**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): September 22-25, 2020***

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

## Rating Definitions

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

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

## Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:
Jonathan Thompson, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Marvin D. Bliss, Office of Accountability and Program Support, Lead Reviewer (Standard 2)
Stephanie Shay, Office of Accountability and Program Support, Central Region Deputy Supervisor (Standard 2)
Greg Mahoum-Nassar, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Shawna Sweney, TrueCore Behavioral Solutions, Health Services Administrator (Standard 4)
Kara Brown, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Melissa Johnson, Office of Accountability and Program Support, Regional Director, Central Region (Standard 5)
Amanda Nelson, Office of Accountability and Program Support, Regional Monitor (Interviews)
Cindy Jones, Office of Education, South West Region Education Coordinator (Standard 2)

Program Name: Youth Environmental Services
Provider Name: AMIkids Inc.
Location: Hillsborough / Circuit 13
Review Date(s): September 22-25, 2020

MQI Program Code: 388
Contract Number: 10172
Number of Beds: 32
Lead Reviewer Code: 176

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

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 1.17 Advisory Board | 2.10 Performance Plan Revisions |
| 1.20 Recreation and Leisure Activities | 2.14 Incorporation of Other Plans Into Performance Plan |
| 2.06 Gang Identification: Prevention and Intervention Activities | 5.04 Ten Minute Checks * |
| 2.09 Performance Plan Development, Goals and Transmittal * | 5.13 Tool Inventory and Mangement |
| 3.09 Psychiatric Services * | |
| 5.01 Youth Supervision * | |
| 5.06 Logbook Entries and Shift Report Review | |
| 5.08 Contraband Procedure | |
| 5.09 Searches and Full Body Visual Searches | |
| 5.15 Outside Contractors | |

# 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 | Limited |
| 1.18 | Program Planning | Satisfactory |
| 1.19 | Staff Performance | Satisfactory |
| 1.20 | Recreation and Leisure Activities | Limited |

* 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 | Limited |
| 2.07 | Residential Assessment for Youth (RAY) | Satisfactory |
| 2.08 | Youth Needs Assessment Summary (YNAS) | Satisfactory |
| 2.09 | Performance Plan Development, Goals and Transmittal * | Limited |
| 2.10 | Performance Plan Revisions | Failed |
| 2.11 | Performance Summaries and Transmittals | Satisfactory |
| 2.12 | Parent/Guardian Involvement in Case Management Services | Satisfactory |
| 2.13 | Members of Treatment Team | Satisfactory |
| 2.14 | Incorporation of Other Plans Into Performance Plan | Failed |
| 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 |
| 2.22 | Safety Planning Process for Youth | 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 * | Limited |
| 3.10 | Suicide Prevention Plan * | Satisfactory |
| 3.11 | Suicide Prevention Services * | Satisfactory |
| 3.12 | Suicide Precaution Observation Logs * | Satisfactory |
| 3.13 | Suicide Prevention Training * | Satisfactory |
| 3.14 | Mental Health Crisis Intervention Services * | Satisfactory |
| 3.15 | Crisis Assessments * | Satisfactory |
| 3.16 | Emergency Mental Health and Substance Abuse Services * | Satisfactory |
| 3.17 | Baker and Marchman Acts * | Non-Applicable |

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# Standard 4: Health Services
# Residential Rating Profile

## Indicator Ratings

| Standard 4 - Health Services | | |
|---|---|---|
| 4.01 | Designated Health Authority/Designee * | Satisfactory |
| 4.02 | Facility Operating Procedures | Satisfactory |
| 4.03 | Authority for Evaluation and Treatment | Satisfactory |
| 4.04 | Parental Notification/Consent | Satisfactory |
| 4.05 | Healthcare Admission & Rescreening Form | Satisfactory |
| 4.06 | Youth Orientation to Healthcare Services/Health Education | Satisfactory |
| 4.07 | Designated Health Authority/Designee Admission Notification | Satisfactory |
| 4.08 | Health-Related History | Satisfactory |
| 4.09 | Comprehensive Physical Assessment/TB Screening | Satisfactory |
| 4.10 | Sexually Transmitted Infection & HIV Screening | Satisfactory |
| 4.11 | Sick Call Process | Satisfactory |
| 4.12 | Episodic/First Aid Care/Emergency Care | Satisfactory |
| 4.13 | Off-Site Care/Referrals | Satisfactory |
| 4.14 | Chronic Illness/Periodic Evaluations | Satisfactory |
| 4.15 | Medication Management | Satisfactory |
| 4.16 | Medication/Sharps Inventory and Storage Process | Satisfactory |
| 4.17 | Infection Control/Exposure Control | Satisfactory |
| 4.18 | Prenatal Care/Education | Non-Applicable |
| 4.19 | Licensed Medical Staff* | Satisfactory |

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# Standard 5: Safety and Security
# Residential Rating Profile

## Indicator Ratings

| Standard 5 - Safety and Security | | |
|---|---|---|
| 5.01 | Youth Supervision * | Limited |
| 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 * | Failed |
| 5.05 | Census, Counts, and Tracking | Satisfactory |
| 5.06 | Logbook Entries and Shift Report Review | Limited |
| 5.07 | Key Control* | Satisfactory |
| 5.08 | Contraband Procedure | Limited |
| 5.09 | Searches and Full Body Visual Searches | Limited |
| 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 | Failed |
| 5.14 | Youth Tool Handling and Supervision | Satisfactory |
| 5.15 | Outside Contractors | Limited |
| 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 |

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

## Program Overview

The 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, when applicable. The primary services used by the program are Cannabis Youth Treatment (CYT), which is an evidence-based practice and Aggression Replacement Therapy (ART), which is a promising practice. Additionally, the program offers Impact of Crime (IOC), which is a promising practice, and The Council for Boys and Young Men, which is a practice with demonstrated effectiveness. 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. Services provided by the case manager include initial contact with the parent/guardian, orientation of the youth to the program, and notification to the court of the youth's admission to the program. Other responsibilities include completion of the Youth Needs Assessment Summary (YNAS), Residential Assessment for Youth (RAY), reassessments, development of the performance plan, facilitating formal and informal treatment team meetings, completing performance summaries, and transition planning.

The layout of the program includes: six buildings, one for administration, two classrooms, and two 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 participates in bi-annual Summer (South Carolina State University Campus) and Winter Challenge (Hudson, Florida) events, where youth compete against other AMIkids programs spanning 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.

- The program has a vocation program in which youth are able to earn industry recognized certifications in the following areas: SafeStaff (Food handler Certification); First Aid, The National Center for Construction Education and Research (NCCER) which offers Core Carpentry and NCCER Carpentry Core Carpentry and NCCER Carpentry Level one certifications.

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

# 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 policy and procedures addressing pre-employment background screenings. Twenty-four applicable staff records were reviewed for background screenings. All twenty-four new staff records reflected a completed background screening from the Agency for Healthcare Administration (AHCA) Clearinghouse through the Department's Background Screening Unit (BSU). All twenty-four personnel records reviewed, which verified background screenings were completed and passed prior to the date of hire, criminal histories were reviewed, and a pre-employment assessment tool was administered to direct care applicants, all of which attained a passing score, which were stored in their individual employee record. Reviewed documentation confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, and the Florida Department of Law Enforcement (FDLE), and the Automated Training Management System (ATMS). The program's Annual Affidavit of Compliance with Level 2 Screening Standards was completed for the program and sent to the BSU on January 20, 2020, meeting the annual requirement.

| 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 maintains a policy and procedures to address five-year background rescreenings. The policy dictates a rescreening to be completed every five years, calculated from the staff's original hire date with the program or five years from the date the staff was screened through the Department's Background Screening Unit (BSU)/Clearinghouse. During the annual compliance review, the program's staff roster was reviewed and only one staff was applicable for a five-year rescreening. A rescreening/resubmission was submitted to the BSU/Clearinghouse at least ten business days prior to the five-year anniversary or retained prints expiration date. Additionally, there were no volunteers eligible for a five-year background rescreening.

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

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

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

The program has a policy and procedures for reporting abuse and for providing an abuse-free environment. The policy reflects youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. Staff adhere to a code of conduct, as indicated in the receipt of the employee handbook contained in the seven staff records with signatures. A facility tour was conducted and postings of the Florida Abuse Hotline and Central Communications Center (CCC) telephone numbers throughout the program were observed. The program's policy clearly outlines reporting procedures for all staff in the event of a youth reporting abuse. A resident handbook includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC telephone numbers is provided to each youth upon admission. The executive director 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 direct care staff notifies a shift leader, and the youth is taken to a telephone where they may make the call in private. The program completed a yearly Trauma Informed and Caring Environment (TRACE) self-assessment on July 30, 2020, which includes surveys designed to gauge the progress of implementing a trauma-responsive approach and caring environment for youth and staff.

Documentation since the last annual compliance review was evaluated for allegations of abuse to the Florida Abuse Hotline or CCC and five reports alleging abuse were found. All five abuse related instances confirmed a report was made by staff to the CCC within two hours of staff being made aware of the incident. All five incidents reflected management took immediate action to investigate the allegations and determined all, but one case, was unsubstantiated. The one substantiated incident reflected a breach of conduct, in which the direct care staff employment was terminated during the internal investigation process. Five interviewed staff, as well as an interview with the executive director, confirmed the program's abuse reporting

practice. Five interviewed youth reported feeling safe in the program and indicated all staff are fair and consistent in their treatment of the youth. Each youth reported never being denied access to contact the Florida Abuse Hotline, but they confirmed staff would provide them the opportunity to call, if needed.

| 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 policy and procedures which address management's response to allegations of abuse. A review of internal incidents and reports made to the Department's Central Communications Center (CCC) found the program had two applicable incidents concerning allegations against staff for incidents of physical, psychological, and/or emotional abuse since the last annual compliance review. No other CCC incidents were applicable for managerial response actions. Documentation confirmed a call was made by staff to the CCC within two hours of staff being made aware of the incident. Reviewed documentation for the incident reflected management immediately initiated an internal investigation and took appropriate precautions until findings of the cases were determined. Only one of the two incidents required inspector general intervention to investigate the claim, in which, there was no evidence of abuse. The one substantiated incident reflected a breach of conduct; however, the direct care staff employment self-terminated their employment during the internal investigation process.

During an interview with the executive director (ED), it was confirmed staff are trained on incident reporting as part of their pre-service training. The ED indicated the single substantiated incident involving one staff member was pending disciplinary action due to allegations of abuse, however, the staff resigned from their position prior to the completion of the internal investigation.

| 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 maintains a policy and procedures to address reporting incidents occurring at the program to the Department's Central Communications Center (CCC). The program had twenty-three incidents reported to the CCC during the last six months, of which five were reviewed. The reviewed documentation validated four of the five incidents were reported to the CCC within the mandatory two-hour time frame and in accordance with CCC reporting procedures. One of the five CCC reports was reported to the CCC one hour late. All five reviewed CCC's required an accompanying logbook entry and all were properly documented. A comparison of reportable incidents during the last annual compliance review period showed a decrease of the reportable incidents from annual review period, to fourteen incidents in the current year. The program's executive director stated all youth are explained their rights and how to report abuse during their program orientation.

| 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 policy and procedures regarding Protective Action Response (PAR) . The program's PAR plan was submitted and approved by the Department's Office of Staff Development and Training on February 2, 2020. The program had four PAR reports during the previous three months and a total of five since the last annual compliance review. All five reports were reviewed. All reports reflected a review by a PAR-certified instructor, reports were processed within the seventy-two-hour required time frame by all required parties, and a post-PAR interview was conducted within thirty-minutes of each incident. A review of the PAR incident reports and comments by the executive director (ED) or designee within seventy-two hours of the incident was found in each PAR report. All five PAR instances required a medical PAR report which was properly completed in all cases. Each report was examined by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. None of the five PAR incidents included the use of mechanical restraints. The program's PAR rate has decreased since the last annual compliance review. The program's PAR rate during the annual compliance review period was .52 which is below the statewide Residential PAR rate of 2.23. An interview with the ED indicated PAR incidents are documented in the facility logbook, discussed with management team during the daily meetings, and a PAR report is completed for each PAR incident which is maintained in a binder organized by month.

| 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 policy and procedures addressing pre-service training. The program utilizes a pre-service training plan curriculum for all new staff which was submitted to the Department's Office of Staff Development and Training and approved on February 17, 2020. The required pre-service training is facilitated for new staff by utilizing a combination of instructor-led, web-based courses, and on-the-job training. Staff must complete the full certification process within 180 days of hire, accomplish a minimum of 120 hours of training inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, human trafficking, and Prison Rape Elimination Act (PREA) training prior to having any contact with youth. Five staff training records were reviewed for pre-service training. Two staff training records showed documentation of employment exceeding 180 day, both of which, accomplished the required 120 hours of training. The other three employees were in the first 180 days of hire. All three employees, within 180 days of date of hire, have accomplished in excess of seventy-five hours of training and are on track to have it accomplished before the deadline. All five staff reviewed accurately reflected pre-service training progress within the Department's Learning Management System (SkillPro) which met the contractual requirements for training.

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

The program maintains a policy and procedures which governs annual in-service training. The program has an in-service annual training plan which was submitted and approved by the Department's Office of Staff Development and Training on February 17, 2020. Reviewed documentation confirmed the training plan is a fluid document which is updated as changes occur. Five staff training records, including two supervisory records, were reviewed for completion of in-service training and all staff had current certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), active shooter, human trafficking, and cardiopulmonary resuscitation (CPR). Each of the five staff exceeded the twenty-four hours of required in-service training. Supervisory staff are contractually required to complete eight hours of management training and twenty-four hours of in-service training, and all were completed. Both supervisors reflected the required amount of training in the Department's Learning Management System (SkillPro). The program has two licensed nursing staff, both of which, have a current certification in both cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) techniques. All five staff reviewed accurately reflected in-service training progress within SkillPro which met contractual requirements for training.

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

The program has a policy and procedures which regulates training and implementation requirements regarding the grievance process. The policy explains the grievance process is threefold (informal, formal, and appeal). The informal phase is accomplished through a "411" form which is checked each shift by supervisors. If the informal phase does not gain resolution, then youth may progress to the formal stage by filling out the formal grievance form and placing it in the grievance box located outside of each dormitory. Observations during the annual compliance review found grievance forms and "411" forms are in each dormitory. Supervisors have seventy-two hours to review, investigate, and respond to the youth. If resolution is not achieved with the supervisor, then the youth may pursue a grievance which will be processed with the director of operations and executive director (ED) within seventy-two hours of receiving the grievance. If the youth is not satisfied with the formal supervisor phase, then they can progress to an appeal phase which must be reviewed and decided within six days. There were no appeal-level grievances for review since the last annual compliance review.

The program's grievance binder is sorted by months of the year and each month has a dedicated grievance log along with the grievances filed for each month. There were four total

grievances filed since the last annual compliance review period. All four grievances were resolved during the formal phase and within seventy-two hours of the youth filing the grievance. Five youth were interviewed and were able to explain the process for completing a grievance and the time frames in which the grievances are to be handled. The five reviewed pre-service training records confirmed all staff received grievance process and procedural training as required. Five staff were interviewed and explained the process when youth request a grievance, assistance in completing the grievance form if needed, and the time frames in each phase. The ED interview provided confirmation on the processing of grievances to include all three phases and the time frames associated with each phase.

| **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 contractually prescribed delinquency interventions through evidence-based practices, promising practices, and practices with demonstrated effectiveness groups to youth. The evidenced-based interventions are those designed to reduce the influence of risk factors related to reoffending 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 curriculum. 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.

A review of the program's activity schedule, logbook transition entries, and an observation of groups conducted at the time of the annual compliance review confirmed the program is providing structured, and planned programming, or activities at least sixty percent of the youth's waking hours. Group sessions are held daily and are one hour in duration. A review of the group sign-in sheets validated groups were delivered as prescribed. There are six staff teaching delinquency interventions on-site. Review of the six staff records validated all members were trained with the appropriate education and qualifications to facilitate delinquency intervention groups in their respective positions. Staff education and work experience are considered by the administration when determining staff delivery of delinquency intervention services.

Interviews with the executive director confirmed youth are matched with clinicians based on the youth's individual needs identified in the pre-classification meeting during the youth's admission. The pre-classification meeting involves consideration of intake information, assessments, youth and parent/guardian input, departmental heads report on interaction with the youth, security risk, medical risk, and staff experience. Youth are matched to the proper evidence-based, promising practice, or a practice with demonstrated effectiveness which is best geared to address youths' individual criminogenic needs as outlined in the youth's treatment plan. Youth can demonstrate skills during treatment team meetings and through interactions with other youth and staff. Seven youth were interviewed, and all stated they actively participate in groups.

| 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 policy and procedures which governs interventions and instruction with a concentration on developing life and social skill competencies to youth through classroom and group instruction, hands-on experiences, and role modeling by program staff. The program's activity schedule allots for scheduled interventions for youth to receive life skills training and is in-line with contractual obligation.

Review of five youth individual performance plans and sign-in sheets validated the youth are participating in life skills 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 which are trained to deliver their respective courses.

Reviewed documentation in each staff's training record confirmed each has received the required training to teach respective curriculum. The clinical staff facilitate The Prepare Curriculum and is utilized as the foundation for interventions offered to youth. Properly qualified staff facilitate The Council for Boys and Young Men to youth. The executive director stated, in an interview, all youth in the program participate in life skills groups. Five youth were interviewed and all stated they attend groups daily where they learn new skills such as anger management, communication skills, decision making skills, and how to process grief. Each of the five-youth stated they practice the newly acquired skills during group, as well as individually during their daily routines and encounters with staff and youth.

| 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 restorative justice activities through the Impact of Crime (IOC) curriculum. The curriculum includes victim impact, restorative justice, personal accountability, introduction to harm, consequences of making decisions, personal accountability, managing conflict, the road to reparation, and the impact of crime on victims, families, and the surrounding community. The reviewed documentation reflected IOC groups occur twice a week for one hour in duration. Review of the daily schedule and group sign-in sheets indicated groups are held on-site as outlined. Other restorative justice efforts include a guest speaker who was a victim and speakers with previous criminal history, victim apology letters, and community service. An interview with the program's executive director confirmed interventions are to be delivered by qualified staff who possess the required training to facilitate their respective class, which was validated during the annual compliance review. A review of five case management records and group sign-in sheets indicated services are being delivered, as required. All five interviewed youth reported they participated in IOC group and were able to explain what they do in groups.

| 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 policy and procedures to dictate the delivery of gender-specific programming for a male population as required by the contract. All youth in the program participate in The Council for Boys and Young Men, which is an evidence-based gender-specific curriculum educating the youth in being a role-model, building valuable relationships, individual empowerment, building confidence, and leadership development skills. The Prepare Curriculum and is utilized to augment the core curriculum for gender specific programming. The classes are geared to open the youth's perception on different ways to look at a situation, what they believe, and gives hope youth can influence change to their circumstances by making weighed decisions instead of emotional responses. Five case management records were reviewed which confirmed all youth were participating in The Council for Boys and Young Men groups twice a week, for one hour in duration, and were offered as the program's activity schedule specified. During the annual compliance review week, groups were held, by a qualified facilitator, as indicated on the daily schedule, as required, by the curriculum. All five interviewed youth reported they are actively participating in groups. An interview with the program director confirmed the program schedule allows for ample time for youth to participate in the targeted gender group and all youth are involved.

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

The program maintains a policy and procedures regarding security, medical, and mental health alerts to ensure all staff are made aware when medical or mental health issues exist which may affect the security and safety of the youth in the program. The program's policies regarding alerts detail the alert system, how and when management reviews the alerts, who is responsible for updating the Department's Juvenile Justice Information System (JJIS), and how staff are informed of youth alert updates. The program utilizes the JJIS daily youth detail report to capture all open alerts and alert updates on youth in the production of their internal medical alert log, chronic conditions listing, and their master alert logs located in the front office. Staff are to review the alert log prior to their assumption of shift duties and discuss alerts during shift turn-overs. Discontinued or downgraded internal and JJIS alerts must be approved by medical staff, the program's director of operations, and/or a licensed mental health staff. Reviewed documentation indicated the program's internal alert information is actively reviewed daily, during shift briefings, and by the program's supervisory staff as required.

Five youth records were reviewed for case management, medical, and mental health and substance abuse alerts, and all applicable alerts were current and accurately entered in JJIS. Five staff were interviewed, and all reported they are informed of youth alerts during shift meetings, and they can review the program's alert log for youth alerts in the front office conference room.

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

The program maintains individual healthcare, mental health and substance abuse, and case management records for each youth. All five reviewed case management, healthcare, mental health, and substance abuse records were marked "confidential" and each record contained all the required documents. The case management records contained all required documentation on the spine and front of the binder, including each youth's name, Department of Juvenile Justice Identification Number (DJJID), date of birth, county of residence, date of admission, and committing offense. The documents were organized into the required sections. All case management records, mental health and substance abuse records, and healthcare records were secured inside in a file cabinet in a locked room, when not in use. The program's file cabinets were marked "confidential."

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

The program promotes the gathering of constructive input from youth by using multiple feedback platforms. The program has a youth advisory board which allows youth to provide feedback through regular meetings which exceeded the quarterly requirement. Youth dorm representatives are selected by the treatment team which serves as an incentive to demonstrate positive behavior and youth treatment goal progression. Members of the youth advisory board serve as liaisons between the youth and program administration. The program maintains a binder of youth advisory board meeting minutes with agendas and sign-in logs. The program also utilizes additional feedback platforms to gather youth input which includes youth and parent/guardian exit surveys, youth interviews, and the idea suggestions box. Survey results are formally reviewed and discussed during morning management meetings and monthly all staff meetings.

Five youth were interviewed and reported the process which youth can provide input through youth advisory council meetings. An interview with the executive director indicated the youth complete and sign the 411 form as a first attempt to voice issues and concerns in the program and during the youth daily meeting. Additionally, the youth advisory board has a formal process to promote constructive input by youth to the program.

| 1.17 Advisory Board | Limited 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 is required to have a community support group with the representatives from law enforcement, the judiciary community, the school board or district, the business community, the faith community, from the lesbian, gay, bi-sexual, transgender, queer, and intersex (LGBTQI) community, and a victim services community and a parent/guardian whose child was previously involved in the juvenile justice system. The program maintains a community advisory board binder which was reviewed. An interview conducted with a current board member confirmed the program is receptive to feedback from the board and the board is frequently involved in program activities. An interview with the executive director (ED) revealed the program's community advisory board meetings are held quarterly and strong recruiting efforts are applied to filling the community advisory "Board of Trustees" seats.

The review of advisory board documentation found there was no documentation to support the advisory board had representatives from the following organizations: school board, faith community, judiciary community, LGBTQI community, victim services community, and a parent/guardian whose child was previously involved in the juvenile justice system. Additionally, there was no documentation to support recruitment efforts were made to solicit representation of these areas, as required. Review of the youth advisory binder verified quarterly meetings are taking place with documentation containing meeting agenda, minutes, and sign-in sheets.

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

The program holds a multitude of meetings at various times and frequency which serve to assist in program planning and to ensure proper provisions for staffing. The executive director (ED) explained how data is used for future program planning including the use of the Comprehensive Accountability Report, various Departmental reports, youth and parent/guardian exit surveys, youth advisory board feedback, and employee satisfaction surveys. The program provided a sample of the youth and parent/guardian survey results to the review team which were reviewed and retained. Meetings consist of daily shift briefings, weekly management meetings, and all staff monthly meetings, as well as on an as-required basis, and supervisors are informally updated of any development changes. Results are discussed with staff and improvements are made along with any deficiencies noted. Pertinent information, such as published reports, policy and procedural clarification or adjustments, and survey results are discussed during monthly staff meetings and reflected on meeting minutes. To assist with employee morale, the program has an employee of the month and yearly awards. Additionally, the program offers various staff appreciation events and tuition assistance for employees. Five staff were interviewed, and all indicated staff meetings are held daily to discuss a wide-array of topics.

| 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 procedure which ensures a system for evaluating staff, at least annually, based on established performance standards. Staff are evaluated at ninety-days and then annually by their departmental head which included staff comments, signatures and dates, as well as the supervisor's signatures, dates, and performance rating calculations. The performance evaluations were specific to the applicable staff's job description. All performance evaluations are confirmed by human resources and the executive director. A review of five staff records indicated the program maintains position descriptions for each position title which outlines the position expectations and essential functions, requirements of the position, knowledge, skills and abilities, physical requirements, and work environment. A review of five staff records revealed all employees had received an annual evaluation which was filed in the personnel record, except for one record not containing an evaluation. Staff evaluations are geared to rate the staff's quality of work, modeling appropriate behavior, and each evaluation included ratings on the staff's job-specific responsibilities. All five staff interviewed reported they receive a formal evaluation annually. Two staff, in their first year of employment also stated receiving evaluations at forty-five days and then ninety days from the date of hire. The employee performance evaluation practice was confirmed in an interview with the executive director.

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

The program maintains a policy and procedures which governs recreation and leisure activities. The program's activity schedule outlines a block of time for daily large muscle activity for youth, as well as group time. Youth movement transitions are located in reviewed logbooks align with the activity schedule recreational times allotted. The program utilizes a covered pavilion as a sheltered location for the youth to have an outdoor gym to help protect them from potentially hazardous weather and provide shade while allowing youth opportunities for outdoor large muscle activity. Supervised and structured indoor recreation activities available to youth include television, card tournaments, letter writing, playing of cards, and board games. Youth are encouraged to provide input to the program on recreation and leisure activities along with other subject matters through the youth advisory board process.

The reviewed activity schedule and logbook entries confirmed youth are receiving recreational activities, as required. Five interviewed youth indicated they are provided a variety of activities with varying degrees of mental and physical exertion throughout the day. Five interviewed youth and five interviewed staff indicated youth are provided with at least one hour of large muscle activity each day. All five interviewed youth indicated they view the youth advisory board as an effective feedback process.

The current contract requires the program to have a recreational therapist. This position has been vacant since January 2020. The program did not meet its contractual requirement for the annual compliance review period, so a limited compliance rating was assigned during the annual compliance review. A minor deficiency was assigned to the program in May 2020 for having a key position vacant over ninety-days. A contract amendment dated for October 1, 2020

removes this requirement from the contract. Therefore, a new deficiency will not be assigned for this indicator for the unfilled position.

# 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.* | |

The program has policy and procedures to address initial contact with a youth's parent/guardian and for court notification upon a youth's admission to the program. The policy requires telephonic contact with the parent/guardian within twenty-four hours of admission. The policy further requires the program's assigned case manager to send written notification and specific program information within forty-eight hours of admission. Five case management records were reviewed. Each record contained documentation of telephone contact with the youth's parent/guardian on the day of the youth's admission to the program. Each record included a letter to the youth's parent/guardian within forty-eight hours of admission. The program contacted each youth's juvenile probation officer/post-residential services counselor and the committing court within five working days of the youth's admission to the program.

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

The program has policy and procedures to address the youth orientation process. The program provides an orientation to each youth on the day of admission, which is completed by a case manager. Youth receive an overview of the program's services and a student handbook, which includes a more detailed description of program services and a review of the rules governing conduct and positive and negative consequences for behavior. The case manager and youth sign an orientation checklist to document a review of each topic. The program's orientation process includes all mandatory elements of the indicator, as required. The medical department reviews medical topics as required. A review of five youth records confirmed each contained documentation to show the youth received an orientation on the day of admission to the program. Each record documented the orientation process, expectations, and responsibilities of each youth. Each youth signed a form to document their review of the orientation checklist and all covered topics. Daily schedules were posted in multiple locations. The program's behavior management system was posted throughout the program. There were no admissions during the annual compliance review. Five youth were interviewed and all reported having orientation on the date of admission to the program.

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

The program has a policy and procedures to address written consent for youth who are eighteen years of age or older, which requires the program to obtain written consent of any eighteen-year-old youth prior to providing or discussing any information with the youth's parent/guardian. Five case management records were reviewed and three youth were applicable for youth being eighteen years of age or older. All three youth records contained the signed written consent of the eighteen-year old youth.

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

The program has a policy and procedures to address the classification process and reassessment for activities. The program's classification includes all of the mandatory elements of the indicator, as required. On the day of a youth's admission, the program conducts an admission classification meeting to discuss classification factors, which is attended by the youth, case manager, and program administration. Five case management records were reviewed. Four of five records contained a completed classification form with all required elements. One of the youth records did not have the completed classification form; however, a copy of the meeting sign-in sheet was maintained in the youth record with all required staff's and youth signatures. Living unit assignments were derived from the information gathered from the classification process. The program has open bay living units, so youth room assignment is not applicable. Every newly admitted youth receives a new Victimization and Sexually Aggressive Behavior (VSAB) screening which is entered into the Department's Juvenile Justice Information System (JJIS) prior to each youth's room/bunk assignment. Each record contained a Victimization and Sexually Aggressive Behavior (VSAB) entered into the Department's Juvenile Justice Information System (JJIS) system. Reassessments for classification were completed during monthly treatment team meetings and took into consideration an increase in the youths' privileges, participation in work projects, and off campus activities. The executive director was interviewed and reported the program uses the initial classification factors which are the following: physical characteristics, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization. The classification includes identified or suspected risk factors, including suicide risk, medical risk, escape risk, and security risk. A review of the JJIS alert system was completed and all alerts matched the program's internal alert list which is being maintained continually for staff.

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

The program has a policy and procedures to address gang identification, which includes notification of law enforcement. Five case management records were reviewed, but only one was applicable for gang involvement or suspected involvement, therefore, one additional applicable youth record was reviewed. In each of the applicable youth records, the program notified local law enforcement regarding the youth's gang status. The program provided notification to each youth's juvenile probation officer, local school district, and law enforcement in the youth's home county. The program maintains a binder with gang information for youth in the program, which identified the two youth with gang affiliations. Notifications to law enforcement were documented for each youth and a gang alert was entered into the Department's Juvenile Justice Information System (JJIS) for the applicable youth.

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

The program has a policy and procedures to address a youth's participation in gang prevention and/or intervention activities. Five case management records were reviewed, but only one was applicable for gang involvement or suspected involvement, therefore, one additional applicable youth record was reviewed. In review of the Gang Binder, there are two youth in the program with gang affiliation. One youth participated in monthly gang prevention and intervention strategies; the other youth is waiting for the new group to start. None of the youth had gang interventions addressed in their performance plans but one youth had his gang intervention addressed in his treatment plan. The executive directors interview indicated 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 psychoeducational group session aimed to educate youth 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.* | |

The program has a policy and procedures to address the completion of Residential Assessment for Youth (RAY) and reassessments. The policy requires the completion of an initial RAY within thirty days of admission to the program and the completion of a reassessment prior to the program preparing a ninety-day summary. Five case management records were reviewed. All five youth records supported the initial RAY assessment was completed within thirty days of the

youth's admission. Of the five records, a RAY reassessment was required in all five and each record had a RAY reassessment completed within the ninety-day requirement. All RAYs and RAY reassessments were completed in the Department's Juvenile Justice Information System (JJIS) and documented in the youth case management record.

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

The program has a policy and procedures to address the completion of a Youth Needs Assessment Summary (YNAS), requiring the completion of the YNAS within thirty days of admission. Five case management records were reviewed, and each contained a YNAS completed within thirty days of the youth's admission. Each YNAS was documented in the Department's Juvenile Justice Information System (JJIS).

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

The program has a policy and procedures to address the intervention and multidisciplinary treatment team. The treatment teams are required to develop an individualized performance plan within thirty days of admission to the program. Five case management records were reviewed. Performance plans were completed for each youth within thirty days of the youth's admission. All performance plans were developed after the initial assessment. Each performance plan was developed by the treatment team, and all relevant members participated during the development, including the youth's parent(s)/guardian(s). Each performance plan included goals for the youth to complete prior to release from the program. The goals were individualized and based on prioritized needs reflecting the risk and protective factors identified during the initial assessment. All performance plans contained target dates for completion of goals. Court-ordered sanctions were not addressed in the performance plan of all five youth records reviewed. Specific delinquency interventions were missing in four of the five youth performance plans reviewed. None of the five youth performance plans addressed the recreation plan. Youth responsibility to accomplish goals, and the program's responsibilities to assist the youth to achieve the goals were addressed in four of the five individualized performance plans reviewed. One youth record was missing the staff's responsibilities on one goal. Each performance plan included the top three criminogenic needs to be addressed. Each of the performance plans were signed by the youth and treatment team leader. All five were

signed by the administrative representative, treatment staff, medical staff, and education staff. Two were missing the living unit representatives' signature. Three of five performance plans were signed by the parent(s)/guardian(s) and two were not applicable due to the youth being eighteen years old. Each performance plan was sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of the plan being completed. There were no applicable Department of Children and Families youth at the time of the annual compliance review. Five youth were interviewed and each reported they participated in the development of their performance plan, knew their current performance plan goals, and they had a copy of their performance plan.

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

The program has a policy and procedures to address revisions to individualized performance plans, when determined necessary, by the intervention and treatment team. The policy requires revisions when new criminogenic needs are identified during the Residential Assessment for Youth (RAY) reassessments, when the youth demonstrates progress or lack of progress toward completing a goal, or when new information is acquired or revealed. Five case management records were reviewed. None of the five records had a performance plan revision. There were nine total RAY reassessments completed for the five youth and seven required a revision to the performance plan, none were completed. There were no revisions to the performance plan based on youth who were identified by the program to have had newly acquired information, progress towards completing goals, and/or lack of progress toward goal completion.

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

The program has a policy and procedures to address the requirements for completion of performance summaries every ninety days. The summaries are due within ninety days of the signing of the youth's performance plan, or at shorter intervals, if requested by the committing court. The policy further requires the treatment team to prepare a performance summary prior to the youth's release, discharge, or transfer from the program. The performance summary provides information to the youth, parent/guardian, juvenile probation officer (JPO), and other parties related to the status of each performance goal and describes the youth's overall adjustment to and performance in the program. Five case management records were reviewed, all of which were applicable for the completion of at least one performance summary and transmittal. Each of the five summaries were completed within ninety days of the performance plan. Each of the five summaries contained all the elements required including the youth's status on each goal, treatment progress, academic status, behavior, interaction with peers,

interaction with staff, adjustment to the program, and positive/negative events. Each of the five summaries were signed by the applicable treatment team members, four of the five were signed by the youth and two of the five did not have youth comments. Two of the five youth records did not address the youth's level of motivation/readiness to change. Each summary was filed in the case management record. Each of the five summaries were sent to the committing court, juvenile probation officer (JPO), and parent/guardian within ten working days of completion. Each youth was provided the opportunity to read and add comments and a copy of the summary. None of the active case management records reviewed were applicable for a release summary, therefore three closed records reviewed were reviewed for release summaries. Each contained a copy of the original summary sent to the JPO along with the Pre-Release Notifications (PRN) at least forty-five days prior to the youth's anticipated release date. Each summary contained the justification for release. The program provided written notification to the parent/guardian of the approval for release. The program completed an Exit Residential Assessment for Youth (RAY) for the exit assessment in each record. The Sexually Violent Predator Program (SVPP) and victim notifications did not apply to the reviewed records. The program provided the performance summary and transition plan to the JPO. Five youth were interviewed. Each of the five reported receiving a copy of their performance summary.

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

The program has a policy and procedures to address the inclusion of parent(s)/guardian(s) in the case management process. Five case management records were reviewed. In each of the five case management records, the case manager sent an admission letter to the parent/guardian, which included the dates/times for treatment team meetings. Each record had documentation to show the parent/guardian was involved in the assessment process and participation in the development of the performance plan and received progress reviews. None of the five youth were applicable for transition planning at the time of the annual compliance review. Two of the five youth were eighteen years or older and signed consent for the parents/guardian to participate in their treatment teams. A copy of the performance plan was mailed to each parent/guardian with a request to sign and return the signature page. There was documentation to show the parent/guardian was called for each treatment team meeting. The program has family days quarterly. The program has family days quarterly. Due to the recent COVID pandemic, family days have temporarily been placed on hold as a precautionary measure. Case managers keep in contact with parents/guardians and promote involvement through phone contact, video chat, and other approved social media outlets. An interview with the executive director (ED) validated the program emphasizes parent/guardian involvement throughout the youth's stay in case management developments as the youth progress in the program. Five youth were interviewed, and all reported their parent(s)/guardian(s) were involved in their case management process.

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

The program has a policy and procedures to address the members of the treatment team. The policy identifies the case manager to be the treatment team leader. The program's treatment team members consist of the case manager/treatment team leader, youth, and representatives from program administration, education, the youth's living unit representative, mental health, education, and medical. The juvenile probation officer (JPO) is also part of the treatment team, and, when applicable, the transition case manager and the youth's parent/guardian or the Department of Children and Families (DCF) case worker are included. Five case management records were reviewed. Each of the records documented the notification to the required participants of the treatment team meetings and who attended. If the parent/guardian and/or JPO did not participate in the treatment team meeting, there was documentation to show attempts to contact the parent/guardian and JPO. All forms contained signatures from required team members. There were no Department of Children and Families eligible youth at the time of the annual compliance review.

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

The program has a policy and procedures to address the incorporation of other plans into a youth's performance plan. Five case management records were reviewed. Each record contained a performance plan. One of the youth's academic plans was referenced in the performance plan and three youth's transition plans was referenced in the performance plans. Four of five youth were missing a reference of the youth's academic plans in their performance plan. Five of five youth were missing a reference to their treatment plan in their performance plan. Five of five youth were missing a reference to their recreation plan and two youth were missing a reference to their transition plan in their performance plans. There were no youth applicable to have a case plan through the Department of Children and Families or the Agency for Persons with Disabilities.

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

The program has a policy and procedures to address the provision of intervention and multidisciplinary treatment teams. The treatment teams are required to meet every thirty days to formally review each youth's performance, to include progress on individualized performance plan goals, and positive and negative behavior, including behavior which resulted in physical interventions and to include Residential Assessment for Youth (RAY) reassessment results. The policy requires the case manager to conduct informal reviews of each youth's performance

monthly. The case manager meets with the youth during informal reviews and uses input from treatment team members, as needed. Five case management records were reviewed. Each of the records documented formal treatment team reviews were held at least every thirty days. Treatment team documentation included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, and treatment progress. All five youth records did not cover a review of the RAY results or RAY reassessment results. Each of the five records had informal reviews. Documentation of informal reviews included the youth's name, date of review, comments from treatment team members, progress in the program, progress of goals, behaviors, skills, and treatment progress. Five youth were interviewed. All youth reported to have the opportunity to demonstrate skills during the treatment team meetings. Each of the five youth reported staff review their performance to include progress on the performance plan goals, behaviors, and treatment progress.

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

The program has a policy and procedures to provide for career education. The program provides Type 2 career education development which includes personal accountability skills as well as completing employment applications and developing a résumé summarizing their education, work experience, and/or career training. A review of three closed youth records found one youth had documentation of a Florida identification card, one record included a statement indicating the youth already had a Florida identification card, and the third youth record indicated required documentation to obtain a Florida identification card had not been received from the parent/guardian. The career courses are age appropriate and aligned with the educational goals and abilities of the population served. The program provides vocational programming appropriate for the youth, their education abilities and goals, and the typical length of stay in the program. The program utilizes education services and assessments to include My Career Shines, Worldwide Interactive Network, Inc. (WIN) Common Assessment, and Standardized Testing and Reporting (STAR). The program provides the National Center for Construction Education and Research (NCCER) curriculum which leads to certifications in the field of construction, as well as Occupational Safety and Health Administration (OSHA) and food handler trainings and certifications. Three closed youth case management records were reviewed, and all included a completed employment application, résumé, a calendar identifying an appointment with their local Career Source Center, and documentation to support the youth's parent/guardian and juvenile probation officer were made aware of the youth's vocational plan. An interview with the lead teacher revealed the program offers education services and assessments utilizing My Career Shines. The interview with the executive director concerning career vocation services found the program provides Type 2 career education programming which includes an orientation to a broad scope of career choices, based on personal abilities, aptitudes, and interests.

| **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 has a policy and procedures to provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of the required

minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and incorporated the required 250 days of instruction with ten days used for teacher planning. This schedule provided six, fifty-minute class periods fulfilling the weekly requirement of twenty-five hours of instructional time. Youth are enrolled in academic courses through the Hillsborough County School District and receive credit for course completions as appropriate. An interview with the lead educator verified the youth are attending school according to the daily schedule. In a review of the five youth interviews, four of the five indicated there are no interruptions during the school day, and the one response with a yes answer provided no explanation for the choice. The logbook review confirmed the program is following the school schedule as required.

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

The program maintains a policy and procedures providing for an educational transition plan to be developed upon admission. Three closed youth case management records were reviewed. All three youth records included an individual education transition plan, developed upon entry, and included the youth's post-release goals. The records documented specific monitoring responsibilities by individuals who were responsible for the reintegration and coordination of the provision of support services post release. Each record included an Electronic Educational Exit Plan (EEEP) which identified the next educational placement information and input from the post release school district representative. All youth records contained the youth's current educational records to be used for the post release placement. The youth interviews were reviewed, and two of the five youth indicated they had been involved in the development of their education transition plan, while the others provided a non-applicable response, with no explanation. All five youth indicated the program had prepared them well for their next educational placement.

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

The program has a policy and procedures to ensure the treatment team plans for the youth's successful transition to the community upon release from the program. Five active youth records were reviewed, and none were applicable for transition. Three closed case

management records were reviewed. Documentation in each of the applicable records confirmed transition conferences were conducted at least sixty days prior to the youth's release from the program. The required participants were in attendance for each transition conference. All required participants were invited to participate by telephone or in person. If participation was not possible, the members were invited to provide written input prior to the meeting. The treatment team reviewed transition activities, identified additional transitional activities, target completion dates, any updates needed for the performance plan, and identified persons responsible for completion. There were no youth identified with a history of human trafficking or being in the Department of Children and Families. The treatment team leader obtained signatures of all applicable members. In each closed record, there was documentation to reflect a Community Re-Entry Team (CRT) meeting invite and to show a CRT meeting was conducted prior to the youth's release along with youth and case manager participation. Each of the three closed records contained a copy of the plan being sent with a request for return with the signature.

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

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed. The exit portfolio was discussed during transition in all three records. Each exit portfolio contained the transition plan, calendar with all dates/time/locations of the upcoming community appointments, educational/vocational certificates, educational records, transcripts, résumé, and sample employment application. A review of three closed youth records found one youth had documentation of a Florida identification card, one record included a statement indicating the youth already had a Florida identification card, and the third youth record indicated required documentation to obtain a Florida identification card had not been received from the parent/guardian. The other two records had a copy of the youth's birth certificates in the youth's closed record. Each of the exit portfolios were verified at the exit conference and given to the youth. Documentation confirmed the exit portfolio was forwarded to the juvenile probation officer (JPO) in each 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.* | |

The program has a policy and procedures to address the transition and exit process. Three closed case management records were reviewed. Each record documented an exit conference was held at least fourteen days prior to the release date. Each exit conference was conducted after the juvenile probation officer (JPO) was notified of the release. Each record had documentation of the exit conference date, signatures, and a summary pending transition goals. Each record had documentation to show the treatment team leader, parent/guardian, education representative, therapist, JPO, youth, and other pertinent parties participated in the exit conference. Each record had documentation of the status of transition activities and finalized plans for the youth's release. The date of admission and date of release correlated with the Department's Juvenile Justice Information System (JJIS). Each exit conference was held separate from the transition and Community Re-Entry Team meetings (CRT).

| 2.22 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 maintains a policy and procedures which require individualized, on-going safety planning for youth. The program must develop a Safety Plan identifying stimuli which have positive and negative effects on youth. Each youth's plan must be completed within fourteen days of admission and updated every thirty days which was confirmed by the executive director's interview. Five youth records were reviewed for Safety Plans. Each of the records showed Safety Plans were created within fourteen days of the youth's admission to the program. All records indicate the Safety Plans were jointly prepared by the youth, parent/guardian, and program clinical staff. The Safety Plans incorporated recommendations from previous or current clinical assessments and included trauma responsive practices. Documentation indicated all five Safety Plans were reviewed for updates every thirty days during the formal treatment team. Seven staff were interviewed validating the Safety Plans are located a binder in the control office, and are updated/reviewed by therapist, during formal treatment teams, every thirty days.

# Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the director of clinical services and the program's designated mental health clinician authority (DMHCA). The DMHCA is responsible for the coordination and implementation of mental health/substance abuse services. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:00 p.m. and is on-call and available to provide emergency consultation twenty-four hours a day, seven days a week. The DMHCA has a back-up licensed LMHC who provides coverage when the DMHCA is on leave. The back-up LMHC's license is clear and active in the State of Florida with an expiration date of March 31, 2021. 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 informal 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 new youth admissions, for an initial psychiatric evaluation to determine what, if any, psychiatric interventions are needed. 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 validates the services provided and serving as the program's mental health and substance abuse authority. The DMHCA is responsible for ensuring the proper completion of documentation and integration of the mental health delivery system and for directing the program's psychological and treatment services to include technical and administrative duties, testing, therapeutic activities, research, and participation in the overall programming and administration. The DMHCA confirmed the scheduled times and hours they are in the program. A review of the DMHCA's sign-in log for the six months prior to the annual compliance review confirmed the DMHCA was 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 the executive director is responsible for ensuring non-licensed mental health and substance abuse treatment services are provided by individuals with appropriate qualifications and training. The designated mental health clinician authority (DMHCA) ensures clinical staff working under 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 three non-licensed clinicians who provide regular mental health and substance abuse services to the youth in the program. All three non-licensed clinicians hold a master's degree in social work, mental health counseling, or counseling education. All three non-licensed clinicians completed the required training and supervised observations in order to assess suicide risk. Review of documentation confirmed each non-licensed clinical staff completed the required education and training for Florida Statutes and the program's contract. The program holds an active Department of Children and Families (DCF) Chapter 397 license which allows for the provision of substance use treatment services by non-licensed clinicians. The programs Chapter 397 license is posted in the program's lobby and is valid through April 7, 2021. A review of supervision logs for the prior six months documented one-hour weekly supervision for all non-licensed mental health and substance abuse treatment staff. All clinicians received weekly supervision for treatment services provided. Training and supervision provided by the clinical director to the non-licensed therapists was documented and maintained in the supervision binder. The reviewed schedules confirmed the non-licensed clinicians were on-site daily.

| 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 maintains a policy and procedures regarding mental health and substance abuse admission screening. The program identifies the mental health and substance abuse needs of youth through a comprehensive screening process to ensure referrals are made when youth have mental health and/or substance abuse needs or suicide risk. The program has a comprehensive plan for mental health and substance abuse services which includes a standard admission mental health and substance abuse screening, and the administration of the Massachusetts Youth Screening Inventory – Second Version (MAYSI-2). 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 administering the screening and was conducted in a confidential manner. Reviewed documented practice supported the clinical staff and treatment team members reviewed all available information to include the commitment packet, reports, and existing mental health and substance abuse documentation during the admission screening process, and the information was documented on the Records Review form. As a program practice, all youth are screened at the time of admission, regardless of the MAYSI-2 results, utilizing the Department's Assessment of Suicide Risk (ASR) administered by the assigned therapist or the licensed mental health counselor (LMHC). The information is entered into the Department's Juvenile Justice Information System (JJIS) as required. The MAYSI-2 is a validated instrument and includes the youth's mental health and substance abuse history, history of trauma, medical status, and a suicide risk screening instrument. The completed MAYSI-2 includes findings and recommendations for further evaluation and treatment. All five reviewed youth MAYSI-2 assessments indicated the need for further evaluation. The program's executive director or designee was notified, and referrals were made. None of the reviewed youth MAYSI-2 assessments indicated a suicide ideation category; however, due to the intake process each youth did receive an ASR completed by the non-licensed master's-level therapist. All assessments documented a conference with the licensed mental health professional and the program director or designee prior to lowering the supervision level, as required. An interview with the executive director validated the screening process utilized during the intake screening process in order to identify youth at risk for mental health and substance abuse problems, suicide risk and human trafficking.

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

The program has a policy and procedures addressing mental health and substance abuse comprehensive evaluations. The program's practice involves each youth receiving a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation within thirty days of admission. The comprehensive assessment includes elements for both mental health and substance abuse. During the admission process, clinicians complete a Substance Abuse Subtle Screening Inventory (SASSI), a Social Skills Improvement System (SSIS), and a Trauma System Checklist for Children (TSCC) along with the recommendations from the initial psychiatric evaluation which aid in the completion of the Comprehensive Mental Health and

Substance Abuse Bio-Psychosocial Evaluation. Each of the five reviewed records indicated new comprehensive evaluations were completed by a non-licensed clinical staff within thirty days of admission and all five were reviewed and signed by a licensed qualified professional within ten days, as required. The comprehensive evaluation includes demographic information, justification for the evaluation, reason for the assessment, behavioral observations, mental status examinations, methods of assessment, interviews, or other procedures used to acquire the needed information, patterns of alcohol and drug usage, impact on major life areas, risk of continued usage, discussion of findings, diagnostic impressions including the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis, recommendations, and relevant background information. Relevant background information includes home environment, family functioning, history of abuse to include physical and sexual, history of neglect, witnessing of violence and other forms of trauma, behavioral functioning, physical health, and educational functioning. Results of the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation aid in the development of each youth's individualized treatment plan.

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

The program maintains a policy and procedures ensuring all mental health and substance abuse treatment services are available to each youth who meet clinical criteria to receive services. Mental health and substance abuse treatment is given based on an individualized treatment plan addressing all the youth's needs in accordance with Florida Administrative Code. A review of five youth mental health and substance abuse records found each was assigned to a multidisciplinary treatment team upon admission into the program. 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. All five youth were prescribed mental health and four of the five youth were prescribed 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 which expires on April 7, 2021.

A review of five youth mental health and substance abuse records validated education, vocation, and medical staff were identified as treatment team members. Reviewed documentation validated three out of five youth had a properly executed Authority for Evaluation and Treatment (AET) and a signed Substance Abuse Consent and Release form. The other two youth were eighteen and had completed the signed consents.

Treatment notes were maintained in each of the five youth's mental health and substance abuse records and documented by week on the required Department form. Each youth record included documentation indicating the youth received daily group therapy, monthly individual therapy and family therapy as needed. 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. According to Florida Administrative Code, mental health groups are limited to ten or fewer youth and substance abuse group are limited to

fifteen or fewer. Reviewed group documentation and attendance logs found all mental health groups were ten or less and all substance abuse groups were less than fifteen.

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 informally 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 reported they are involved in family and/or individual counseling. Three youth reported to receive family counseling once a month. One youth reported to receive individual counseling once a week and another youth reported to receive individual counseling twice a month. Each of the five interviewed staff reported direct care staff do not facilitate mental health or substance abuse groups. All five interviewed youth reported participating in groups, individual and family therapy. An interview with the designated mental health clinician authority confirmed the various treatment services provided and who facilitates the services.

| **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.*<br><br>*All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.* | |

The program maintains a policy and procedures outlining responsibilities and required elements of mental health and substance abuse treatment services and planning. All mental health and substance abuse treatment services at the program are provided by a licensed therapist or a non-licensed master's-level therapist working under the direct supervision of the licensed clinician.

Five reviewed mental health and substance abuse records supported the multidisciplinary treatment team developed an initial treatment plan on each youth's date of admission to the program. Each initial plan was signed by treatment team members participating in the development of the plan. The initial treatment plans were documented on a form containing all required elements, as outlined in Florida Administrative Code, and on the Department's Initial Mental Health/Substance Abuse Treatment Plan form.

Each reviewed plan contained mental health and substance abuse planning for the youth. During the annual compliance review period, only one youth record was applicable for admission on prescribed psychotropic medications and the initial treatment plan reflected

psychiatric services were required. Reviewed documentation supported all five youth's individualized treatment plans were completed within thirty days of admission and documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form which contained all elements outlined in Florida Administrative Code. Each reviewed plan documented the designated mental health clinician authority (DMHCA) reviewed and signed the plan within ten days of completion, as required. Each reviewed plan contained the required signatures of all treatment team members who participated in the development of the plan with the exception of one whereby the living unit representative did not sign the plan; however, documentation supported the living unit representative submitted information to the multi-disciplinary treatment team to utilize in the development of the treatment plan. Three youth were currently on prescribed psychotropic medications, one admitted with medications and two subsequent to admission were prescribed psychotropic medications, and the individualized treatment plan included psychiatric services, including psychotropic medication and frequency of monitoring. Each reviewed plan documented the prescribed services the youth receives daily, weekly, and monthly. All reviewed youth records required monthly treatment team reviews, and each was completed, as required. Reviewed group schedules, attendance sheets, weekly progress notes (which ensured services are individualized for each youth), and an interview with the DMHCA indicated groups were scheduled and conducted as required. Each youth released from the program are required to 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. Three closed records were reviewed, and each contained the appropriate discharge plan documentation. None of the applicable discharges were applicable for youth released on suicide precautions/suicide alert. All three records applicable for an exit conference documented the juvenile probation officer (JPO) and parent/guardian participated in a discussion regarding the discharge plan. All three reviewed records documented a copy of the discharge plan was provided to the parent/guardian and assigned JPO. Each reviewed discharge plan contained clear treatment recommendations for continuing mental health and applicable substance abuse services.

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

The program has a policy and procedures to address the provision of specialized treatment services for the youth. 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 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 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, two non-licensed clinicians are assigned a caseload of eleven youth and one non-licensed clinician is assigned a caseload of ten youth. 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. The program director and

DMHCA were interviewed verifying the MHOS services are offered daily to youth and include individual, family, and group counseling, and AA/NA groups.

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

The program has a policy and procedures to address the provision of psychiatric services to the youth. 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 a clear and active 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. Since March 2020, the program received an Executive Order 20-52, COVID-19 Alternative Methods of Service Delivery which allowed the psychiatrist to provide tele-psychiatry services in compliance with the Residential COVID-19 Telemental Health Protocol provided by the Office of Residential Services.

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 time frame. 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 program's T1015 Psychiatric Update/Medication Management. The form does not meet the Department's Clinical Psychotropic Progress Note (CPPN) form requirement due to missing the following components: date of birth, allergies, diagnosis/target symptoms, diagnosis/clinical justification, usual dosage range, selection to indicate whether parent/guardian agrees to the treatment plan, a place for the signature and printed name of a witness to parental verbal consent, and date. 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 the program's T1015 Psychiatric Update/Medication Management form for each youth which detailed medications.

The program sent the DJJ Parental Consent for Psychotropic Medication form; however, there is no documentation to support whether the CPPN nor the program's T1015 Psychiatric Update/Medication Management was sent as an attachment as required. Due to this lack of documentation, signatures for the psychiatrist and a witness, indicating the parent/guardian were notified and gave consent when the youth was prescribed new medication, or the medication was changed was unable to be confirmed by the annual compliance review team member.

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) confirms 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 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 practice registered nurse (APRN). The psychiatrist's contract confirmed provision of these services.

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

The program has a suicide prevention plan which is part of a comprehensive plan for mental health and substance abuse services, crisis intervention, suicide prevention, and emergency care. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and a review process, as well as mock suicide drills. The program's suicide prevention plan has been reviewed annually. The plan was recently signed on September 12, 2020 by the facility administration (FA) and the designated mental health clinical authority (DMHCA). The program's suicide prevention plan was signed previously on July 30, 2019.

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

The program maintains a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. All youth admitted into the program are screened for suicide risk factors as part of the initial intake and admission classification meeting process. The clinical therapists' complete screenings immediately upon intake and ensure the constant supervision of the youth throughout the intake process. A review of five youth mental health and substance abuse records validated each youth was screened for suicide risk utilizing the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR), regardless of the MAYSI-2 results. All five youth ASRs were completed by the master's-level non-licensed therapists. All assessments documented a conference with the licensed mental health professional and the program director or designee prior to lowering the supervision level,

as required. None of the five reviewed ASRs were identified with an elevated risk of suicide. Precautionary observation 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 Precautionary Observation 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 as outlined in the program's policy and interviews with staff. The program maintains two suicide response kits which were found to include all required items which are located in the administration office and the medical room.

Five staff interviews were conducted, and each reported in the event a youth expresses suicidal thoughts, staff are to notify mental health. Four staff reported they would have constant sight and sound of the youth and document supervision. One staff reported they would complete a referral. Each of the five staff identified the suicide response kit is located in master control and four staff reported the suicide response kit is located in the medical room.

| **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 all were applicable for placement on Precautionary Observation (PO). Each of the youth records included documentation the youth were maintained on PO during the intake admission process and 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. Five youth interviews were conducted with youth who had been on PO. Each of the five 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 2019 through September 2020, and a drill was conducted on each shift in all quarters. The program conducted a total of twenty-four drills during this time frame. There were twenty-four staff identified to be reviewed for drill completion. Each of the staff had documented participation in a mock suicide drill or a documented review of the drill in a staff meeting sign-in records for all four quarters reviewed.

All staff participate in mock suicide and mental health emergency drills. 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 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 program. 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, three out of five staff indicated they had participated in medical and mental health drills at least monthly. One staff stated at least once every other month and one staff reported the drills are held 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 crisis intervention plan last approved by the executive director and designated clinical mental health authority (DMHCA) on September 15, 2020 and outlines the policy and procedures for responding to youth in crisis in the least restrictive method possible without compromising the safety of the youth in crisis and others. The plan includes a notification and alert system, means of referral including youth self-referral, communication, supervision, and documentation and review of the crisis.

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

The program has a policy and procedures addressing crisis intervention services. Procedures state staff should utilize the Department's Crisis Assessment form when engaged in a crisis intervention. None of the five original youth were applicable for crisis assessments; therefore, the program provided one additional applicable youth record. A review of the applicable record confirmed the youth was seen within two hours of being determined to be in crisis. The provided

assessment included the reason for the assessment, a mental status exam and interview, the determination of danger to self and/or others, clinical impressions, and recommendations for supervision, treatment, and follow-up for further evaluation. The supervision was documented on a Mental Health Alert Log and an alert was entered in the Department's Juvenile Justice Information System. The youth was stepped down to standard supervision after completion of a follow-up mental status exam. The crisis intervention plan includes procedures for the notification of the youth's parent/guardian which was completed in the reviewed assessment. The assessments were either completed by a licensed clinician or a non-licensed clinician, followed by a review by a licensed clinician within the required twenty-four-hour time frame.

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

The program has an emergency mental health and substance abuse and crisis intervention plan which was reviewed and signed by the executive director and by the designated mental health clinician authority (DMHCA) on September 15, 2020. 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, Florida Statutes (Baker Act), transport for emergency substance assessment and treatment under Chapter 397, Florida Statutes (Marchman Act), documentation, training (including mock drills), and review.

| **3.17 Baker and Marchman Acts (Critical)** | **Not Applicable** |
|---|---|
| *Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.* | |

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

## Standard 4: Health Services

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

The contract between the program and designated health authority (DHA) requires conducting one visit a week for a minimum of two hours Sunday through Saturday and be available twenty-four hours a day seven days a week in the event of an emergency. The DHA is responsible for communication with program staff regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. The DHA was interviewed and described his role to include performing Comprehensive Physical Assessments upon youth admission, conducting periodic evaluations every sixty days, and review and follow all policy and procedures. The DHA must available by phone twenty-four hours a day, seven days a week. The program's designated health authority (DHA) is a licensed internal medicine physician who holds an unrestricted license with an expiration date of January 31, 2021 and meets all requirements for independent and unsupervised practice in Florida. The physician's specialty training is in pediatrics. Reviewed documents confirmed DHA is on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. A review of documentation for the past twenty-seven weeks was reviewed and reflected the DHA is on-site once a week for a minimum of two hours. At the time of the annual compliance review, the program had an open major deficiency, assigned in July 2020, for not meeting the contractual requirement of having uninterrupted and equivalently qualified coverage of physician services. The deficiency was assigned when the DHA was not on-site from February 15th to 29th, 2020 and there was no coverage provided by an equal licensure practitioner. The deficiency verification was completed during the annual compliance review and found the program now has a contract with an equivalently qualified physician to provide services in the event of DHA absence. The contract was initiated and signed by the executive director and back-up physician on August 26, 2020. The deficiency was closed based on the program securing coverage. Since the deficiency was assigned, the program has not had an opportunity to use the back-up coverage. The DHA was interviewed and described his role to include performing Comprehensive Physical Assessments upon youth admission, conducting periodic evaluations every sixty days, and review and follow all policy and procedures. The DHA is available by phone twenty-four hours a day, seven days a week.

| 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, health-related procedures, and protocols. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. The DHA and executive director have signed and dated all respective treatment protocols and medical facility operating procedures (FOPs). Nursing protocols were signed by the DHA, executive director, and psychiatrist on May 17, 2020. On May 4, and May 16, 2020, nursing staff signed and dated a cover page on which all medical FOPs, treatment protocols, and other procedures are listed. A review of orientation documentation for new healthcare staff was conducted. All newly employed healthcare personnel received a comprehensive clinical orientation to the Department's healthcare policies

and procedures, which is given by a registered nurse. Approval of treatment protocols or standing procedures were written and authorized by the DHA and were not delegated to any other person. The review and development of FOPs, or other protocols related to psychiatric services and psychotropic medication management is only performed by the program's psychiatrist. A review of the program's health-related policies, procedures, and protocols indicated they have been reviewed and approved by the appropriate provider and outline the programs' health care services.

| 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 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). Five IHCRs were reviewed. Two of the records had a signed AET form stamped with the word "copy" in red ink. One youth had an original AET, stamped "original" in red ink. One youth was eighteen years old before admitted to the program and a form for release of information was completed. Another youth turned eighteen years old while in the program, a form for release of information was signed by the youth on his eighteenth birthday. Copies of completed parental notifications were maintained behind the AET form in four of the IHCRs. Youth who are eighteen years of age do not require parental notifications unless noted on the release of information form. The AET form is printed from the Department's Juvenile Justice Information System prior to admission. If an updated AET is needed, the juvenile probation officer (JPO) is contacted. A registered nurse was interviewed which indicated medical staff will contact parent(s)/guardian(s) or JPO to obtain a new or current AET, if the current AET is invalid or missing.

| 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 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. Five records were reviewed. Three records were applicable for and contained documentation of parental notifications for over-the-counter medications beyond those covered by the Authority for Evaluation and Treatment (AET) form. Additionally, notifications were sent, as needed, for issues such as the discontinuation of medication prescribed prior to youth entering custody, changes in conditions/medications for youth with chronic conditions, and for new medications. Nursing staff stated the parent/guardian is contacted by telephone in addition to sending out a written consent to be signed and returned. Documentation of the verbal contact, along with a witness, is noted on the chronological nursing notes and the copy of the mailed consent is maintained in the youth's medical record. The nurse further stated verbal and written notifications are made when giving a medication not listed on the AET form, for significant medication changes, and when going off-site for an appointment or an emergency. None of the five youth records had documentation indicating the youth had been off-site for medical treatment. An additional sample of three off-site medical treatment records were requested for review and the program provided a youth who went off-site for on three separate occasions for routine specialist care visits. This youth was eighteen years of age and

did not require parental notification. Out of five records reviewed, two youth were admitted on medications for chronic conditions and two youth were admitted on psychotropic medications. Three of the five reviewed youth records were applicable for psychotropic medication. Three youth had significant changes in psychotropic medications. Two youth had proper documentation, in the nursing progress notes, indicating the parent/guardian was notified and consented to changes. One youth was eighteen years of age. The Clinical Psychotropic Progress Note (CPPN) form was not utilized by the program. The Parental Notification form for psychotropic medications was sent to parent(s)/guardian(s) in all cases, as required. The program psychiatrist has been performing telephonic medicine conferences with the youth, due to COVID-19 restrictions. The program has the appropriate documentation for telephonic medicine conferencing. All youth admitted to the program have their immunization records verified within thirty days of admission through the Florida Shots website and school records. None of the youth reviewed were applicable for refusing consent due to religious reasons.

| **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 has a policy and procedures in place which requires each youth to receive a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. Five Individual Healthcare Records were reviewed for completion of a Facility Entry Physical Health Screening (FEPHS) form. Documentation in all five records reflected a FEPHS form was completed by a registered nurse on their date of admission. One youth required a rescreen to the program on February 24, 2020 for exceptions noted which was completed, as required. The designated health authority (DHA) reviewed and signed all FEPHS forms, as required. An interview with the nurse verified health screenings are offered upon admission and during each physical custody changes in which they are readmitted to the program.

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

The program has a policy and procedures to ensure the healthcare admission screening includes health orientation education to each youth admitted to the program. Five youth Individual Healthcare Records (IHCRs) were reviewed for healthcare orientation. Documentation in each of the five IHCRs reflected the youth received healthcare services orientation on the day of admission. The program's healthcare orientation included the following: access to medical care, sick call, what constitutes an "emergency" and when to notify staff, medication process to include side-effect monitoring, the right to refuse care, what to do in the event of sexual assault or attempted sexual assault, and the non-disciplinary role of healthcare providers. A signed and dated receipt of healthcare orientation was observed in all five records reviewed. All five interviewed youth confirmed they received orientation within twenty-four hours of admission.

| 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 to notify the designated health authority (DHA) for all admissions to the program. All five reviewed records contained documentation reflecting the DHA was notified by telephone for each youth upon admission to the program. The DHA notification was documented in the chronological progress notes in all five youth Individual Healthcare Records.

| 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 policy and procedures to ensure nursing staff complete the Department's Health Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). Five youth Individual Healthcare Records (IHCR) were reviewed for completion of an HRH form. In all five IHCRs reviewed, a new HRH form was completed on the day of admission by a registered nurse (RN). All five CPAs indicate the designated health authority (DHA) reviewed the HRH form. All HRH forms were completed prior to the CPA's. A nurse was interviewed and stated the time frame for HRH forms to be completed is within seven days of admission.

| 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 designated health authority (DHA) completes a new Comprehensive Physical Assessment (CPA) for each youth within seven days of admission and annually thereafter. The program uses the Department's CPA form. A review of five Individual Healthcare Records (IHCR) found a new CPA was completed within seven days of admission for all five youth. The DHA completed each CPA, in which, the medical grade was documented. One youth is a medical grade one, two youth were a medical grade two, and two youth were a medical grade five. Each CPA was completed in accordance with Department requirements. All sections of the CPA were marked with an "O" or an "X." Those sections marked with an "X" reflected comments by the DHA in the comments section of the form. The Department's Problem List was updated for the four applicable youth. All five indicated the term "deferred by clinician" without a specific reason for referral on sections twenty-four and twenty-five of the form which relates to genital area evaluation. All five youth had at least one verified tuberculin skin test (TST) completed and documented within the last year. Each youth was assessed prior to being placed in the general population. Results of the TST were documented on the CPA and Infectious Communicable Disease forms in all five records reviewed. The policy and procedures follow the Centers for Disease Control and Prevention new 2006 recommendation and Occupational Safety and Health Administration standards. A nurse interview was conducted and confirmed the required time frame for the HRH and TST processes.

| 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 policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). A review of five Individual Healthcare records (IHCR) indicated each youth was screened and evaluated for sexually transmitted infections (STI). Documentation reflected all youth received a STI screening upon admission to the program. Testing, screening, results, clinical evaluation, and diagnosis were documented on the Infectious and Communicable Disease (ICD) form. One of the five youth reviewed were out of the Department's custody, therefore none required a rescreen. Referrals for testing were documented on the STI screening form and in the progress notes upon admission. One youth's IHCR noted the DHA orders for STI testing on July 7, 2020 proceeding the youth's admission. The nurse indicated youth requested testing from the DHA. There was no documentation indicating the youth requested or consented to the testing in the nursing progress notes. Documentation in all five youth reviewed records reflected youth were offered human immunodeficiency virus (HIV) testing, counseling, and treatment upon admission to the program. One youth did not consent to HIV testing, but the Health Education Record indicated the youth received pre/post-test counseling. One youth denied HIV testing on admission but consented to testing on a later date. Two youth received HIV testing Pre/Post counseling utilizing zoom and provided by Metro Wellness, due to COVID restrictions which was annotated in the Health Education Record. Results were not located in the youth records in a sealed envelope marked "confidential." While the annual compliance review team was at the program, the nurse was able to contact Metro Wellness to have the results mailed to the program. The results arrived and were placed in the youth's IHCR and marked "confidential." HIV results are not located on the alert system within the program. There is no record of the DHA reviewing the test results. The nurse indicated if the youth had a positive result, Metro Wellness would notify the DHA and a treatment plan would be implemented. The 501/500 certification were in place and copies retained for HIV testing and counseling. Five youth were interviewed which confirmed youth can request an HIV test.

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

The program maintains a 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. During the annual compliance review period, there were no youth who presented a similar sick call complaint three or more times within a two-week period. None of the five reviewed youth Individual Healthcare Records (IHCR) indicated the youth presented with complaints in which medical staff were unfamiliar with. Completed Sick Call Request forms were observed to be filed with the corresponding progress note for one applicable youth, in reverse chronological order. Sick call was completed by a

registered nurse (RN). The program does not utilize restricted housing. The program conducts sick call at 9:00 a.m. and 4:00 p.m. seven days a week. Sick call times were observed posted throughout the program. In the event a nurse is not on-site to conduct sick call, the shift supervisor will review sick call requests within two hours and contact the designated health authority (DHA), if determined urgent in need. Progress notes were documented in accordance with the Department's Health Services Rule. Sick calls were documented on the individual youth Sick Call Indexes in the IHCRs as well as the Sick Call Referral log. Sick call forms were observed to be available to youth throughout the program. No sick calls were able to be observed during the annual compliance review. A review of five IHCR's found each youth completed a sick call request while in the program. Review of the records indicate the Sick Call Request forms were completed accurately, the treatment was provided compliant with approved protocols, the sick calls were noted on the Sick Call Referral Log with one exception, the Sick Call Referral Log noted toothache but did not have the date or facility listed. Medications were accurately noted in the Medication Administration Record. One referral was made to the DHA as required. All five interviewed youth indicated they will receive immediate care when placing the sick call request. All five interviewed staff confirmed the RN conducts and reviews sick calls.

| **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 policy and procedures requiring the program to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Five youth Individual Healthcare Records (IHCRs) were reviewed for episodic care. Four of the five youth IHCRs were applicable for episodic care. Progress notes contained all required elements, including referral needed, parental notification, and plans for follow-up or future care. On-site care provided by licensed healthcare staff was documented in the required subjective, objective, assessment, and plan (SOAP) format. The Episodic Care Log documents all instances of first aid/emergency care. It was noted in two episodic care scenarios which were provided by non-licensed health care staff, the registered nurse (RN) did not perform an assessment the following day of the youth, as required. Episodic Care logs for the previous six months corresponded with all on-site events observed in youth records. Emergency medical and dental care, including emergency medical services, are available twenty-four hours a day. The program has six first aid kits. First aid kits are located in administration, kitchen, and four kits in the medical office for transport care. All first aid kits were checked, and all were fully stocked with the designated health authority (DHA) approved items. A review of documentation indicated first aid kits are inspected monthly by an RN, as indicated by first aid inspection forms. The program has one suicide response kit located in the administration building. The program's suicide response kit contained a knife-for-life, wire cutters, and needle nose pliers as required. The program has one automated external defibrillator (AED), which is located in the main administrative outside hallway. Instructions are located inside the AED. The batteries expire October 2020, and the pads expire June 2021. The RN performed a self-test during the annual compliance review, which found the AED to be operational. A review of drill documentation reflected the program has conducted drills quarterly, alternating shifts. Ten of the twelve drills reviewed included CPR and/or AED administration. The program has a list of emergency numbers, including Poison Control Information Center, which are inaccessible to youth. The program has an approved list of five non-licensed healthcare staff who are authorized to assist youth with medication administration or use of an Epinephrine Auto Injector. A review of training records for these staff indicated they have completed the required training. All five interviewed staff advised they can call 9-1-1 if a youth has a medical emergency. Five youth were

interviewed. Three of the five youth stated they could request to see a dentist when needed and four of the five youth stated they could see a doctor if needed. Review of the youth records, program policy and procedures, staff interviews, and a review of the applicable two youth medical records reflected no evidence of unfilled requests for referral to doctors.

| 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.* | |

Five Individual Healthcare Records (IHCR) reviewed and were not applicable for non-emergent off-site services. An additional record was reviewed for off-site care services. The additional record reviewed, contained documentation of verbal and written parental notification for three provided off-site care services. Completion of the Summary of Off-Site Care form was filed in the IHCR. Discharge documents and instructions were in the three records reviewed. The designated health authority's signature was observed Summary of Off-Site Care forms. Appointments are tracked which confirmed each youth received appropriate, timely follow-up care, as required.

| 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.* | |

Three of the five reviewed Individual Healthcare Records (IHCRs) were applicable for chronic conditions. All three IHCRs were identified as having a chronic condition on the Facility Entry Physical Health Screening (FEPHS) form. None of the three youth reviewed had a communicable disease. All three youth were taking prescribed medication on an ongoing basis. All three youth were identified as having a chronic illness on the program's internal alert roster. The chronic conditions roster includes the due dates for each youth's next periodic evaluation. Documentation reflected all three youth received periodic evaluations every sixty days and there were no instances of lapses in care or missed periodic evaluations. All periodic evaluations were conducted on-site. The Department's Problem List for each youth was updated in accordance with the governing Health Service Rule. Evaluations are conducted prior to the renewal of a prescription medication about to expire. Treatment orders were observed to be written clearly for clinical staff. The executive director advised alerts are reviewed by staff daily prior to the assumption of shifts and weekly during managerial meetings. The designated health authority (DHA) advised medical uses a tracker for periodic evaluations which is updated daily. Interviews with the DHA and nurse indicated youth are evaluated at a minimum of every sixty days.

| 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.* | |

Two of the five reviewed youth Individual Healthcare Records (IHCR) were for youth taking prescribed medication upon entry to the program. Prescription verification for youth taking

medication upon entry to the program was documented in the chronological progress notes in the records. Documentation reflected the registered nurse (RN) contacted the designated health authority (DHA) and psychiatrist with requests to resume medications. All medications were observed to have a current, valid order and were given pursuant to a current prescription. Each of the five youth were applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). The OTC medications were administered in accordance with approved protocols. The program utilizes a pre-printed pharmacy Medication Administration Record (MAR). Documentation reflected staff initial each administered medication. There were no undocumented explanations for lapses or errors in medication administration. One youth refused medications and did not sign or initial the MAR and the nurse did not complete a refusal form. Nursing staff document weekly side effect monitoring on the MAR. The Six Rights of Medication Administration are maintained by both the licensed and non-licensed staff. Review of one Controlled Substance form was filled out incorrectly by nursing staff on 2nd to 3rd shift. Counts are accurate for controlled medication. All other forms reviewed for youth were filled out correctly.

All medications were observed to be stored in separate, secure areas inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications are not stored with injectable or topical medications. Medications requiring refrigeration are stored in a secure refrigerator, which is used for medication only. Syringes and sharps are secured. The medication cart was observed to be clean, organized, and stock items are kept separate from specific youth medications. Expired medications are destroyed using the Medication Disposal Container once a month according to the agreement with the pharmacist. Medication pass was able to be observed during the annual compliance review with no issues noted. Five youth were interviewed. Three of the youth indicated the RN provides them their medicine. Two of the five youth indicated they do not take medication. Five staff interviews confirmed only RNs and trained staff can issue medication to youth.

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

The program has a policy and procedures in place ensuring the appropriate storage of all medication and equipment classified as sharps. Medical equipment classified as sharps were securely stored and inventoried by using a perpetual inventory. All medications are identified and secured in the locked area designated for the storage of medications. Medications such as injectables, topicals, drops, and liquids were separated. All controlled substances were observed maintained behind two locks, stored separately from other medications, and were being tracked with a perpetual inventory. Pursuant to the Board of Pharmacy regulatory requirements, a shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. The program has a process in place for disposal or destruction of expired and discontinued medications. A perpetual inventory of all sharps and stock over-the-counter (OTC) medications was observed. The program maintains an approved list of supervisory level, non-healthcare staff trained in the delivery of medication self-administration in the event nursing staff is not on-site. Observations of the registered nurse (RN) inventory three youth medications, three being a narcotic/controlled medication, three OTC medications, and three sharps, all of which matched the perpetual inventory. Reporting criteria and procedures for inventory discrepancies are in place. Perpetual

inventories of medications and sharps for the previous six months were available for review, inventory is conducted weekly for OTC medications and sharps. According to the RN, all controlled medication is stored in a locked box within the secure medication cart and medication inventory is done daily and the stock room is inventoried weekly.

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

The program's infection control procedures include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC) guidelines. The program's infection control procedures include the following: common, infectious diseases of childhood; self-limiting, episodic contagious illness; viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV; pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. The hepatitis B immunization is available to staff. There have been no instances in which the local health department, CDC, or the Central Communications Center (CCC) should have been notified. The program has a comprehensive process for needle stick post-exposure evaluation. The executive director (ED) will maintain a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary. The program's exposure control plan was found to be written in accordance with Occupational Safety and Health Administration (OSHA) standards. The plan is available to all staff. The plan is reviewed and signed annually by the program. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. According to the ED, the plan is located in the medical clinic and is reviewed with staff annually.

| 4.18 Prenatal Care/Education | Not 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, the indicator is rated as non-applicable.

| 4.19 Licensed Medical Staff (Critical) | Satisfactory Compliance |
|---|---|
| The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA. | |

Medical on-site coverage is provided by licensed registered nurses (RN). A review of nursing licensure credentials on the Florida Department of Health Medical Quality Assurance website confirms each of the nurse licenses were clear and active. Each nurse has a current cardiopulmonary resuscitation certification card. There is a health services administrator on-site forty hours a week. Additionally, the other RN work at the program forty hours a week, in compliance with the eighty an hour week nurse requirement.

# Standard 5: Safety and Security

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

The program has a policy and procedures regarding youth supervision. Staff-to-youth ratios at the program are one staff to eight youth during awake hours and one staff to twelve youth during sleeping hours. Video reviews and observations while on-site confirmed staff-to-youth ratios were in compliance.

During the annual compliance review, youth were observed in class, attending treatment team meetings, participating in meals, participating in recreation, transitioning from education to lunch, and transitioning from education to the dorms. The program has a full schedule of activities planned and youth were observed to be actively engaged and not sitting around. The daily schedule is available to youth and is posted in each dorm. Staff were actively supervising youth and youth were always accompanied by staff. Interactions observed between staff and youth were positive. Counts of youth were observed when movement occurred, and staff were able to immediately communicate how many youth they were supervising when asked. Five staff were interviewed, and all were able to explain the procedures when the count cannot be reconciled. Staff indicated movement is stopped and a recount is conducted.

During the annual compliance review period, it was discovered two youth escaped from the program during the night shift on July 6, 2020. The staff to youth ratio during sleeping hours is one staff to twelve youth. The shift report for July 6, 2020 documented thirteen youth assigned to dorm one and twelve youth assigned to dorm two. There is no documentation to support the staff to youth ratio was met and there were two staff providing supervision to the youth in dorm one. There were twenty-five youth and three staff on campus during the night shift on July 6, 2020. In order to meet ratio, there should have been an additional staff on shift to account for staff breaks. Staff failed to maintain supervision of the youth as evidenced by two youth escaping from the program during the night shift on July 6, 2020.

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

The program has a detailed description of their collaborative behavior management system (BMS). The BMS is clearly written and is in the youth handbook to allow easy access for youth. A review of five case management records revealed each youth received a review of the BMS during orientation and received a youth handbook detailing the BMS at the time of admission. The program's BMS consists of a point card system, token economy, and level system. Youth

can earn points for each activity of the day to earn incentives and increase their level. A board is posted in the program's multi-purpose room including photos of each youth indicating their current BMS level.

The program's BMS details the rules governing conduct and positive and negative consequences for behaviors. The BMS helps to maintain order and security, promotes and protects youth rights, includes positive and negative consequences, allows for constructive disciplinary actions, provides opportunities for positive reinforcements, promotes socially acceptable means for youth to meet their needs, and provides a process for explaining to youth the reason for any sanction imposed. The youth are given an opportunity to explain their behavior, and staff and youth are given the opportunity discuss the impact of the youth's behavior on others and discuss alternate behaviors.

The program provides opportunities for positive reinforcement and recognition of accomplishments and positive behaviors at a minimum ratio of four to one positive to negative consequences. The BMS does not include an increased length in stay, denial of basic rights or services, promotion of group punishment, punishment by youth, or disciplinary confinement. During the annual compliance review, staff were observed offering verbal praise to youth for positive behaviors and redirecting youth regarding negative behaviors. Five staff were interviewed, and all were able to explain the program's BMS, including utilization of a point system, level system, and rewards and consequences at a four to one ratio. The five interviewed staff indicated rewards provided as part of the BMS include snacks, being served meals first, extra telephone time, and earning of token economy for the canteen. All five staff indicated items cannot be taken away from youth as a consequence. Five youth were interviewed, and each indicated they can receive a write-up or receive a one on their point card as a consequence. All five youth were able to explain how youth in the program are rewarded. The youth stated rewards include a top fifteen pizza party, extra telephone time, snacks, top three fast food, and token economy. An interview with the executive director indicated the program's BMS is designed to decrease unwanted behaviors and increase desired behaviors through positive reinforcements at a four to one ratio.

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

The program has a policy and procedures to ensure staff are provided feedback regarding their implementation of the behavior management system (BMS). Position descriptions include required qualifications of staff who implement the program's BMS. The program's BMS includes a process for staff to explain to the youth the reason for any sanction imposed and for the youth to explain their behavior. The program does not utilize room restriction or extend the youth's length of stay as a sanction. Five staff were interviewed, and each indicated the youth are able to explain their behaviors. One staff stated youth receive two verbal warnings before receiving a

one on their point card. Three staff indicated the youth are able to make a statement on the comment section of the behavior report, and one staff indicated they engage in a discussion with youth after a situation has de-escalated to help the youth to learn to problem solve. Five youth were interviewed, and each was able to explain the level system, including the difference between each level and how to move from level to level.

Five staff training records were reviewed, which validated each staff received training in the specific BMS implemented at the program. Documentation revealed staff were trained in the jointly combined BMS plan to include the use of BMS during school. The director of operations trained the education staff for use of the BMS during school. Five youth interviews indicate youth are never allowed to punish other youth. Four interviewed youth stated all staff use rewards the same. The remaining youth indicated rewards were not always equal but would not explain their answer. Three of the interviewed youth believe the BMS is fair, one stated it is good, and one stated it is very good. Four of five interviewed staff were able to explain how supervisors provide feedback to staff regarding the implementation of the BMS. Three staff stated supervisors will coach them how to implement the BMS, one staff said feedback is provided during meetings, and the remaining staff was unsure. The program's executive director was interviewed and stated the director of operations monitors the earning of points to ensure the system is free from abuse. The executive director confirmed all consequences and sanctions are administered on an individual basis, the BMS does not violate basic youth rights, and youth are not allowed to directly impose disciplinary sanctions. The executive director stated all staff are trained in the BMS and their performance evaluations include assessment of use of rewards and punishment and understanding of the BMS.

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

The program has a policy and procedures ensuring staff observe youth at least every ten minutes while they are in their sleeping quarters and the observations are conducted in a manner to ensure the safety and security of each youth. Staff shall document observations in real time. The program has a total of thirty-two cameras, all of which are operational; however, there are no cameras located in the youth living units. Video recordings are kept for forty-five days. An informal staff interview while on-site indicated checks are done every ten minutes and are documented in real time. Staff will walk through the youth living unit, do a skin check for each youth, and will initial on the log the check was completed. A review of ten-minute check logs for the last six months, one date for each month, for a one-hour period on each dorm was conducted. The review found checks were conducted at least every ten minutes, taking place every eight to ten minutes. All reviewed logs included the time, youth count, and staff initials for each check. Additionally, there is a place on the log to document if a youth is using the restroom or any other activity which may occur during the shift. Each log was signed by a shift leader. Five staff were interviewed, and each indicated room checks are conducted every ten minutes when youth are sleeping.

During the annual compliance review week, it was discovered two youth escaped from the program during the night shift on July 6, 2020. A review of the night supervision log dated July 7, 2020, indicated there were thirteen youth in dorm one from 9:00 p.m. to 6:15 a.m. the

following morning. The form was completed in a manner to appear staff completed ten-minute checks throughout the entire shift. The shift supervisor signed the bottom of the night supervision log. An internal investigation completed by the program substantiated staff falsified ten-minute bed checks.

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

The program has a policy and procedures regarding youth's census, counts, and tracking. Observations of youth counts during the annual compliance review indicated counts were conducted by the shift supervisor prior to youth movement. A random review of the dorm logbooks for the last six months revealed documentation of a count being conducted at the beginning and end of each shift. There were no emergency situations during the annual compliance review period. The review revealed total daily census counts, youth movements, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program are documented in the logbooks. Youth counts are not being documented in the logbook after each outdoor activity. The program's general practice is to document youth movement by dorm. Although youth movements are being documented in the logbooks, there are not a lot of head counts being documented when the movements are being done. Five staff were interviewed, and all were able to explain the procedures for when there is a discrepancy in the count. One interviewed staff stated counts are conducted every ten minutes at night and hourly by the supervisor. One staff stated counts are conducted every thirty minutes, and three staff stated counts are conducted any time there is youth movement. Each staff indicated movement is stopped and a recount is conducted if there is a discrepancy in count.

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

The program has a policy and procedures for logbook entries and shift report reviews. A review of program logbooks for the past six months revealed all logbooks are bound with numbered pages. All entries were made with ink with no erasures or white-out areas. One entry was crossed out with a single line, dated, and initialed by the person correcting the error. No logbook

entries were destroyed or removed. All entries included the date and time of event, the name of the staff and youth involved, a brief description of the event, and the name and signature of the staff making the entry; however, not all signatures were legible. One program logbook is maintained, so there is not a logbook at each living unit. The program maintains shift reports summarizing the events, incidents, and activities documented in the program's logbook. Incoming staff are briefed on the contents of the shift reports, and there is a section on the shift report where staff signs to document they were briefed on previous shifts. A copy of the shift report is maintained at each living area for forty-eight hours in a shift report binder.

Required events, incidents, and activities including emergency situations, population counts at the beginning and end of each shift, perimeter security checks, transports away from the program, requests by law enforcement to access any youth, and admission and releases were documented in the logbook. The logbooks were reviewed for telephone calls to the Department's Central Communications Center (CCC), and the Florida Abuse Hotline. One CCC was documented on a shift report but was not documented in the logbook.

A review of the logbook for July 6, 2020, found staff made a log entry every hour throughout the night. Every entry indicated, "formal skin checks were completed, and twenty-seven youth were on campus." The entry indicated a perimeter check was conducted and there were no discrepancies found. Upon further review it was determined two youth escaped from the program during the night shift on July 6, 2020. Documentation in the logbook reflected all youth were accounted for at the time of the youth's escape.

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

The program has a policy and procedures on key control including the control and use of keys. The program's key control system includes 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, and reporting and replacement of damaged keys. All necessary program staff have permanent keys, except for the shift supervisors, who pass their keys on from shift-to-shift. It is documented on the shift report when the keys are passed on. There are no other shift keys. The program maintains an inventory of permanent keys including the ring number, list of keys and number of keys on the key ring, and a signature sheet signed by staff indicating they received their keys and confirmed the number of keys on the ring. The program maintains a key report, listing all key numbers and identifying what they are used for. The program's key report shows key six as having multiple uses. One use is to open the suicide response kits; however, this is not reflected on the key report. Personal keys are collected from staff and visitors when they enter the program and secured in a locked box. All restricted keys are locked in a separate locked box inside the locked key box. Keys to medical, areas where staff and youth records are held, and youth and staff locker keys are restricted to staff in the respective areas.

The program did not have any lost or missing keys during the annual compliance review period; however, a process is in place should a key be lost or damaged. If a key is lost or missing all program movement is to be stopped. A search is to be conducted and the Central Communications Center (CCC) is to be contacted if the keys are not located within two hours. The program would then contact a locksmith to change the lock. The program utilizes Brandon Locks if a key requires replacement. There were no CCC incidents related to key control during the annual compliance review period.

A random sample of three key rings were observed and compared to the inventory and key log. Two of the three key rings matched the inventory and key log. One of the key rings had six keys on it; however, the inventory and key log stated it only had five keys. The missing key was documented and added to the inventory prior to the end of the annual review. The shift supervisor key ring was not listed on the inventory or key log, but this was corrected prior to the end of the annual compliance review. Five staff were interviewed, and all were able to explain the program's key control process and what to do if a key goes missing.

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

The program has a policy and procedures addressing illegal contraband and prohibited items and how they are to be disposed of. The program defines items listed as contraband including sharps, escape paraphernalia, tobacco products, electronic cigarettes, and non-facility issued electronic devices, cellular devices, keys, lighters or matches, intoxicating beverages, beverages which cause intoxicating effects, or smartwatches. Each youth is provided with a list of contraband and the consequences for having contraband in the youth handbook upon admission. The program conducts contraband searches of the physical plant and facility grounds daily. The searches are documented on a Facility Inspections form and attached to the shift log. Any contraband items found are documented on the contraband seizure log. The searches were not documented in the facility logbook. Searches of the youth are conducted prior to every movement. Incoming and outgoing mail is searched when received or prior to being sent out. The program documents any confiscation of contraband on the contraband seizure log. The log documents what was found and how it was disposed of. There was no illegal contraband found during the annual compliance review period; however, the program's

policy and procedures state law enforcement will be contacted if any illegal contraband is found. There were two Central Communications Center (CCC) reports made during the annual compliance review period related to contraband. Law enforcement contact was not required as both reports were related to missing cellular telephones. Both the program cellular telephone and a personal cellular telephone were located. The program's policy and procedures do not address how any staff who is found in possession of contraband in a program will be subject to disciplinary action up to and including dismissal. An interview with the executive director revealed contraband which is not illegal is either discarded, returned to its original owner, mailed to the youth's home, or stored and returned to the youth upon their release, at the discretion of the director of operations. Illegal contraband is turned over to authorities and a request is then made for a copy of the criminal report affidavit.

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

The program has a policy and procedures to ensure searches are performed to ensure no contraband is being introduced into the program. Searches are to be conducted upon admission, after visitation, when youth return from any off-site activity, and before and after any movement. No transports, admissions, visitation, or off-campus activities took place during the annual compliance review. Observations during the annual compliance review verified staff conduct searches before and after any movement; however, the searches are not being completed as outlined in the policy and procedures. The program's policy and procedures indicate for clothed searches youth should empty their pockets, untuck their shirts, their hair, ears, mouth, and nose should be checked, collars, shoulders, underarms, undergarments, and waistbands should be checked, and the youth's shoes and socks should be removed and checked. These procedures are not being followed, and quick pat down searches are being completed. Youth were given instructions and treated with dignity and respect to minimize their stress and embarrassment. Six months of Youth Full Body Visual Search (FBVS) logs were reviewed to verify searches were conducted by the appropriate number of staff. FBVS's are to be conducted with two staff of the same gender as the youth present. If two staff of the same gender are not available, one staff of the same gender should conduct the search while the staff of the opposite gender is positioned to observe the staff conducting the search but cannot view the youth. A review of the FBVS logs found sixteen of fifty-eight logged searches were only conducted by one staff member. Five staff were interviewed, and each staff indicated a search is conducted before and after any movement. Five youth were interviewed, and each youth stated they are searched for every movement. Two youth indicated they are searched when returning from off-campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail.

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

The program has a policy and procedures ensuring all vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment, so the vehicles are operated in a safe manner. The program has two vans which are used to transport youth. One van received an annual safety inspection on September 8, 2020 and the other van received an annual safety inspection on September 10, 2020. A maintenance log containing maintenance records is maintained by the program. Both vans contained a fire extinguisher, seat belt cutter, window punch, and the appropriate number of seatbelts. Approved first aid kits are kept in medical to be signed out when vehicles are in use. There was no transport during the week of the annual compliance review, therefore, transportation observations were not completed. Informal interviews with transport staff and two youth verified seatbelts are always worn during transports. Youth are not attached to any part of the vehicle by any means other than proper use of a seat belt. The door to the youth passenger area could not be opened from the inside on one of the vans; however, the door could be opened from the inside on the other van. A random check was conducted on seven personal vehicles while on-site and all vehicles were locked. The program vans were checked three times while on-site and one of the program vans was found to be unlocked during one check.

| 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 to ensure compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. Driver's license checks are conducted, and a list of approved drivers is maintained. AMIKids YES Trip Plan forms for the past six months were reviewed. The review found the one staff to five youth ratio is being maintained during all transports and there is one staff of the same gender as the youth being transported. An inspection of the vehicle is completed prior to each transport. No transports took place while the reviewer was on-site. An informal interview with two youth found youth are not left unsupervised in the vehicles and no youth are permitted to drive program vehicles. Five staff interviews indicated a cellular telephone is provided to staff during transports and first aid kits are in the transport vehicles. All staff indicated staff are not allowed to use personal vehicles to transport youth and transport vehicles are searched for contraband prior to and after each transport. Three staff were able to explain the emergency response process during vehicle transport and stated the program should be called in the event of an emergency. Four staff indicated the ratio during transports is a minimum of two staff. One staff stated there is three staff if there are more than five youth, and one staff was unsure. Five youth were interviewed. All five youth stated they have never seen anyone place contraband in a transport vehicle and they feel staff are driving transport vehicles safely.

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

The policy and procedures designate the director of operations as the person responsible for conducting a weekly safety and security inspection of the premises. The program utilizes a Facility Security Audit and Safety Inspection form. The form documents a description of what is being looked at, comments, corrective action needed, and the date the repairs were completed, or due to be completed. All forms were reviewed and signed by the director of operations. The forms cover radios, cameras, keys, metal detectors, mechanical restraints, transportation, youth rooms and living areas, education, kitchen, grounds, exterior structure, perimeter, chemicals and storage, tool and sensitive item control, and other security operations. Facility safety and security audits are completed weekly to ensure follow-up on any issues. A review of Facility Safety and Security Audit forms from the last six months indicate they are completed every seven days. An interview completed with the executive director confirmed the weekly safety audits are conducted weekly to identify any security issues.

| 5.13 Tool Inventory and Management | Failed 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 addressing the issuance, inventory, and control of equipment and tools. All observations during the annual compliance review found all tools were secured when not in use. Kitchen sharps are locked in the kitchen. Class B tools are kept in a locked storage area. Youth can sign these items out when cleaning the dorm area and a sign-in/out log is utilized. Class A tools are kept in the maintenance shed or in a locked office in the vocational shop. All areas are locked and not accessible to youth. The class A tools are marked and labeled or placed on shadow boards. All class A tools kept in the maintenance shed are inventoried daily by the plant manager. The tools kept in the vocational shop are utilized by approved youth for work projects. These tools are not being inventoried daily as required, they are being inventoried weekly. These tools are not being inventoried prior to being issued to a youth for work or following work activities as required. The program has a tool sign out sheet in the vocational shop, but it is not being utilized as required.

Machetes, bowie knives, and other long blade knives are prohibited at the program. The plant manager stated if a tool is dysfunctional it is marked as broken, disposed of, replaced, and documented in the tool log. Five staff were interviewed, and all indicated youth can use mops and brooms. Four staff stated youth can use scrub brushes and one staff stated youth can use rakes.

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

The program has a policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries to the youth and staff. The program utilizes a risk assessment to determine a youth's eligibility to use tools. The youth are reassessed monthly during their

monthly treatment team meetings. Risk assessments were reviewed for five youth who are currently participating in the vocational program and are able to use class A tools. All five youth were assessed monthly and were eligible for the use of class A tools. One youth's most recent risk assessment was not completed correctly, as it indicated he was eligible for the use of class A tools but not class B tools. The youth in the vocational program who are utilizing class A tools are screened daily prior to working with tools. A daily roster is completed which asks if the youth has had any incidents within the previous twenty-four hours. If the youth has had any incidents his privileges may be suspended, or depending on the severity, he may be removed from the program.

Staff-to-youth ratio is to be a minimum of one staff to five youth during activities involving tool use and one staff to three youth during disciplinary work projects, although the program does not utilize disciplinary work projects. The staff-to-youth ratio for vocational training was not listed in the contract with the Department. The director of operations and vocational teacher indicated they utilize a one staff to three youth ratio during vocational projects. A random review of three days of video surveillance confirmed the program is providing the appropriate ratio during activities involving tools. An informal interview was conducted with one youth in the vocational program who stated there is never more than three youth working in the vocational shed at once. The youth indicated he is searched before and after each work project. The program's practice is to search each youth every time movement occurs. Five youth were interviewed and four indicated they are allowed to use scrub brushes, mops, and brooms. The remaining youth stated they are not allowed to use tools. One youth was further interviewed and indicated they can use saws but only in the vocational program.

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

The program has a policy and procedures addressing when an outside contractor or worker enters the program to perform a work project requiring the use of tools. The program restricts tools to those necessary for the work conducted, completes an inventory upon the worker's arrival and departure, restricts youth access to the work area, ensures immediate reporting of any tool the worker cannot locate, and follows-up if any tool is missing. The outside contractor is provided a written Notification to Outside Contractors/Vendors form informing them of these requirements to sign upon arrival when signing in. The written notification includes a tool inventory list where the inventory is documented upon arrival and departure of the contractor. These forms are maintained in a work project binder. A random sample of nine project invoices submitted to the program by vendors were reviewed. Of the nine invoices, there was no written notification or inventory form for four vendors, and eight of the vendors did not sign-in or out on the visitor's log. Personal cellular phones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area. The program's policy and procedures outline the executive director is responsible for providing approval/permissions if such items are required.

| 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.* | |

Drills are conducted in accordance with the program's disaster plan or Continuity of Operations Plan (COOP) and facility operating procedures. Drills are conducted monthly on each shift. The program has conducted fire, smoke, COOP, bomb threat, and escape drills during the past twelve months. The program is operating on two, twelve-hour shifts. The drill documentation included the type of drill, date and time of the drill, participants, a brief scenario, and findings/recommendations. Drill documentation was not located for an escape drill completed in May 2020. One bomb threat drill completed in July 2020 was not documented in the program's logbook. Fire evacuation routes and egress plans were observed to be posted throughout the program and fire extinguishers throughout the program were inspected annually. The program has conducted fire drills across all shifts in accordance with the program's COOP. All five interviewed youth knew what to do in case of a fire and stated drills are conducted between one and three times a month. Of five interviewed staff, staff reported they have participated in weather, bomb threat, hostage situation, chemical spills, terrorism, escape, fire, medical, and mental health drills in the last twelve months. The executive director reported drills are conducted monthly on each shift and COOP drills are conducted quarterly for the program.

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

The program's Continuity of Operations Plan (COOP) is readily available to staff and located throughout the program. There is a COOP posted in administration, the cafeteria, education, the multi-purpose room, and in each dorm. At the time of the annual compliance review, each posted COOP only contained the odd numbered pages and were missing all the even numbered pages. The program was notified of the issue, stated it was a printing error, and reprinted and posted full COOPs throughout the program prior to the end of the annual compliance review. The program's COOP was reviewed and submitted to the Department on March 24, 2020 by the program's executive director. On March 31, 2020 the COOP was reviewed and signed by the Department's residential regional director. The COOP addresses fire prevention and evacuation, severe weather, program disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorist threats or acts, staff roles and responsibilities, any equipment and supplies needed, information about the youth which may be needed, alternative housing arrangements, provisions for continuity of care and custody of youth, and provisions for public protections. The program has food and necessary supplies readily available in case of an emergency. The program maintains an emergency food supply stored in orange bins in the kitchen. Other items including towels, blankets, and batteries are stored in bins in the chemical shed. The program maintains an administrative hard-copy record on all program youth in case

of emergency. All required information is included and located in a binder in administration. An interview conducted with the executive director verified COOP plans are printed and posted in a manner which all staff have access.

| 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 for the storage and inventory of flammable, poisonous, and toxic items and materials. Chemicals are secured and inventoried as outlined in the program's policy and procedures. All chemicals were observed to be secured during the annual compliance review. The flammable items are stored in a locked cabinet behind a locked door in the tool shed. Chemicals are stored and secured in the chemical shed, kitchen, laundry room, and COVID storage bin. The director of operations, plant manager, and food manager are the only ones with a key to the chemical shed. A selection of four random chemicals in the chemical shed were counted and compared to the inventory list. The inventory was accurate for all reviewed items. The inventories in the kitchen and laundry room were accurate and up-to-date. A separate inventory is kept for bottles of bleach stored in the locked COVID bin. The inventory was accurate and up-to-date. Safety Data Sheets (SDS) were in a binder in each area where chemicals were stored. The SDS matched the chemicals in each storage area.

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

The program has a policy and procedures regarding youth handling and supervision of flammable, poisonous, and toxic items and materials. The program maintains strict control of flammable, poisonous, and toxic items and materials. The program policy and procedures indicated youth are not allowed to use, handle, or clean-up dangerous or hazardous chemicals. Observations throughout the week of the annual compliance review confirmed the youth do not use or have access to the chemicals. The program's Preventative Maintenance Checklist was reviewed to ensure maintenance schedules and repairs are being completed as required. Five youth were interviewed regarding the handling of chemicals. Four youth stated they do not use any chemicals or cleaning products. One youth reported he sprayed the window or toilet cleaner on one occasion.

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

The program has a policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items which is in accordance with the Occupational Safety and Health Administration (OSHA) standards twenty-nine. The program identifies the plant manager as the person authorized to dispose of all hazardous waste and/or solid waste. The plant manager has received training for disposing of hazardous items and toxic materials. There is no current disposal log for chemicals; however, the plant manager has not had to dispose of any hazardous chemicals during the annual compliance review period. The plant manager indicated if there were any waste to dispose of, these would be taken to waste management. The program utilizes Stericycle to dispose of any bio-medical waste and Chris' Plumbing to empty the grease traps. Each of these program practices are documented and tracked. All other kitchen liquid waste is disposed of in the kitchen. Liquid waste, including dirty mop water, is disposed of in the plumbing drains. The plant manager stated no chemical spills have taken place during the annual compliance review period, but if a chemical were to spill, they would follow the process outlined in the Continuity of Operations Plan (COOP). The executive director reported the program disposes of waste in accordance with the safety date sheets and maintains documentation of proper disposal of hazardous chemicals. The executive director further stated special marked containers are provided for flammable liquids and rags used with flammable liquids.

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

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

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

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

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

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

The program has a policy and procedures in place regarding participation in water-related activities. The program's water safety plan addresses all required elements including safety issues, emergency procedures, and the rules to be followed during water-related activities. The program is not currently participating in water-related activities and have not participated in any water-related activities during the annual compliance review period. The program does not currently have a lifeguard on staff and the youth are not being assessed as the water-related activities are not taking place. Five interviewed youth stated they do not participate in water activities.

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

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

The program has a policy and procedures to allow visitation and communication for youth while in the program. The visitation procedures and schedule are posted on the front of the building next to the entrance. The visitation and communication procedures are covered in the youth handbook and addressed on the orientation checklist. Five interviewed youth said they can call or send a letter to their parent/guardian. The program is currently not allowing visitation due to

the COVID-19 pandemic. The program ceased visits in March of 2020. The program introduced zoom calls as an option for visitation during the interim. Visitation resumed for a short time in June and July of 2020 but were stopped again due to COVID-19. The visitation, telephone, and mail logs were reviewed. The logs revealed youth are only having contact with approved persons. A review of the visitation logs revealed only five visits took place during the time visitation had resumed. Of the five visits, all were with an approved person and documented on the visitation log; however, none of the logs were filled out in full, with some missing the time out, tag number, purpose of visit, and whether the visitor was checked with the wand upon arrival. Youth are allowed one phone call with a parent/guardian each week. Incoming and outgoing mail is searched and recorded in the correspondence logs. There were no youth applicable for a history of human trafficking, so the program is not required to request clarification from youth's juvenile probation officer (JPO) about any parent/guardian past or current human trafficking investigation involvement.

| **5.23 Search and Inspection of Controlled Observation Room** | **Not Applicable** |
|---|---|
| *The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.* | |

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

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

The program's policy, procedure, 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** | **Not Applicable** |
|---|---|
| *The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.* | |

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