the program with. All youth had documentation of a Tuberculosis Skin Test (TST) screening being completed, as required. An interview with the nurse indicated a TST screening shall be completed within seventy-two hours of admission if one is not documented in the youth's individual healthcare record (IHCR) within the past year.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). A review of five youth individual healthcare records (IHCRs) found each youth was not identified as needing an STI screenings; however, one youth requested the screening. Testing was provided and filed in the ICHR for STIs utilizing the Department's Sexually Transmitted Infections Screening form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. The program maintains a written policy and procedures to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. Youth who consent to receive counseling and testing sign the Department's HIV Antibody Test Youth Consent form. The program utilizes a local provider to provide pre-counseling, testing, and post-counseling services. A copy of the certificate of registration for the local provider with the Florida Department of Health HIV/AIDS Section found it was valid through June 2020. A review of youth records validated when youth receive pre-counseling, testing, and post-counseling, the youth's health education record was updated in the respective IHCR. Test results were placed in a sealed envelope marked 'confidential' with the youth's name, program name and address, date of test, and youth signature documented on the outside of the envelope and filed in the IHCR. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not

include HIV status as part of the internal alert system. All five interviewed youth stated they could request a HIV/AIDS test.

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

The program maintains a written policy and procedures to ensure all youth can make sick call requests and have their complaints treated appropriately through the program's sick call system. Completed sick call request forms are submitted by each youth into a secured box located outside the clinic, which is checked at least daily by the healthcare staff and every four hours by shift leaders when medical staff are not on-site. The program's licensed nursing has set sick call hours 9:00 a.m. and 4:00 p.m. daily, and as needed. Hours are posted throughout the program. A review of five youth individual healthcare records validated four youth completed at least one sick call request form during their stay, the registered nurse documented the treatment and/or services provided to each youth during the sick call event on the sick call request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period; however, program procedures outlined the healthcare staff would automatically refer such youth to the designated health authority or dentist for an evaluation and treatment. Dental sick call is incorporated into the healthcare sick call process, as was observed during the annual compliance review. When a licensed healthcare staff is not on-site, the shift leader is required to review the sick call complaint and notify licensed healthcare staff who are on-call and are available for consultation to determine if the sick call requires immediate attention and/or for instructions. Sick call observation was completed with the youth's permission on Wednesday August 7, 2019 at 9:15 a.m. Sick call was conducted in the privacy of the nursing office, behind a curtain. The registered nurse (RN) provided a thorough assessment of the youth, including vitals, and questions pertaining to the youth's issue. The youth was provided over-the-counter medication, registered nurse and youth signed the medication administration record, and the parent was notified. Staff was present for safety and security reasons. Sick call was documented in the sick call index and sick call log. Five youth interviews indicated they were seen within twenty-four-hours of submitting their sick call.

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

The program maintains a written policy and procedures requiring a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff are to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth individual healthcare records found four youth required episodic and/or first aid care. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting. Nursing staff also maintained an episodic/first aid/emergency care log documenting all incidents inclusive of care date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA) and/or off-site care. The program maintains first aid kits in the administration building,

cafeteria, and medical office. There are three first aid kits assigned for use when transporting youth in the program vehicles, which are maintained in the medical office. Three first aid kits were opened and each included the required DHA approved contents. All expiration dates were valid. First aid kits are checked monthly and as needed to replace supplies. Documentation of these checks is documented on the internal tracking sheet titled first aid kits monthly checks and maintained in the medical office. Nursing staff check the first aid kits weekly, and the automated external defibrillator (AED) and suicide response kits are checked monthly. The AED is in a secure box, accessible to staff, outside of the administration building. The directions of use are located with the AED. The AED's current batteries expire October 2020; the batteries were last changed on June 2019. The pads expire May 2021 and were last installed on June 2, 2019. A review of ten training records supported all non-healthcare staff who have direct contact with youth maintained current certification in first aid, and cardiopulmonary resuscitation (CPR) with AED. The program's registered nurses (RN) also each maintain current certifications in CPR/AED and basic first aid. Suicide response kits containing a knife-for-life, wire cutters, and needle nose pliers are maintained in the medical office and staff control room. Reviewed documentation showed the program conducted medical drills monthly on each shift. Reviewed documentation found the program conducted a CPR/AED medical drill three times on the second shift, and three times on the first shift in the last nine months; currently, the program is running two twelve-hour shifts. Observations made during the tour of the program found postings informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were maintained in master control and the medical clinic. All five youth interviewed indicated they can see the doctor when needed.

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

The program maintains a written policy and procedures to require any evaluation conducted off-site be recorded on the Department's Summary of Off-Site Care form (HS033). The designated health authority (DHA) is to review, sign, and date the off-site care instructions. A review of five youth individual healthcare records (IHCRs) revealed no youth required off-site care and/or emergency care. There were no offsite records applicable to be reviewed since the last annual compliance review.

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

The program maintains a written policy and procedures to require youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen be adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth individual healthcare records (IHCRs) indicated one youth was admitted with an identified chronic condition, as documented on the Facility Entry Physical Health Screening (FEPHS) form. Reviewed documentation in nursing progress notes of the IHCRs reflected the youth received consistent periodic evaluations at intervals no greater than two months, as required. There was one indication of a lapses in care or missed periodic evaluations from the designated health authority (DHA) for the March 23, 2019 visit. An interview with the DHA indicated youth

are evaluated at a minimum of every sixty days. The psychiatrist evaluates each youth on psychotropic medication every thirty days. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The Department's Problem List was updated as required for each applicable youth.

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

The program maintains a written policy and procedures requiring medical staff to verify any medication arriving with a newly admitted youth and to continue all currently prescribed medications and to ensure all medications have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of five youth individual healthcare records (IHCRs) indicated two youth were admitted into the program on prescribed psychotropic medications and one was admitted on an over-the-counter (OTC) medication. Review of the nursing admission notes documented the youth's current medication and the designated health authority (DHA) notification of admission documented current prescribed medications for each of the three applicable youth. Reviewed documentation confirmed the nursing staff verbally notified the DHA of each admission on the youth's day of admission. It is the program's practice to notify the DHA of every admission. The DHA or psychiatrist resumed the prescribed medication for each applicable youth and reviewed Medication Administration Records (MARs) validated the practice. One youth received a new medication order due to not arriving with his inhaler. Three of the five youth received OTC medications. All medications were documented on MARs, including weekly side effects monitoring. The MARs were initialed by staff and contained stop and start dates. One of the five youth had a pro-re-nata (PRN) medication administered on June 14 and July 7, 2019 with no documentation on the back of the MAR indicating dosage/reason/results. One of the five youth received an OTC medication from a non-licensed healthcare staff. The initial of staff on the MAR was not legible and the youth did not initial the MAR. There were no lapses in medication delivery. Medication pass observation was completed on Thursday August 8, 2019 at 3:30 p.m., the registered nurse and youth followed the five Rights of Medication Delivery. The youth stated their name, date of birth, and allergies. The nurse reviewed the youth's MAR for medication, signed the MAR, and provided the medication to the youth. The youth's mouth was swept and verified again by another staff member. An interview with the nurse indicated non-healthcare staff will adhere to the protocols for non-healthcare staff which include: standing orders for psychotropic medications, emergency treatment orders for psychotropic medication or PRN orders for psychotropic medications which are in the front of the medication administration record book and document care provided on the Report of On-Site HealthCare by Non-Health Care Staff HS049 form. Five youth interviews indicated four youth received medications from a nurse and one did not take medications.

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

The program maintains a written policy and procedures requiring all medications to be identified and secured in a locked area designated for the storage of medication, chemical products, and medical and dental instruments assigned to the medical department to be securely stored,

properly maintained, regularly inventoried, and disposed of in accordance with federal and state laws. Observations of the medical clinic confirmed all medications were securely stored and inaccessible to youth. All narcotics and controlled medications were securely stored within the double locked medication cart. Oral medications were stored in the medication cart separately from injectable and topical medications. The program has a refrigerator in the medical clinic utilized solely for medications requiring refrigeration. The program did not have any parenteral medications nor any medications requiring refrigeration at the time of the annual compliance review. The program securely stores sharps including needles, syringes, scissors, scalpels, and staple and suture removal kits in a locked cabinet, separate from medications. A review of three sharps and three over-the-counter (OTC) medications found all counts matched the inventory count total. Based on a review of five youth records, an inventory of OTC medications is conducted on a weekly basis. A controlled count is kept on medication using the controlled inventory form. Each count contains two initials of the staff conducting the count. The program's policy and procedures also include a written process for the destruction and disposal of expired or discontinued medication. The program's disposal practice is to place the medication in prescriptions (Rx) destroyer chemical drug destruction neutralizer under the joint supervision of the registered nurse and the consultant pharmacist. An interview with the nurse indicated counts are conducted weekly, all medications and sharps are behind two locks, disposal of discontinue medication is done by two nurses using Rx destroyer with the contracted licensed pharmacy is diamond pharmacy.

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

The program maintains a written exposure control plan addressing risk assessment, methods of compliance, engineering and work-place control, as well as training requirements for the provision of a safe environment for youth, staff, and visitors. The infection control plan is combined with the program's exposure control plan. The plan was reviewed and approved by the executive director (ED). The program's exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910). The exposure control plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes hepatitis A, B, C, human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens, and a needle stick process is in place, located in the infection control plan. The plan addresses outbreaks in pediculosis and/or scabies outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist agents, chemical exposures, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms and is available to staff. A review of five individual health care records (IHCR) found youth received education of hand washing/infection control and infection control training within seven days of admission to the program. The program reports there were no incidents involving a contagious disease requiring the quarantine or hospitalization of ten percent of the total population of youth and staff. An interview with the registered nurse indicated there were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the ED

indicated the exposure control plan is in the medical clinic and the plan is reviewed with staff annually. Education on handling exposures is conducted several times each year in all-staff meetings and indicated in the ten staff training records reviewed, through the Department's Learning Management System (SkillPro), and through medical drills. Staff is provided Hepatitis B immunizations annually.

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

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

Standard 5: Safety and Security

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

Youth and staff observations were conducted each day during the annual compliance review week, at various times and during various activities. The daily schedule was posted in each living unit. A review of the schedule and observations indicated the program adhered to the contractual compliance for the program's staffing ratio of one staff to every eight youth during awake hours and one staff to every twelve youth during sleeping hours. Staff were aware of the youth under their supervision and provided appropriate daily counts when asked. Informal interviews with staff confirmed staff were aware of the program's ratio requirements. Staff were able to explain the process when youth counts are not accurate.

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

The program has a clearly written behavior management system (BMS), which has not changed since the last annual compliance review. An interview with the compliance specialist indicated the program's BMS is designed to decrease unwanted behaviors and increase desired behaviors through positive reinforcements of four-to-one ratio. Rewards earned include a variety of incentives based on earning points and what level the youth is at. Negative consequences used by the program include failure to earn points, and for more serious infractions a referral for a special treatment team meeting would be required.

The program has annual in-service training and pre-service training plans which includes the BMS for all staff. A review of five staff training records for in-service and five pre-service training records verified each staff completed the required BMS training during the first 180 days of hire and annually thereafter. The BMS has a detailed explanation of the expectations and outlines daily, weekly, and monthly incentives to include responsibilities, expectations, and level advancement. A review of five youth case management records indicated the youth received orientation and a handbook which included a review of the program's BMS. Rules specify the conduct of positive and negative consequences for behavior and is posted throughout the facility including the living units. An interview with the executive director indicated the BMS is monitored daily by the program's management team which also includes the case management department. Five staff were interviewed and indicated they understood how the BMS should be implemented, the point system used by the program, and could explain what type of rewards are given to youth. Five youth were interviewed, and each was able to explain the program's level system and how to progress to the next level. During the annual compliance review week,

staff were observed interacting positively with youth. Staff were observed counseling youth regarding their behavior and offering verbal praise for accomplishments.

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 written behavior management system (BMS), which outlines infractions and system monitoring. The BMS has guidelines for staff to explain to the youth the reason for any infractions imposed, and youth to explain their behavior. Consequences for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and consistently enforced. The program does not utilize room restriction as a form of imposing infractions for inappropriate behavior or utilized increase length of stay. An interview with the director of operations indicated he tracks all youth consequences. The management team and case management department review all youth and their progress daily. Employee position descriptions contained required qualifications of staff whose job functions includes implementation of the program's BMS. Five staff were interviewed, and each indicated youth are informed of any infractions immediately and when they attend treatment team meetings, also staff indicated they are given feedback on the BMS on their annual evaluations and throughout their shift. Five youth were interviewed and indicated they have never been sent to their room for punishment and are not allowed to punish other youth. The youth also indicated staff provide rewards and consequences fairly. The program's education staff are employees of the program and are trained in the implementation and on-going maintenance of the BMS.

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

The program has a written policy and procedures regarding ten-minute checks. The policy requires staff to observe and document in real time on a head count log while youth are in their sleeping quarters. Documentation shall include initials of the staff conducting the check. The program is equipped with a thirty-two-camera system; however, none of the cameras are placed in the youth living units. The program's living units are open bay sleeping units with eight bunks each. All youth are visible from the front and rear of each housing unit. Staff are required to ensure youth are present in their bunk by visually confirming the actual body skin is present. A review of the past six months of head count logs on various days and times for ten-minute checks was conducted. The review found the checks were documented every eight-minutes or less in real time, without exception. The logbook, as well as the shift reports were reviewed for ratio, which was also met consistently. None of the reviewed logs contained preprinted times.

Five staff were interviewed and indicated room checks are to be completed every eight minutes while the youth are sleeping, and a supervisor completes a check every hour.

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

The program has a written policy and procedures regarding youth census, counts, and tracking. Formal, informal, and emergency head counts are documented in the facility logbook. A random review of the program's logbooks for the past six months revealed documentation of youth counts at the beginning and end of each shift, after outdoor activities, and movement from school, and groups. Documentation in the logbooks also included youth temporarily away from the program and released or admitted to the program. Observations of youth counts during the annual compliance review indicated the supervisor on duty conducts all counts prior to any youth movement, as well as all formal, informal, and emergency head counts. Five staff were interviewed and indicated youth are counted every hour, between movements, and during emergencies. Counts were observed being conducted throughout the annual compliance review anytime youth movement occurred such as youth moving to classrooms, lunch, or restroom.

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

The program has a written policy and procedures for logbook entries and shift report reviews. The program's practice is to have the on-duty supervisor maintain the logbook, and a shift report. A review of the program's logbooks and shift reports for the past six months included entries with the date and time, all emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from precautionary status, admission, releases, and calls to the Department's Central Communications Center (CCC), and the Florida Abuse Hotline. The logbooks were bound with numbered pages and had entries completed in ink. There were no white-out areas observed and errors were struck through with a single line and initialed by the person correcting the error. Also, a review of logbooks and shift reports confirmed shift briefings are signed by all staff in the logbook reviewing the past two shifts, as well as the shift report which are maintained in the living units for the past forty-eight hours.

5.07 Key Control	Satisfactory Compliance
The program has a system in place to govern the control and use of keys including the following: • *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 written policy and procedures for key assignment, inventory of keys, tracking, and storage of keys. The policy requires all visitors and all staff to turn in their personal 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. All keys are maintained in the administration area within three individual locked boxes. The program also does not issue direct care staff facility keys, only administration, the physical plant manager, supervisors, and medical and mental health staff are issued restricted keys which are kept in a separate locked key box. Staff who are issued permanent keys sign a pre-printed roster with assigned key log before and at the end of each shift. A random check of three staff indicated none of the staff had personal keys on their person, and each had their assigned keys. Five staff were interviewed, and all were aware of the program's key control policy. The program recently underwent an escape resulting in two youth gaining access to a staff's personal vehicle keys. The program's corrective action plan was to include disciplinary actions, replace new locking metal cabinet key boxes, training for all staff on escape prevention plan, youth classroom movement procedures, staff positioning/behavior warnings signs, transitioning around the facility, key room secured, and internal alert system. Also, staff reporting to work for 8:00 p.m. to 8:00 a.m. shifts are to secure their personal vehicles with an assigned vehicle club provided by the program. During the annual compliance review, a review team member observed tasks assigned from the corrective action plan were met.

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

The program has a written policy and procedures which identifies a list of unauthorized and illegal contraband and how it is to be disposed of. Youth are informed through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor sign-in sheets verified a list of the required unauthorized items not permitted to include personal cellular telephones, devices capable of taking photos, and/or audio/video recordings. The program conducts contraband searches of the youth rooms, facility, and perimeter checks at least once a day and findings are documented on the program's room search checklist, facility inspections form, and logbooks. The director of operations is responsible for reviewing and signing the search report forms. An interview with the director of operations indicated staff are to follow their facility operating procedures (FOPs) should illegal contraband be found. Any contraband and/or illegal contraband discovered by staff are to notify the Department's Central Communications Center (CCC). Illegal contraband is handled and disposed of in consultation with law enforcement.

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

The program has a written policy and procedures in place addressing searches and full body visual searches. Searches are conducted upon admission, after visitation, when youth return from any type of off-site activity, and movement to and from class. Observations during the annual compliance review verified the program's practice of searches following movement from group, school, and transportation to ensure the safety of youth and staff. The searches and full body visual searches were conducted in accordance with the Department's Protective Action Response (PAR) training policy. All searches were conducted by staff of the same gender as the youth. Staff gave instructions and explained the reason and the extent of the search. All five interviewed staff were aware of the process for conducting searches and when to conduct a

search on youth. All five interviewed youth indicated knowledge of when visual and full body searches are conducted.

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

The program has a policy and procedures for vehicles and maintenance. The program has three vans which are used to transport youth. In all three vans a fire extinguisher, window punch, and a seatbelt cutter was observed. All passenger seatbelts were operational. The program stores the vehicle's first aid kits in medical and staff check them out prior to each transport. There were no transports during the annual compliance review; therefore, an interview was conducted with a transport staff which explained, in detail, what is to transpire before, during, and after a transport; there were no issues identified. A random check of personal and transport vehicles was found locked. The program provided documentation of ongoing preventative maintenance being completed, along with annual inspections for all three vehicles. The program provided documentation weekly vehicle inspections were conducted.

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

The program has a policy and procedures regarding the transportation of youth. The policy states, youth are transported with a ratio of one staff to five youth. All transports must have one staff of the same gender on the transport with the youth. Youth are not left unsupervised in the vehicles and no youth are permitted to drive program or staff vehicles. All staff operating a program vehicle must have a current driver's license. The program's business manager conducts driver's license checks on all staff, monthly. Documents were provided showing all approved transport staff are up-to-date on their driver's license checks. An inspection of the vehicles prior to the transport is completed to ensured they are equipped with safety equipment and seatbelts for each youth and staff. Five staff were interviewed and indicated they are issued a program cellular phone during a youth transport, and staff are not allowed to use their personal vehicles to transport youth.

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

The program has a policy and procedures regarding weekly safety and security audits. The policy requires weekly safety and security audits to be completed, which are the primary responsibility of the physical plant manager and director of operations. The program utilizes a security audit and safety inspection form to document weekly audits. All major deficiencies are to be reported to the executive director and a corrective action is created until the deficiency is corrected. The physical plant manager is responsible for completing all work orders submitted

by staff. The weekly safety inspections were reviewed for the last six months and confirmed the inspections were completed weekly. An interview with the physical plant manager was conducted which he confirmed this 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 for the access and inventory of tools. The physical plant manager is responsible for the inventory, storage, and usage of the tools. Mops, brooms, and dust pans are the only tools in the program and are kept in a locked storage room. All other tools are kept outside the main building in a locked shed inaccessible to youth. Kitchen sharps are kept in the kitchen in a locked cabinet inside the kitchen storage closet and inventoried every day or after they are used. An observation of the tool storage area indicated it was clean, neat, and each tool was accounted for. All tools are marked with an identifier and/or located on a shadowed pegboard and inventoried by the physical plant manager at the beginning of the shift and end of the shift. A review of inventory reports for the past six months confirmed this practice.

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

The program has a written policy and procedures to safeguard youth handling of tools. The program completes a risk assessment on all youth to determine their eligibility to use tools. The policy also requires youth to be trained on using tools properly.

A review of youth risk assessment confirmed they were completed on each youth prior to the youth utilizing tools and updated as needed. Class A tools can only be used by the highest-level privileged youth as identified on the program's behavior management system, and risk assessments completed. The policy also states youth are not allowed to handle kitchen tools. Youth who earn their certification for safe serve may only be in the kitchen area to help serve food. During the week of the annual compliance review, it was confirmed the program provides the appropriate minimum staff-to-youth ratios during activities involving tools. A review of five youth case management records and five staff training records confirmed youth and staff were trained to use tools in a safe manner. Five staff were interviewed and indicated youth can use class A and B tools depending on their risk assessment. Five youth were interviewed and indicated they can use class A and B depending on 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 written policy and procedures for outside contractors prior to beginning work projects in the program. All contractors are provided a contractor agreement outlining the inventory of tools being used, signing in, and example of items not allowed in the facility. An interview with the director of operations indicated when contractors are on-site, youth are not allowed near the work area. While the work is being performed, the physical plant manager or

director of operations is assigned to the contractor to ensure the work is being completed and all tools are accounted for. A review of randomly selected work invoices along with the corresponding visitors sign-in logs indicated contractors did sign in on the visitors log once on-site and the contractor agreement was signed with a list of tools if applicable.

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 written policy and procedures for fire, safety, and evacuation drills. The program performs monthly fire and safety drills on all shifts. The program conducts evacuation drills quarterly. A review of fire, safety, and evacuation drills for the past six months indicated drills were conducted and documented on a drill safety form and maintained in a drill binder secured in administration area. All drills were also documented in the program 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 one COOP drill, 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. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program has a continuity of operations plan (COOP). The plan provides for basic care and custody of youth in the event of an emergency or disaster. The plan was forwarded to the Department for approval on March 26, 2019 and approved and signed on the same date. Review of the plan indicated alternative housing if the program must be evacuated due to an emergency or disaster. An interview with the compliance specialist indicated a copy of the COOP is located in every area within the facility for staff easy access. Critical information on all youth is maintained in the case management office within a secured locked file container.

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 in place regarding the storage and inventory of flammable, poisonous, and toxic items. A review of the program's storage area found flammable, poisonous, and toxic materials stored in a secure room located in the maintenance area which is inaccessible to youth. A review of Safety Data Sheets (SDS) for stored materials was conducted and verified they are maintained for all materials on-site. Observations made during the annual compliance review confirmed the program maintains a list of staff authorized to handle flammable items posted on the doors in the designated areas. When comparing the chemicals stored in the secure and locked cabinet with the SDS records, there was a SDS for all chemicals in inventory.

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

The program has a written policy and procedures which prohibits youth from handling flammable, poisonous, and/or toxic items and materials. The program maintains strict control of these items. Youth do not use, clean, or dispose of any bio hazardous material, bodily fluids, or human waste. Observations made during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. Informal interviews with the physical plant manager and director of operations confirmed the program's practice. Five interviewed youth reported they are not allowed to handle cleaning products.

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

The program has a written policy and procedures for disposing chemicals. The physical plant manager oversees the disposal of chemicals. The physical plant manager takes the chemicals to a local hazardous waste drop-off site, when needed. The program also has a contract with an outside contractor who comes on-site to retrieve any grease, when needed. Kitchen liquid waste, except grease, is disposed of in the kitchen. Disposal of hazardous materials are in accordance with Occupational Safety and Health Administration (OSHA) standards. All hazardous materials are secured and inaccessible to youth. The program maintained a log sheet to track the disposal of such items. There have not been any incidents of a chemical spill at the program within the last six months according the physical plant manager. An informal interview with the physical plant manager and director of operations confirmed the program has a process in the event of a chemical spill and procedures for disposing of chemicals.

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

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

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

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

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

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

The program has a comprehensive water safety plan which contains all the required elements to ensure proper supervision and youth safety during water-related activities. The plan lists a variety of standards for various water activities including scuba diving, snorkeling, canoeing, kayaking, sailing, and fishing. The plan also includes the required ratio of one certified lifeguard instructor to eight youth when related to visits to local water parks. The program provided a binder of information regarding lifeguard certification, youth swim tests, and trip planning for swim practice. A review of these documents verifies the program's practice is consistent with their water safety plan. The program employs one staff member who is a certified lifeguard. A copy of his American Red Cross Certificate of Completion form indicating an up to date lifeguard certification, cardiopulmonary resuscitation (CPR) certification, and first aid certification dated May 3, 2019, which is valid for two years. All youth receive a written test before undergoing a swim test. Each swim test 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.

Five youth were interviewed, of which four indicated they have not participated in water activities or had taken the swim test as the youth had not been in the program long enough; one said they

had received a swim test. A review of logbooks did not indicate any water activities had taken place.

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

The program has a written policy and procedures in place for youth to have visitation and communication with family members. Youth and parent/guardian are informed of visitation during the orientation process. The program encourages visitation from the parents/guardians by sending out a welcome letter upon each youth's admission, notifying them of the days and time of visitation, who can visit, and the corresponding rules for visitation. Visitation is held once a week on Sundays and a family day is held every quarter. A list of authorized visitors and correspondence is placed in each youth's case management record. Youth are provided writing materials and a self-addressed stamped envelope to send letters to family members. A review of five youth case management records indicated each record contained an approved correspondence, visitation, and telephone log. The visitation and telephone schedules are visibly posted in the youth's living area. Five youth were interviewed, and each stated they are given the opportunity to communicate with family members by mail, telephone, and during visitation.

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

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

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

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

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

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

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

The program has a policy and procedures in place to address a safety plan for each youth admitted to the program within fourteen days of admission and updated every thirty days. The policy indicates the safety plan will be prepared jointly by the youth, parent/guardian, and multidisciplinary treatment team. The plan is to contain the youth baseline behaviors collected from history, parents/guardians, warning signs, and evaluations. There is to be crisis recognition, coping strategies and perception of verbal and nonverbal stimuli which have both positive and negative effects on the youth. The plans are to be in a centralized location for easy access to all staff. A review of the program's safety plan binder contained a safety plan for every youth currently at the program and is located in the staff briefing room. Each plan contained all required elements. Five youth were interviewed, three indicated they were involved in the development of the safety plan, two indicated they were not. Five staff were interviewed, two indicated they reviewed safety plans, and three indicated they have not. An interview was conducted with the compliance specialist concerning the outcomes of the interviews, which she provided documentation staff were provided training on safety plans, and each briefing staff are to review, also there is an upcoming refresher training on safety plans. As for the youth response, each youth had signed every safety plan indicating they were involved in the development of the plan.