

STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

**BUREAU OF MONITORING AND
QUALITY IMPROVEMENT**

Annual Compliance Report

Columbus Youth Academy

Sequel TSI of Florida

(Contract Provider)

9502 East Columbus Drive
Tampa, Florida 33619

Review Date(s): April 5 - 8, 2022



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:

Teresa Andersen, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Jennifer Bailey, Office of Accountability and Program Support, Bureau Chief (Standard 2)
Renee Boston, Office of Education, Operations Coordinator (Standard 2)
Christine Calvert, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Renette Crosby, Office of Accountability and Program Support, Regional Monitor (Standard 5)
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Melissa Johnson, Office of Accountability and Program Support, Central Region Supervisor (Interviews and Standard 1)
Patrick Morse, Office of Accountability and Program Support, South Region Supervisor (Standard 3)
Maryann Sanders, Office of Accountability and Program Support, South Region Deputy Supervisor (Standard 4)

Program Name: Columbus Youth Academy
Provider Name: Sequel TSI of Florida
Location: Tampa County / Circuit 13
Review Date(s): April 5-8, 2022

MQI Program Code: 1442
Contract Number: 10476
Number of Beds: 50
Lead Reviewer Code: 155

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
1.02 Five-Year Rescreening 2.09 Performance Plan Development, Goals and Transmittal * 2.1 Performance Plan Revisions 3.13 Suicide Prevention Training * 5.04 Ten Minute Checks *	1.08 In-Service Training 1.13 Gender-Specific Programming

Standard 1: Management Accountability **Residential Rating Profile**

Indicator Ratings		
Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Limited
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	Failed
1.09	Grievance Process	Satisfactory
1.10	Interventions 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	Failed
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Staff Performance	Satisfactory
1.19	Recreation and Leisure Activities	Satisfactory

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

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

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

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

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

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

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Standard 5: Safety and Security **Residential Rating Profile**

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

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Program Overview

Columbus Youth Academy is a fifty-bed program, for thirteen to eighteen year old males, located in Hillsborough County, Florida. The program is operated by Sequel TSI of Florida, through a contract with the Department. The program provides the following services: Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) with a specialized emphasis on juvenile sexual offender (JSO) treatment services. In addition, the program fosters each youth by providing Pathways, Skillstreaming the Adolescent, Passport, Living in Balance, Coping with Depression, Coping with Stress: A Cognitive Behavioral Therapy (CBT) Guide for Teens with Trauma, and Life Skills Training. The non-clinical curricula used by the program includes Thinking for a Change, Impact of Crime, and Young Men's Work. Additional treatment services provided includes family therapy, individual therapy, group therapy, and recreational therapy. Program administration is comprised of an executive director, assistant facility administrator, designated mental health clinician authority (DMHCA), designated health authority, director of nursing, director of case management, human resource director, and a community liaison. Case management services are provided by the director of case management, four case managers, one transitional case manager, and one recreational therapist. Mental health staff at the program includes the clinical director, a licensed mental health counselor (LMHC) who serves as the DMHCA, five additional LMHCs, and one licensed clinical social worker (LCSW). Medical services are offered daily from 7:00 a.m. to 7:00 p.m. and are provided by the director of nursing, one full-time registered nurse (RN), one part-time RN, and one RN providing services pro re nata (PRN). Educational services are provided by the Hillsborough County School Board. The layout of the program includes: one building, which consist of administration, master control, three youth dormitories, three group rooms, three classrooms, a kitchen area, and a game room. The program has thirty-two operating security cameras providing coverage; however, only twenty-four were operable during the annual compliance review week. The program submitted work orders and is addressing the inoperable cameras. At the time of the annual compliance review, the program had fifteen vacant positions; twelve youth care workers, one housekeeper, one medical clerk, and one dietary staff.

Strengths and Innovative Approaches

- During the holidays, the program was able to have the youth make crochet hats and Christmas cards which were gifted to a residential nursing facility.
- The program continues to work with community service organizations on various projects, which includes working with local organizations to provide meals and care packages to the less fortunate, helping to sort and pack grocery items for families in need, as well as minister to youth regarding the importance of giving back to those who have less.
- Multiple youth have been Baptized while at the program.
- A volunteer cooks pancakes, eggs, and sausage breakfast for the youth once a month.
- The program's clinical team works closely with victim and family re-unification and victim's therapist.
- The program provides additional services and resources for families such as food, shelter, and health services.
- The program provides independent living for the young men who are difficult to place and procure donations for them, such as dishes, house hold items, food, clothing, and televisions.
- The program utilizes Florida Licensing on Wheels (FLOW), which dramatically enhances the program's ability to make sure all youth have proper identification upon release.
- The program offers Animal Assisted Therapy which is a pet therapy for the youth.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
<i>Background screening is conducted for all Department staff and volunteers and all contracted providers and grant recipient staff, volunteers, mentors, and interns with access to youth and confidential youth records.</i>	
<i>A contracted provider may provide <u>training and orientation</u> to a potential staff before the screening process is completed. However, these individuals may not have contact with youth or confidential youth records until the screening is completed, the determination is “eligible,” a copy of the criminal history report has been reviewed, and the staff demonstrates he or she exhibits no behaviors warranting the denial of employment.</i>	
<i>An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.</i>	

A review of seven staff personnel records confirmed all staff received an eligible background screening prior to contact with youth and confidential youth records. A criminal history report was reviewed for each of the seven staff. None of the reviewed staff required an exemption prior to working with youth, nor was there a break in service indicated in the Department's Staff Verification System (SVS). Five of the reviewed staff were eligible for a pre-employment assessment tool and a review of personnel records confirmed each completed and passed the administered assessment tool. Two staff were not applicable, as one was an administrative assistant and one was a therapist. Upon initial review of Clearinghouse, five of the seven staff were not listed in the program's employment roster. The human resource director entered each of the five staff into the program's employment roster during the annual compliance review week. The program maintains volunteers; however, all were background screened prior to the annual compliance review period. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit on November 4, 2021. The Annual Affidavit of Compliance with Level 2 Screening Standards for the teachers who are paid by the school board, was completed and sent to the Department's Background Screening Unit on December 21, 2021. The human resource director was interviewed and indicated all information is submitted to Clearinghouse and reviewed prior to all staff/volunteers screening. Each of the seven staff's personnel records documented the provider reviewed the staff's criminal history report, the Department's Central Communications Center (CCC) person involvement history report, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS), as required. The human resource director was interviewed and confirmed this process.

1.02 Five-Year Rescreening	Limited Compliance
<i>Background rescreening/resubmission is conducted for all Department staff and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Staff and volunteers are rescreened every five years from the initial date of employment. When a current provider staff 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.)</i>	

Seven staff were eligible and reviewed for a five-year background rescreening. Five staff rescreens were submitted no more than twelve months prior to the staff's five-year anniversary date, but within ten days of the anniversary date. One staff rescreen request was submitted seven days prior to the anniversary date, making it five days late. The remaining staff rescreen

request was submitted the week of the annual compliance review, making it nine months late. Upon initial review of Clearinghouse, three of the seven staff were not listed in the program's employment roster. The human resource director entered each of the three staff into the program's employment roster during the annual compliance review week.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
<i>The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.</i> ▪ <i>The program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center (CCC) telephone number for youth eighteen years of age and older.</i> ▪ <i>All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.</i> ▪ <i>Youth and staff have "unhindered access" to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.</i> ▪ <i>The environment is free of physical, psychological, and emotional abuse (incorporating trauma-responsive principles).</i> ▪ <i>A code of conduct for staff which 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.</i>	

The program had three incidents involving allegations of abuse since the last annual compliance review, all of which were reviewed. Two of the three allegations were substantiated and one was not. For each of the three incidents, the Department's Central Communications Center (CCC) and Florida Abuse Hotline were contacted. Each of the incidents were allegations of physical abuse on a youth by a staff member. The program has had no potential human trafficking, commercial sexual exploitation, or labor trafficking victims since the last annual compliance review. The program's policy and procedures address the program's code of conduct and each of the seven reviewed staff signed acknowledging their review of the policy and procedures. A tour of the program during the annual compliance review week confirmed the posting of signage for the Florida Abuse Hotline and CCC telephone numbers. The program has a process for responding to allegations of abuse in their policy and procedures. The program completed a Trauma Responsive and Caring Environment (TRACE) self-assessment on July 6, 2021. With the three exceptions of allegations of abuse, the program is free of physical, psychological, and emotional abuse. Seven staff were interviewed. Six stated they allow the youth to make a call to the Florida Abuse Hotline or CCC; four staff indicated they notify the supervisor in the event a youth would like to make a call to report an allegation; two staff indicated they notify the executive director; and one staff indicated staff are permitted to call the Florida Abuse Hotline and CCC, if needed. All seven staff indicated they have never observed a co-worker telling a youth they could not call the Florida Abuse Hotline. Six of the seven staff indicated they have never observed a co-worker using profanity, using threats, intimidation, or humiliation when interacting with youth. The remaining staff indicated there are times when staff's language could be better when direct-care staff interact with the youth, the staff curse in front of the youth; however, the profanity is not directed towards the youth. Seven youth were interviewed and each indicated they feel safe at the program and could call the Florida Abuse Hotline, if needed. All seven staff and seven youth indicated they know the telephone number or know where to find the telephone number to the Florida Abuse Hotline. All seven youth indicated staff are respectful when talking with them and other youth. Four of the seven youth indicated they have never heard staff curse in front of or at them or other youth. Two indicated

they have heard staff use profanity once and the remaining youth stated occasionally. The three who indicated they had heard staff curse in front of the youth stated it was not directed towards the youth. All seven youth indicated they have never shared any social media contact information with staff. The executive director (ED) was interviewed and was able to explain the code of conduct expectations and consequences. The ED further stated the program utilizes information from the TRACE survey and action plan to enhance training, treatment, and operational services. The program is utilizing the Sanctuary Model which promotes trauma inclusion and sensitivity in daily operational practices. The ED indicated all staff are trained during pre-service training and during annual in-service training on the process of making abuse allegation calls.

1.04 Management Response to Allegations (Critical)	Satisfactory Compliance
<i>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.</i>	

The program had three incidents involving allegations of abuse since the last annual compliance review, all of which were reviewed. The program's supporting documentation confirmed management took immediate action to address each of the incidents. Two of the three incidents were substantiated and one of the two staff were terminated. The staff involved in the remaining substantiated incident was disciplined for their involvement in the incident. The executive director (ED) confirmed the one staff was terminated as a result of the substantiated abuse allegation. The ED indicated once an allegation of abuse has been made, the alleged staff member involved is immediately removed from youth contact and placed on administrative leave pending the outcome of the investigation. The Florida Abuse Hotline, local Sheriff's Office, and the Department's Central Communications Center were all contacted within the required time frame.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
<i>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.</i>	

The program reported fifty-eight incidents to the Department's Central Communications Center (CCC) since the last annual compliance review. Forty-eight of the incidents reported were COVID-19 related; therefore, five CCC incident reports were reviewed. All five incidents were reported to the CCC within the required two-hour timeframe. Four of the incidents were applicable for documentation in the program's logbook, of which three were documented. The remaining incident was reported by someone other than program staff or youth; therefore, the incident did not require a logbook entry. There were no additional internal incidents/grievances which should have been reported to the CCC and were not. The program experienced an increase in CCC reportable incidents since the last annual compliance review. During the last annual compliance review period, there were three reportable incidents. The program was asked for their response as to why there was an increase from three incidents to ten incidents and the executive director (ED) indicated the increase was not significant and there was not a specific reason. The ED was interviewed and was able to explain the program's incident reporting process. The ED indicated staff and youth are made aware of the process for contacting the Florida Abuse Hotline. The ED explained all staff are trained during pre-service

training and during annual in-service training on the process of making abuse allegation calls. Youth are also made aware of this process during intake/orientation to the program.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory Compliance
<i>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.</i>	

The program had two Protective Action Response (PAR) incidents during the annual compliance review period; however, only one incident was documented. The staff who was involved in the non-reported PAR incident and who did not document the PAR was terminated as a result. The youth involved in the non-reported PAR reported the incident the following day. The remaining PAR incident was documented and the report was completed by the end of the shift for each staff involved. No mechanical restraints were used in the PAR incident. The PAR did not result in the injury of the youth or staff. The youth did not allege abuse immediately; however, the youth alleged abuse seven days later and the Florida Abuse Hotline was contacted immediately. The PAR was reviewed by supervisory staff. Based on the post-PAR interview, a PAR medical review was not required. The PAR incident was reviewed by the executive director (ED) within seventy-two hours of the incident. A copy of the PAR report was placed in the program's centralized file. A review of monthly summaries since the last annual compliance review, confirmed the program submitted a PAR incident report, documenting the number of PARs, to the Department's regional office by the 15th of each month. The program's PAR Plan was updated on March 19, 2021 and was approved by the Department on April 4, 2021. The program had one PAR incident during the previous annual compliance review period. The program's PAR rate during the annual compliance review period was 0.00, which is below the statewide Residential PAR rate of 1.59. Seven staff were interviewed and three indicated they had used PAR and were able to explain the program's PAR process and procedures. Four of the staff indicated they had never used a PAR. The ED was interviewed and indicated PAR incidents are discussed during daily morning meetings and weekly management meetings.

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

Six staff were hired by the program since the last annual compliance review; however, only five were applicable for pre-service training. The remaining staff is still within the first 180 days of hire. Only direct-care staff and administrative staff supervise youth; not kitchen, maintenance, or other staff. All five applicable staff completed all required pre-service training within the required timeframe of 180 days from their date of hire. Each of the staff completed the essential skills training prior to contact with youth or confidential youth information. The five staff completed between 133 and 134 hours of training. The program's contract required staff to complete trainings, which was included on the program's pre-service training plan. Each of the five staff completed all contract required training. All pre-service training was documented in the Department's Learning Management System (SkillPro). A review of training documentation confirmed the instructors delivering training were qualified to deliver the training provided. A list of pre-service training was submitted to the Department's Office of Staff Development and Training which included course names, descriptions, objectives, and training hours for any

instructor-led training. The 2021 plan was submitted on January 20, 2021 and approved on February 23, 2021.

1.08 In-Service Training	Failed Compliance
<i>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.</i>	
<i>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.</i>	

Seven staff training records were reviewed for in-service training. Four of the seven staff did not complete annual cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), or first-aid training. Seven of the staff did not complete the required number of suicide prevention training hours. One staff completed two hours of web training and one hour of instructional training. Two of the staff completed one hour of instructional training. One of the staff completed three and a half hours of instructional training, one staff completed three hours of instructional training, one completed two and a half hours of instructional training, and the remaining staff did not complete any hours of suicide prevention training. Four of the seven staff did not receive professionalism and ethics training. Three staff were reviewed for supervisory training. One of the applicable staff completed seven of the eight required hours of supervisory training. The remaining two staff did not complete any supervisory training during the annual compliance review period. All staff completed human trafficking training and Protective Action Response (PAR) update training. A review of training documentation confirmed the instructors delivering training were qualified to deliver the training provided. A list of in-service training was submitted to the Department's Office of Staff Development and Training, which included course names, descriptions, objectives, and training hours for any instructor-led training. The 2021 plan was submitted on January 20, 2021 and approved on February 23, 2021. The program maintains a training calendar, which is updated as changes occur. All completed trainings were documented in the Department's Learning Management System (SkillPro); however, not all required training was completed.

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

The program's policy and procedures include the training requirements of the grievance process which indicates staff are required to receive training on the grievance process during pre-service and annually thereafter. Seven pre-service and seven in-service training records were reviewed. All seven pre-service training records confirmed each staff completed grievance process training during their orientation. None of the seven in-service staff completed the grievance process training. The program's grievance process includes all three grievance phases. The steps and the process were documented for each phase, including time frames. The informal phase is utilized as the first step to a grievance and the youth can talk with a staff or complete a Request to Talk form. If the grievance is not resolved, the youth will complete a grievance form and place it in the grievance box as part of the formal phase. The supervisor has four days to

provide a written response to the youth. If the youth is not satisfied with the supervisor response during the formal phase, the grievance will be forwarded to the assistant facility administrator and a written response will be provided to the youth within twenty-four hours. If not resolved, the executive director (ED) will provide a written response, as the appeal phase, to the youth within forty-eight hours. The program maintains copies of each grievance for twelve months. The program had four grievances since the last annual compliance review; therefore, all four were reviewed. Each of the four grievances were resolved in the formal phase. Each grievance documented the reason for the grievance, the date of grievance, date of response, and how it was resolved. None required an appeal phase. All four were responded to within the program's required time frame. Seven staff, seven youth, and the ED were interviewed and each were able to explain the program's grievance process. Each of the seven youth indicated they could ask for assistance if needed to complete a grievance.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
<i>The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.</i>	

The program provides interventions for each youth which incorporates evidence-based practices, promising practices, and practices with demonstrated effectiveness. The clinical curricula used by the program includes Pathways, Skillstreaming the Adolescent, Passport, Living in Balance, Coping with Depression, Coping with Stress: A Cognitive Behavioral Therapy (CBT) Guide for Teens with Trauma, and Life Skills Training. The non-clinical curricula used by the program includes Thinking for a Change, Impact of Crime, and Young Men's Work. The program has a total of six clinical staff, five non-clinical staff, and three clinical staff no longer at the program who facilitated interventions during the annual compliance review period. Training documentation for all staff supported they were trained to facilitate the interventions. All six clinical staff currently working at the program are licensed. Five of the six non-clinical staff hold, at a minimum, a bachelor's-level degree. One staff has a high school diploma and over ten years of experience working with juveniles. All fourteen staff have over two years of experience working with youth. A review of the program's delinquency intervention table identified in the program's contract, activity schedule, and group sign-in sheets supported groups were held, as required. A review of the program's activity schedule supported the program provides structured activity for at least sixty percent of the youth's awake hours. The executive director and designated mental health clinician authority (DMHCA) both provided a list of staff who facilitated groups during the annual compliance review period. The list of groups offered at the program coincide with the list found in the contract. The DMHCA indicated provision of services begins with a comprehensive psycho-social evaluation of the youth along with a psychiatric evaluation. This process accurately determines the unique, individual needs of the youth served beyond the juvenile sex offender services the youth is referred for. From the conclusions of the evaluations, a formal treatment plan is developed to target the needs identified through the assessment process. The treatment plan is then evaluated every twenty-eight days to determine the effectiveness of the intervention services provided with the opportunity to either modify or add treatment objectives as necessary. The program's delivery of service works on several fronts with each youth participating in one therapeutic group each day. Groups consist of multiple interventions which are evidence based. The program offers Coping with Trauma, as well as Coping with Depression for youth who identify as having these issues. Social skills are also addressed through attendance in Skillstreaming the Adolescent and Passport. For youth

identified with substance abuse issues, the program provides Living in Balance and Life skills Training.

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

The program maintains a policy and procedures regarding the provisions of life skills training to the youth. A review of the provider's contract showed life skills is to be integrated into the daily schedule, educational activities, and through groups. The program utilizes Skillstreaming the Adolescent and LifeSkills Training (LST) curricula for group life and social skills training. The Skillstreaming the Adolescent curricula is rated as practice with demonstrated effectiveness, and LST is rated evidenced based by the National Institute of Health. A review of both curricula verified elements included communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, critical thinking, including problem-solving, and decision-making. The program's daily schedule reflected these groups are provided twice each week. A review of sign-in sheets verified the group sessions were provided as scheduled. Seven interviewed youth stated they participate in role playing activities during groups and practice newly acquired skills. The interviewed executive director revealed life and social skills training is also incorporated into the program norms and daily activities.

1.12 Restorative Justice Awareness for Youth	Satisfactory Compliance
<i>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.</i>	

The program has a policy and procedures regarding providing restorative justice awareness to the youth. A review of the program's contract indicates Impact of Crime (IOC) curriculum is a required restorative justice service for youth. The IOC group is designed to assist youth to accept responsibility for harm they have caused by their past criminal actions. The curriculum teaches youth about the impact of crime on their victims, their families, and their communities. The IOC group exposes youth to victim's perspectives through victim speakers, in-person, or through digital video disc (DVD) videos. The IOC group provides ideas and opportunities for youth to participate in reparation activities such as community service projects. A review of three training records verified the staff who facilitated IOC groups during the annual compliance review period were trained by a certified trainer. The IOC curriculum is rated as promising practice by the National Institute of Health. A review of the program's activity schedule and sign-in sheets verified restorative justice and activity groups were provided during the annual compliance review period. Reviewed sign-in sheets reflected three closed cohorts were completed since the last annual compliance review. An interview with the director of case management reported due to the COVID-19 pandemic, off-campus and guest speaker activities have been limited; however, the program has hosted youth presentations and decorations for Black History Month, Women's History Month, gang awareness, participated in a park cleanup, and is working on linking to a veterans and/or children's hospital writing campaign. The interviewed executive director (ED) reported the program utilizes IOC as a primary service. The ED explained the IOC group participants have provided crocheted hats and mittens for nursing homes and have also made holiday cards for nursing home residents. Seven interviewed youth reported participating in groups where they discuss restorative justice, complete community

service, discuss victims' perspectives, learn how their actions have impacted others, and have completed writing activities.

1.13 Gender-Specific Programming	Failed Compliance
<i>The program provides delinquency intervention and gender-specific treatment services.</i>	

The program's contract requires gender-specific programming be provided through the use of Young Men's Work curricula. This gender-specific intervention is evidenced based. A review of the program's activity schedule and group sign-in sheets indicated gender-specific groups were provided weekly on Saturdays for five of the last twelve months; therefore, it was determined seven of the twelve months of the annual compliance review period, the gender specific curriculum was not provided. The executive director indicated all youth assigned to the program are assigned to participate in the evidenced based curriculum, Young Men's Work. The designated mental health clinician authority (DMHCA) also indicated the gender-specific curriculum used by the program is Young Men's Work. The DMHCA also indicated the Pathways curriculum supplements Young Men's Work and the youth attend the Pathways groups three times a week. All seven interviewed youth indicated they receive gender-specific topics in various groups through discussion and videos.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance
<i>The program shall maintain and use an internal alert system easily accessible to program staff and keeps staff 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 after the classification process, the program immediately enters this information into the internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. When risk factors or special needs are identified during, or after, the classification process, the program immediately enters this information into the Department's Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.</i>	

The program's policy and procedures were reviewed which confirmed how the program identifies, documents, updates, and informs staff of alerts. Six of the seven reviewed youth had documented alerts; the remaining youth did not have a documented alert. Each of the alerts reviewed were consistent with the alerts entered into the Department's Juvenile Justice Information System (JJIS). There were no noted issues with case management, medical, mental health, or safety and security alerts. The alerts for the applicable six youth were reviewed and each alert was entered by staff in the appropriate manner as identified by the program's procedures. None of the reviewed alerts were applicable for logbook documentation. There were no alerts open which should have been closed, nor were there any alerts identified which should have been open and were not. Twelve alerts were reviewed for the six applicable youth. All twelve alerts documented the name and title of the staff entering or closing the alert in JJIS. The program's internal alert list matched the alerts open in JJIS and were opened on the same day. Each alert was verified in JJIS. Seven staff were interviewed and indicated staff are informed of alerts through communication from mental health staff, medical staff, or during shift change/logbook review. The executive director was interviewed and indicated the program management team meets daily to discuss alerts and medical issues for youth. The ED stated the program has an internal alert system which reflects all safety and security alerts in addition to all medical, dietary, and mental health alerts. The alert roster is updated as needed but a

minimum of weekly by the medical department and circulated to all necessary parties. Furthermore, the daily alert roster is covered during all shift briefings and the program has a portable alert board with youth pictures which is used to supplement the alert rosters used. The registered nurse was interviewed and indicated healthcare staff are responsible for updating medical alerts.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
<i>The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files:</i> • <i>An Individual Healthcare Record</i> • <i>An individual management record</i>	

The program maintains three separate records for each youth, Individual Healthcare Record, individual mental health record, and individual case management record. Each youth's individual management record contains tabs which include the youth's name, Department identification number (DJJID), youth's date of birth, youth's county of residence, and youth's committing offense. Each individual management record contains a section identifying each youth's legal information, demographics and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Each record is labeled "Confidential." Individual mental health records are kept on a shelf in each therapist's locked office. Individual case management records are kept in two locked cabinets with "confidential" noted on each locked cabinet. Both cabinets are located in a locked office. Individual Healthcare Records are kept in a locked cabinet in medical.

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

The program has a policy and procedures addressing the program efforts to promote constructive input by the youth. The policy indicates the youth are provided opportunities to provide input daily, weekly, and monthly. Input is solicited by grievances, weekly dorm meetings, monthly town hall meetings on each dormitory, and the youth advisory board meets monthly. Reviewed documentation supported the program used these processes to promote constructive input by the youth. The program facilitated weekly community meetings with all the youth. A review of youth advisory board meeting agendas and minutes supported the meetings were conducted monthly throughout the annual compliance review period with the designated mayors of each dormitory and the community liaison staff. Reviewed documentation supported conference requests were submitted by any youth to any staff at any time as a way to communicate with staff. All seven interviewed youth indicated they are able to speak with any staff in the program through the use of a conference request sheet or by talking to the dormitory mayor who will then share the information with the staff. The transition services manager (TSM) has the youth complete a discharge survey a few days prior to the youth's graduation from the program. Copies of completed discharge surveys were provided to the annual compliance review team. The program did not have a process in place to share or use the information gathered from the discharge surveys. An interview with the community liaison staff indicated community meetings are conducted once a week with each dormitory. During these meetings, the staff provides the youth overall information about what is going on in the program. During the community meetings, the dormitory mayors share information from the youth's point sheets and the youth are informed about who earned incentives and canteen. Level progression is also discussed during the community meeting. The dormitory mayors and assistant mayors meet

with the TSM once a month. The TSM will take the information from the mayor's meeting and share it with the program's executive director (ED) and assistant facility administrator during the morning meetings. The ED indicated the program utilizes a conference request system where youth can submit different ideas to discuss different issues with staff members to help improve residential conditions/quality of life. Additionally, youth participate in a weekly community meeting and a monthly youth advisory board meeting with the youth advocate staff member(s) to address any issues, improve conditions within the program, and/or enhance the quality of life for staff and youth.

1.17 Advisory Board

Satisfactory Compliance

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

The program has an established community advisory board which meets quarterly to serve as a support to the program and a link to the community. A review of the program's advisory board agenda and sign-in sheets since the last annual compliance review confirmed meetings were held in-person on a quarterly basis with no more than 120 days between meetings. The program did not cancel any scheduled meetings. The executive director (ED) solicits and maintains a collaborative partnership with the Department and local stakeholders in the community to include representatives from law enforcement, community partners, the business community, the school district, volunteers, judiciary, and the faith community. The community liaison staff member indicated the program has had difficulty obtaining the participation of a parent/guardian of a former youth because of the pandemic. The staff also indicated since the parents/guardians live far away from the program, it is difficult to get participation. The program was not able to provide the annual compliance review team with documentation to support the work in recruitment of parent/guardian involvement because many emails were lost when the company name changed. The ED indicated the program has a community advisory board with representation from a multitude of areas to include but not limited to victim advocates, school board officials, the parent/guardian of a former Department youth, and community leaders. The board meets on a quarterly basis and many of the members play an active role in programming throughout the year. A member of the advisory board was interviewed. The board member indicated all department heads meet with the board members. During the meetings, detailed information is discussed such as youth on medication, youth releases and admissions, and what phases (levels) the youth are currently on. Board members also speak with direct-care staff since the direct-care staff work the most with the youth. The board members are very involved in assisting the youth in order for them to have a smooth transition back into the community after discharge. The goal is to enhance the youth when they are released. The youth use the board member's Work Force contacts to schedule an appointment with the local Work Force office to assist the youth. This board member stated they only have great things to say about the board and the program. The board member stated board members are very involved in assisting the youth to ensure they have a smooth transition back into the community after discharge. The goal is to enhance the youth when they are released.

1.18 Staff Performance**Satisfactory Compliance**

The program ensures a system for evaluating staff, at least annually, based on established performance standards.

The program's policy and procedures were reviewed which indicated all staff are provided with a ninety-day review and an annual performance evaluation thereafter. A review of a job description for youth care worker, shift supervisor, and director of case management confirmed each staff's performance standards were clearly identified. A review of seven staff personnel records confirmed each staff received an annual performance evaluation and were evaluated on established performance standards in 2021. Each performance evaluation matched their respective job description. A review of the program's staff roster confirmed all specific contractually required positions were maintained, as outlined in the contract. Seven staff were interviewed and three indicated communication amongst the staff is very good, two indicated it was good, and the remaining two indicated it was fair. The executive director (ED) indicated the program has had a high staff turnover rate like many other programs within the juvenile justice field; however, staff morale remains high. The ED indicated they continue to give staff monthly gift incentives, staff luncheons, and overall appreciation for the work they do day in and day out. Staff also received a merit increase within the last few months. The ED indicated all staff receive an annual performance evaluation from their direct supervisor and are able to provide input and set goals for the upcoming year on their evaluations. The employee evaluations rate the staff on a variety of different areas.

1.19 Recreation and Leisure Activities**Satisfactory Compliance**

The program shall provide a variety of recreation and leisure activities.

The program's policy and procedures indicated youth are provided at least one hour of large muscle activity daily either indoor or outdoor. A review of the program's activity schedule and logbooks confirmed youth receive recreation including large muscle activity, one hour and fifty minutes each day. The program's policy and procedures indicate the program utilizes the recreational therapist's skills to provide activities based on the developmental levels and needs of the youth in the program, allowing for choices of leisure and recreation options. Youth are able to provide input through the youth advisory board meetings and are encouraged to explore interests. Through observation during the annual compliance review week, it was confirmed youth are engaged in constructive use of leisure time. The activities promote social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Through observations and a review of the program's policy and procedures, it was confirmed youth are provided water during outside recreation, breaks are given, and the heat index is monitored. The program's recreational therapist has the required credentials and education, as outlined in the program's contract. Seven youth case management records were reviewed. Six of the seven youth had recreational therapy as part of their individualized performance plan; the remaining youth did not. The youth participate in a weekly community meeting and a monthly youth advisory board meeting to address any issues, improve conditions within the program, and/or enhance the quality of life for staff and youth. Seven staff were interviewed and indicated youth engage in football, basketball, dodge ball, utilize workout equipment, ping pong, cards, board games, four square, video games, and bean bag toss. Six staff indicated youth receive at least one hour of recreation, but often times more. One staff did not indicate the amount of time spent at recreation. Seven youth indicated the opportunity is provided to exercise, play outside, read a book, or play board games. All seven youth indicated

physical activity is provided daily for at least one hour in the form of basketball, football, running, soccer, play cards, board games, and watching television.

Standard 2: Assessment and Performance Plan

2.01 Initial Contacts to Parent/Guardian and Court Notification	Satisfactory Compliance
<i>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. The program notifies the youth's committing court, assigned juvenile probation officer (JPO), and post-residential services case manager (if applicable) in writing within five working days of any admission.</i>	

Seven youth case management records were reviewed for initial contact with the parent/guardian within twenty-four hours of the youth's admission. Each record included documentation in the chronological notes indicating the parent/guardian was contacted by telephone confirming the youth's arrival to the program. All records included a written letter which was mailed to the parent/guardian within forty-eight hours of the youth's admission and included the youth handbook and other program information. Each record contained documentation confirming the committing court and youth's juvenile probation officer were notified in writing within five working days of the youth's admission to the program.

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

Seven youth case management records were reviewed and each included documentation confirming youth orientation was completed on the day of admission. Each youth record included an orientation checklist which included all of the required topics and was completed on the youth's day of admission. Youth were provided a youth handbook during the orientation process which included information regarding the behavior management system, mail and telephone procedures, and other program procedures. There were no youth admissions during the annual compliance review week; therefore, a youth orientation was unable to be observed. A review of seven youth interviews confirmed orientation began within twenty-four hours of the youth's admission and included a review of the youth handbook, program rules, facility tour, and program services.

2.03 Written Consent of Youth Eighteen Years or Older	Satisfactory Compliance
<i>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 screenings, assessments, or treatment.</i>	

Seven youth case management records were reviewed for the written consent of youth eighteen years of age or older. One of the seven records was applicable, as the other six youth were under the age of eighteen. A request for two additional applicable youth records was requested for review. Each of the three applicable youth records included documentation granting the release of information regarding physical or mental health screening, assessment, and/or treatment with their parent/guardian.

2.04 Classification Factors, Procedures, and Reassessment for Activities	Satisfactory Compliance
<i>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.</i> <i>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.</i> <i>All youth admitted to residential commitment programs shall be screened for vulnerability to victimization and sexually aggressive behavior prior to room assignment. Room assignments by staff shall ensure a youth's potential for victimization or predatory risk has been reviewed. The screening shall be completed in JJIS.</i>	

The program has a policy and procedures regarding the youth classification process. The program's classification process includes identifying the physical characteristics of the youth, special needs, maturity, age, history of violence, gang affiliation, past criminal behavior, sexual aggression/vulnerability to victimization, the youth's perception of vulnerability, and the youth's potential or verified human trafficking. Seven youth case management records were reviewed and found each youth had a classification form completed on the day of the youth's admission. The program's classification forms addressed all of the required information. The classification forms and process are used to assign the youth to a sleeping room and youth group or staff advisor. The program completes a risk assessment for each youth on a monthly basis to determine the youth's eligibility for an increase of privileges, use of tools, and participation in off-campus activities. A review of seven youth records found three youth were applicable for a reassessment. Two of the three youth had a reassessment completed to address the youth's increase in privileges and use of tools or participation in work projects. The remaining youth had a reassessment completed due to inappropriate behavior in the program including using gang signs and interactions with other youth. The executive director was interviewed and indicated the treatment team members review all required factors which are discussed to determine appropriate dormitory assignment and room placement based information provided during the admission classification meeting.

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

Seven youth case management records were reviewed and found two youth were applicable for gang identification and notification of law enforcement. The program had no additional applicable youth records for gang identification during the annual compliance review period. One youth was identified as having suspected gang activity during the initial intake process. Local law enforcement and law enforcement of the youth's home county were notified of the youth's suspected gang activity. A gang alert was also entered into the program's internal alert system, as well as the Department's Juvenile Justice Information System (JJIS). The second youth was identified as having suspected gang activity approximately one and a half months after the youth's admission to the program. Upon this new information, the program notified local law enforcement and law enforcement of the youth's home county of the youth's suspected gang activity. An alert was also entered into the program's internal alert system and JJIS. In

both of the youth records, documentation confirmed the educational provider and the youth's juvenile probation officer were also notified of the suspected gang activity.

2.06 Gang Identification: Prevention and Intervention Activities	Satisfactory Compliance
<i>A program shall implement gang prevention and intervention strategies. The program shall provide intervention strategies when youth are identified as a criminal street gang member, are affiliated with any criminal street gang, or are at high-risk for gang involvement.</i>	

The program has a policy and procedures regarding gang prevention and intervention services which includes providing the youth an opportunity to develop a plan to dis-affiliate with a criminal gang. Seven youth case management records were reviewed and found two youth were applicable for gang prevention and intervention activities. The program had no additional applicable youth records for gang prevention and intervention activities during the annual compliance review period. Both youth participated in gang prevention and intervention activities and each youth's performance plan included goals relevant to gang intervention. The program utilizes 50+ Stories of Fractured Lives, Changing Course – Preventing Gang Membership, and Impact of Crime (IOC) as the gang prevention and intervention strategies and curriculum. An interview with the executive director confirmed the curriculum and strategies and indicated youth are assigned gang goals which are monitored for compliance through the youth's stay in the program.

2.07 Residential Assessment for Youth (RAY) Assessments and Re-Assessments	Satisfactory Compliance
<i>The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. Documentation of the initial assessment process is to be maintained in JJIS. The program shall ensure reassessments are completed for each youth at least every ninety days from the initial assessment. 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.</i>	

Seven youth case management records were reviewed and confirmed each youth had a Residential Assessment for Youth (RAY) completed within thirty-days of the youth's admission. Six of the seven youth were applicable for a RAY re-assessment and all six youth had documentation confirming a RAY re-assessment was completed at least ninety days after the initial assessment. The remaining youth was not applicable as they were not yet due for a re-assessment based on the date of their initial assessment. All initial assessments and re-assessments were maintained in the Department's Juvenile Justice Information System and the youth's record.

2.08 Youth Needs Assessment Summary (YNAS)	Satisfactory Compliance
<i>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.</i>	

Seven youth case management records were reviewed and found six youth had a Youth Needs Assessment Summary (YNAS) completed within the required time frame. The remaining youth

record had a YNAS completed four days late. All records confirmed the YNAS was completed and documented in the Department's Juvenile Justice Information System.

2.09 Performance Plan Development, Goals, and Transmittal (Critical)	Limited Compliance
<i>The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the youth's initial assessment, within thirty days of admission.</i>	
<i>For each goal, the performance plan shall specify the target date for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal.</i>	
<i>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 youth's committing court, the assigned juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) case manager, if applicable.</i>	

The program has a policy and procedures regarding the development of the Individual Performance Plan (IPP) within thirty-days of a youth's admission. A review of seven youth case management records confirmed all youth had an IPP developed within thirty days of the youth's admission. Six of the seven plans were developed after the initial needs assessment summary, as required, with one plan developed ten days prior to the need's assessment. All members of the treatment team were involved in the development of the youth's IPP and all required signatures were documented. One IPP had all participants with signatures dated December 6, 2021; however, the performance plan was developed and created in the Department's Juvenile Justice Information System (JJIS) on December 10, 2021. When discussing this with program staff, they indicated the youth had signed the performance plan first with a date of December 6, 2021 and all other members of the treatment team used the same date. Upon further review in the youth record, the notification letter to the committing judge, as well as a chronological note, indicating the date the performance plan was completed both included December 6, 2021. This was reported to the Department's Central Communications Center (CCC) and was accepted as possible falsification as the created date on the performance plan indicated the plan was created on December 10, 2021. One of seven records included the signed signature sheet from the parent/guardian. The signature sheet was sent to the parent/guardian for the remaining six records; however, the signature sheet was not returned. All plans included individualized goals and the top three criminogenic factors based on the youth's needs assessment. Six of seven plans included transition activities and the youth's recreation/wellness plan incorporated into the IPP. All plans included youth and program staff responsibilities and targets dates for completion. Some target completion dates were identified as the date of the youth's anticipated program completion. Six of seven youth records included documentation the committing court, juvenile probation officer, and parent/guardian were sent a copy of the plan within ten working days of the plan's completion. It could not be determined if the remaining plan was sent within ten working days of the plan completion, as this was the record which had the date discrepancy between the signatures and plan creation. Seven youth were interviewed and all youth indicated they participated in the development of their performance plan and received a copy of the plan. Six of the seven youth indicated they knew what their performance plan goals were, while the remaining youth stated they could not remember their performance goals.

2.10 Performance Plan Revisions**Limited Compliance**

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

Seven youth case management records were reviewed for performance plan revisions. Each youth had performance plan revisions completed every thirty days during their formal treatment team meetings. Revisions contained in one of the seven reviewed youth records documented all required signatures. Four records did not have any performance plan revisions with signatures. One of the two remaining youth records contained three performance plan revisions, of which two did not have signatures and the third did not contain a signature sheet. The remaining youth record had revisions which did not have any updates made to the goals to indicate completion or status since the development of the plan on February 11, 2022. There was also one performance plan revision which was created in the Department's Juvenile Justice Information System on March 3, 2022; however, each of the signatures on the plan were dated March 2, 2022. The Department's Central Communications Center was notified of the falsification during the annual compliance review.

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

Six of the seven youth case management records were applicable for performance summaries and transmittals. The remaining youth was admitted to the program January 27, 2022 and was not yet due for a performance summary. Five of the six applicable youth records documented performance summaries were completed every ninety calendar days following the signing of the performance plan. The remaining youth's record documented one performance summary was completed four days late. All performance summaries included all required elements. Reviewed documentation confirmed the youth were allowed to read and add comments to the summaries prior to signing and each youth was given a copy of the summary. Five of the six records contained the original performance summary. The remaining record contained a copy of the original summary. Each summary was signed and dated by the youth, treatment team leader, and executive director or designee. All summaries, with the exception of one, were transmitted to the youth's committing court, juvenile probation officer, and parent/guardian within ten working days, as required. There was no documentation to confirm the remaining summary was sent to the youth's parent/guardian or committing court.

Three closed youth records were reviewed for release summaries. Reviewed documentation indicated the original release summaries were sent, along with the Pre-Release Notification (PRN), to the youth's juvenile probation officers. One of the three summaries and PRNs were sent within ninety days of the youth's planned release. The remaining two were sent three and four days late, respectively. All three records contained a signed copy of the release summary. Each record contained a Residential Assessment for Youth exit assessment which was completed prior to the youth's release from the program.

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.

A review of seven youth case management records found each youth's parent/guardian was involved in the assessment process, development of the performance plan, progress reviews, and transition planning. A review of documentation determined all parents/guardians were given advanced notice of the dates and times of formal treatment team meetings. A formal treatment team meeting and transition conference were observed during the annual compliance review. Each youth's parent/guardian was contacted and participated during the meetings. The executive director reported parents/guardians are called upon the youth's admission to the program. The case manager invites the parents/guardians to participate in all treatment team meetings. Parents/guardians also receive written communication regarding the youth's progress regularly and are invited to participate in counseling sessions and treatment team meetings in person. All seven interviewed youth reported their parents/guardians are involved in their processes, to include treatment team meetings and therapy sessions.

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 regarding treatment team members. A review of documentation in seven youth case management records reflected all required parties were included in each youth's treatment team, with educational staff providing written input prior to the meetings. The program's policy does not require the gang prevention specialist to participate in treatment team meetings. Observations of a formal treatment team meeting during the annual compliance review found all required parties were present, to include the youth's juvenile probation officer and parent/guardian who each participated by telephone.

2.14 Incorporation of Other Plans into Performance Plans**Satisfactory Compliance**

The youth's performance plan shall reference or incorporate the youth's treatment or care plan.

Seven youth case management records were reviewed for the incorporation of other plans into the youth's initial performance plans. Six of the seven plans included the youth's academic, treatment, and wellness plans. The remaining plan did not include the youth's wellness plan.

2.15 Treatment Team Meetings (Formal and Informal Reviews)**Satisfactory Compliance**

A program shall ensure the intervention and treatment team meets bi-weekly (formally and informally) to review each youth's performance, to include RAY Reassessment results, progress on Individualized Performance Plan goals, positive and negative behaviors, including behaviors resulting in physical interventions. If the youth has a treatment plan, review their treatment plan progress.

Seven youth case management records were reviewed for formal and informal treatment team meetings. A review of documentation confirmed all formal treatment team meetings were held every thirty days with one exception. One meeting was held three days late. Each of the formal reviews documented all required elements, with minor exceptions. Documentation for one meeting did not include the youth's overall progress and another meeting did not include the youth's stages of change or overall progress. All seven records documented informal treatment team meetings were held, as required. All informal treatment team documented all required elements. A formal treatment team meeting was observed during the annual compliance review. All required parties participated in the meeting, to include the youth's parent/guardian and juvenile probation officer who participated by telephone. Education staff provided input prior to the meeting which the youth read to the team. All of the treatment team members were very encouraging in providing feedback to the youth, discussed the youth's positive behaviors, and treatment progress. All seven interviewed youth reported staff reviewed their performance to include progress on their performance plan goals, positive and negative behaviors, and treatment progress during treatment team meetings.

2.16 Career Education**Satisfactory Compliance**

Staff shall develop and implement a vocational competency development program.

The program has policy and procedures in place which supports career education. Type 2 career education curriculum is provided to include personal accountability skills and behaviors from the type 1 curriculum. Instructing youth towards appropriate work habits for employment, communication, prerequisites for entry to definitive occupations, interpersonal, and decision-making skills and living standards is provided at the program. Three youth closed case management records were reviewed. Upon review of the closed records, all included documentation essential for employment, résumé, Florida identification cards, and documents supporting the parent/guardian and juvenile probation officer were made aware of each youth's vocational plan. Two youth records indicated the location of the local Career Source Center and completed job applications for each of the two youth; the remaining youth's record did not include this information. The lead teacher interview verified all students participate in the Florida Ready to Work and My Florida Shines. The executive director indicated youth are enrolled in career classes and the Florida Ready to Work certification program. SafeStaff and ServSafe certifications may be obtained while youth are in the program.

2.17 Educational Access**Satisfactory Compliance**

The program shall integrate educational instruction (career and technical education, as well as academic instruction) into the daily schedule in such a way ensuring the integrity of required instructional time.

The program has policy and procedures in place which supports educational access. The program provided a school calendar for 2021-2022. The calendar indicated instruction is scheduled for 244 days, six days less of the required 250 days of instruction. Three of the 244 days were identified on the school calendar as teacher in-service days. The class schedule provided, along with the program's activity schedule, verified six classes are scheduled at fifty minutes each day with a cumulative twenty-five instructional hours each week. The youth are able to earn credits for both educational and training experience. A review of the logbooks indicated there were no interruptions to the class and the daily class schedule was adhered to. Seven interviewed youth and the lead teacher indicated there are no interruptions during school.

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 has policy and procedures in place which support transition planning upon admission. Three youth closed case management records were reviewed. All three youth closed records included an educational transition plan developed by the youth and educational staff. Key personnel were included in each educational transitional plan. All youth closed records included the Educational Exit Plan which establishes education placement information. Each of the three plans ensured the services, interventions, recommended educational placements for each youth were based on each youth's assessed needs, education plans, and performance. Each plan included specific monitoring responsibilities. The seven interviewed youth indicated they were involved in the development of the transition plan and were well prepared for their next educational or vocational placement. The seven interviewed youth also indicated being prepared for employment upon leaving the program.

2.19 Transition Planning, Conference, and Community Re-Entry Team Meeting (CRT)**Satisfactory Compliance**

A program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay. During the Transition Conference, participants shall review transition activities on the youth's performance plan, revise the activities 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 participant's dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.

Each youth must attend their scheduled Community Re-Entry Team (CRT) meeting prior to discharge.

Three closed youth case management records were reviewed for transition planning, conferences, and Community-Re-Entry Team (CRT) meetings. Each youth's transition conference was held at least sixty days prior to the youth's targeted release date. All required

team members were invited and participated in each youth's transition conference. During the transition conferences, the participants reviewed the youth's transition activities and revised performance plans, if needed. All of the participants signed and dated the transition conference documentation, as required. Each of the transition plans identified the persons responsible for each transition activity; however, two of the plans were missing target completion dates for all of the activities. A transition conference was observed during the annual compliance review. All required parties were in attendance, to include the youth's juvenile probation officer and parent/guardian who participated by telephone. The team reviewed the date and time of the youth's upcoming exit conference, transition plan, positive behaviors, a substance abuse prevention plan, and follow-up appointments with the psychiatrist. Two of the three records documented a copy of the plan was sent electronically to the youth's juvenile probation officer; however, there was not a return email sent back to the program.

Reviewed documentation in all three closed youth records indicated CRT meetings were conducted prior to the youth's release from the program. All three records contained documentation of an invitation to participate in the CRT meeting. A review of each youth's chronological notes reflected the youth, case manager, education, clinical staff, parent/guardian, and program administration were present during the CRT meeting.

2.20 Exit Portfolio	Satisfactory Compliance
<i>The program will assemble an Exit Portfolio for each youth to assist once released back into the community.</i>	

Three closed youth case management records were reviewed Exit Portfolios. Reviewed documentation reflected each Exit Portfolio was initiated during the youth's Transition Conference and finalized during the Exit Conference. Each of the Exit Portfolios contained all of the required elements, with minor exceptions. One youth's portfolio did not contain a calendar with dates and times of upcoming appointments and Social Security Card; however, the parent/guardian provided the youth's Social Security number, allowing for the youth to obtain a state-issued identification card. Another portfolio was missing a copy of the youth's state-issued identification card and birth certificate. Reviewed documentation confirmed the Exit Portfolios were given to the youth and a copy was sent to the youth's assigned juvenile probation officer upon the youth's release.

2.21 Exit Conference	Satisfactory Compliance
<i>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.</i>	

Three closed youth case management records were reviewed for Exit Conference documentation. Each conference was conducted at least fourteen days prior to the youth's release from the program and after the program notified the juvenile probation officer of the youth's release. Documentation reflected the dated signatures of all participants, as well as a summary of pending transition goals. All three records documented all required parties participated in the Exit Conferences, except for education staff. All of the education staff provided written input prior to the conferences. All of the reviewed records contained summaries of the youth's transition goals contained on their exit plans and there was documentation of the status of the transition activities established at the transition conference and finalized plans for youth's release reviewed. A review of the Department's Juvenile Justice Information System

reflected each youth's admission and release dates correlated with the dates documented in their record.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
<i>Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. Programs 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 program.</i>	

The program maintains a policy and procedures ensuring a State of Florida licensed clinician will serve as the designated mental health clinician authority (DMHCA) and will be responsible for providing the coordination and implementation of mental health and substance abuse service delivery. The DMHCA ensures the appropriate coordination and implementation of mental health and substance abuse services and is available twenty-four hours a day, seven days a week for consultation with youth as needed in the event of emergencies. The DMHCA serves as the clinical director, has the final authority on all mental health issues, and is supervised administratively by the executive director (ED). The DMHCA will provide diagnostic assessments, interviewing and examination, administration and interpretation of psychological testing, mental health and substance abuse evaluation and treatment. The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the DMHCA. The DMHCA's license is clear and active in the State of Florida, with an expiration date of March 31, 2023. The DMHCA is scheduled to be on-site Monday through Friday from approximately 8:00 a.m. to 5:00 p.m. and is available for emergency consultation services twenty-four hours a day, seven days a week. An interview with the DMHCA verified they are on-site Monday through Friday and on call, when needed. The program's contract outlines the DMHCA serves as the program's clinical director and has the final authority on all mental health issues and is supervised administratively by the ED. The DMHCA has the responsibility for directing the program's psychological and treatment services to include technical and administrative duties, testing, individual therapeutic services, group therapy, and family therapy. The program does not maintain a sign-in log for the DMHCA since they are a full-time staff member. The DMHCA supervises one LMHC serving as the assistant clinical director, four LMHCs, and one licensed clinical social worker (LCSW). A review of the clinician's licenses validated each was clear and active in the State of Florida with an expiration date of March 31, 2023 for all six clinicians. The interviewed DMHCA stated as the clinical director, they ensure the program is delivering quality service to the youth within their care. The DMCHA reviews assessments and treatment plans to ensure they are accurate and reflect the needs of the youth. The DMHCA conduct fidelity checks on the Standardized Program Evaluation Protocol (SPEP) groups to ensure program staff are implementing the curriculum as designed. The DMHCA ensures staff are qualified to complete their job and assists in monitoring continuing education and certification for the clinical team. The DMHCA completes chart audits on a monthly basis to ensure documentation and delivery of service is current and accurate. In addition, the DMHCA is also responsible for program compliance to ensure documentation and program delivery meets or exceeds standards. The DMHCA indicated they provide occasional coverage if staff are on scheduled leave and/or out sick to include running groups and/or conducting individual therapy sessions. Communication with staff is both on a formal and informal basis. Contact and communication with clinical staff occurs on a daily basis, Monday through Friday. Communication usually centers on case consultation and/or policy review. The DMHCA ensures proper completion of documentation and integration of a mental health delivery system which meets all state and

federal guidelines. The DMHCA is responsible for directing the program's treatment services to include technical and administrative duties, testing, individual, group and family sessions, participating in overall institutional programming and administration, and related work as required. In addition, the DMHCA provides emergency consultation services and conducts fidelity checks and monthly record reviews to also ensure all services are provided. Additionally, responsibilities include oversight of Assessments of Suicide Risk, crisis intervention, diagnostic assessments, interview and examinations, and administration and interpretation of psychological and psychiatric testing. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and participates in weekly meetings with the psychiatrist to discuss each youth receiving services. A review of the DMHCA's position description validated the services provided in serving as the program's mental health and substance abuse authority. The assistant clinical director acts as the back-up when the DMHCA is not available or on scheduled leave.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
<i>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 the staff are qualified to provide based on education, training, and experience.</i>	

The program maintains a policy and procedures ensuring the designated mental health clinician authority (DMHCA) is responsible for providing the coordination and implementation of mental health and substance abuse delivery. The DMHCA serves as the clinical director who also serves as the clinical supervisor. The clinical director ensures all clinical staff are performing services they are qualified to provide based on education, training, and experience. At the time of the annual compliance review, the program's staff included six licensed mental health counselors (LMHC) and one licensed clinical social worker (LCSW). One licensed clinician position became vacant on February 1, 2022 and was filled on March 18, 2022. The newly hired licensed clinician was in pre-service training. One LMHC serves as the DMHCA and one LMHC serves as the assistant clinical director. A review of the licensed clinicians' credentials indicated each is licensed in the State of Florida, with an expiration date of March 31, 2023. The program is designed to serve mental health and substance abuse services with specialized sexual offender treatment services. A review of the clinician's credentials validated each met certification requirements to provide juvenile sexual offender (JSO) treatment at the program. The program maintains an agreement for professional services with a State of Florida licensed psychologist on an as-needed basis, as outlined in the contract with the Department. The number of hours is determined by the needs of the youth and the program. The psychologist is required to complete assessments, Intelligence Quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the DMHCA. A review of the psychologist's license reflected it was clear and active in the State of Florida with an expiration date of May 31, 2022. An informal interview with the DMHCA indicated the program has not required the services of the psychologist in the last twelve months. The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statutes, Chapter 397, to provide substance abuse services for outpatient treatment. The program employs all licensed clinicians; therefore, the Chapter 397 license is not required.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Non-Applicable
<i>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 the staff are qualified to provide based on education, training, and experience.</i>	

The program's policy, procedures, or contracts states the program does not utilize non-licensed clinical staff; therefore, this indicator is rated non-applicable.

3.04 Mental Health and Substance Abuse Admission Screening	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures to ensure each youth's mental health and substance abuse needs are identified through a comprehensive screening process which includes a review of the commitment packet information, reports and records, and review of the Department's Juvenile Justice Information System (JJIS) alerts, administration and scoring of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), or the clinical mental health and substance abuse screening. The program ensures mental health and substance abuse services are available to all youth who are determined to meet clinical criteria and certified to receive such services. Mental health and substance abuse treatment is provided on-site through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) with a specialized emphasis on juvenile sexual offender (JSO) treatment services. Immediately upon the youth's arrival to the program, staff review all available information including the commitment packet, mental health and substance abuse comprehensive evaluations, and a history of human trafficking. An initial mental health and substance abuse screening process is initiated by the multi-disciplinary treatment team staff to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. As a key component of the initial intake process, following the completion of the Facility Entry Physical Health Screening form conducted by nursing staff, the MAYSI-2 is administered by the clinical director and/or assistant clinical director, both of whom were trained as evidence in their training records. A review of seven mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for each youth. The clinical director completed six of the seven screenings and the assistant clinical director completed one of the seven screenings. Each reviewed MAYSI-2 reflected the screening was completed in full in JJIS. Following the MAYSI-2 screening, the clinical therapists review all available information to include the youth's commitment packet information, pre-dispositional reports, previous psychological and/or psychiatric evaluations for information regarding suicide risk, mental health or substance abuse issues to include inpatient and/or outpatient mental health and substance abuse treatment. The review includes the youth's history of drugs, alcohol, emotional instability, significant trauma, mental illness in the family, and any suicide risk factors. The review is documented on the program's Clinical Mental Health and Substance Abuse Intake Screening Checklist form. All seven reviewed MAYSI-2s resulted in the youth requiring a referral for further evaluation with each having a hit and/or an override. The program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results since each youth is

court ordered for JSO services. A Mental Health Services Referral form is completed and submitted to the clinical department. There were no instances where youth had a need for a crisis intervention or emergency service as a result of the screening. There were no applicable youth with an elevated suicide ideation; however, the program completes an Assessment of Suicide Risk (ASR) regardless of the MAYSI-2 screening results. The ASR was completed within twenty-four hours for each reviewed youth. Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an ASR regardless of MAYSI-2 screening results. An interview with the executive director indicated when the youth arrives at the program, the clinical department administers an electronic MAYSI-2 and submits the MAYSI-2, along with a referral form, to the clinical director. Case management also submits relevant background information, including, among other things, the Pre-Disposition Report (PDR), JJIS Face Sheet, and any other relevant psychological evaluations. The therapist conducting the intake reviews the MAYSI-2 and all relevant information, and then documents on the Mental Health Substance Abuse Screening Checklist, everything which was reviewed.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
<i>Youth identified by screening, staff observations, or behavior post-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.</i>	

The program maintains a comprehensive written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. Each youth, regardless of whether the youth was admitted with a current evaluation, receive a new bio-psychosocial entitled Mental Health and Substance Abuse Comprehensive Evaluation, which contains all required elements outlined in Florida Administrative Code. The clinical staff complete a Clinical Mental Health/Substance Abuse Intake Screening identifying the reason for clinical mental health/substance abuse screening, youth interview, current mental health status, substance abuse status, and clinical disposition. As part of the assessment process, the program's clinical staff reviews any psychological and/or psychiatric reports, Pre-Disposition Report (PDR), or other information available in the youth's commitment packet and youth record. An interview with the clinical director and reviewed youth records supported each youth was assessed utilizing the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Beck Depression Inventory-II (BDI-II), Department Assessment of Suicide Risk (ASR), Suicide Probability Scale, Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Becks Depression Inventory, Trauma Symptom Checklist for Children (TSCC), and the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). A review of seven mental health and substance abuse records verified the licensed clinical staff completed the substance abuse assessments which included relevant background information such as home environment, physical abuse, sexual abuse, neglect, trauma, education functioning, physical health, mental health, and substance abuse history. Each bio-psychosocial evaluation was completed by a licensed therapist and signed by the clinical director or the assistant clinical director. Reviewed documentation validated the bio-psychosocial evaluation was completed for each youth within thirty calendar days of admission. Each reviewed bio-psychosocial was completed in full. Reviewed practice supported each youth record had a signed Department Youth Consent for Substance Abuse Treatment form and a Department Youth Consent for Release of Substance Abuse Treatment Records form. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form and the Sequel Authorization for Release of Health Information Pursuant to HIPPA (Health Insurance Portability and Accountability Act of 1996) form. Youth

eighteen years of age and older sign a release form for specific information and to whom the information is shared. A review of three applicable youth records validated this practice. The program is not licensed through the Department of Children and Families (DCF) in accordance with Florida Statutes, Chapter 397, to provide substance abuse services for outpatient treatment. The program employs all licensed clinicians; therefore, the Chapter 397 license is not required.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. All mental health and substance abuse treatment planning focuses on providing mental health and substance abuse interventions designed to target and reduce and/or alleviate the youth's symptoms of mental disorder and substance abuse impairment and enable the youth to improve functioning within the program and ultimately upon release to the community. Each youth's mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. The treatment team is responsible for assisting in developing, reviewing, and updating the youth's Initial Treatment Plan and Individualized Treatment Plan (ITP). Mental health and substance abuse treatment is guided by an ITP addressing all youth needs to include emergent issues, ongoing issues, continuity of services to include contingency planning, future planning, and decisions concerning the youth served to ensure the exchange of information regarding the person-centered plan. A review of seven youth mental health and substance abuse records verified the Initial Treatment Plans were completed on the day of admission. The Initial Mental Health and Substance Abuse Plan form included all of the elements of the Department's form. Each reviewed Initial Treatment Plan was signed by the mental health/substance abuse staff who completed the form. In addition, the youth, case manager, registered nurse, and parent/guardian when applicable, participated in the development of the plan signed accordingly. One of seven reviewed Initial Treatment Plans was signed by the parent/guardian and five were mailed to the parent/guardian. One youth was eighteen years of age and did not require a parent/guardian signature. Two applicable records of youth admitted on prescribed psychotropic medications included the youth's psychiatric needs including any applicable medication monitored by the psychiatrist. The plans included the name of the psychotropic medication, dosage, and the frequency of monitoring by the psychiatrist. A review of seven mental health and substance abuse records verified the ITP was developed within thirty days of the youths' admission to the program. The ITP forms included all of the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Each of the reviewed ITP was signed by the mental health/substance abuse staff which completed the form and were reviewed and signed by the clinical director and all treatment team members. Services were individualized for each youth and included prescribed individual therapy services, group therapy services, family therapy services, and applicable psychiatric services. The program's clinical therapists facilitate mental health and substance abuse groups. Surveillance video footage on randomly selected dates were observed for review of groups. The groups lasted approximately forty-five minutes and documented this time on the sign-in sheets. A review of mental health and substance abuse group sign-in sheets supported groups were provided daily

to youth and mental health groups were limited to ten or fewer youth and substance abuse groups were limited to fifteen or fewer youth. A review of seven mental health and substance abuse records verified treatment plan reviews were conducted every thirty days, as required.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
<i>Mental health and substance abuse treatment planning in programs focus 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.</i> <i>The treatment team is responsible for assisting in developing, reviewing, and updating the youth's Individualized and Initial Mental Health/Substance Abuse Treatment Plans.</i> <i>All youth who receive mental health and/or substance abuse treatment while in a 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 program.</i>	

The program maintains a policy and procedures ensuring all youth determined to have a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis shall have an Initial Treatment Plan and an Individualized Mental Health and Substance Abuse Treatment Plan. All mental health and substance abuse (MHSA) treatment services are provided through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) with a specialized emphasis on juvenile sexual offender (JSO) treatment services. Services are designed and implemented to support recovery, health or well-being of the youth and family, ensure safety and enhance the quality of life, and to reduce symptoms and build resilience. Treatment services conducted at the program are provided by or under the direct supervision the program's designated mental health clinician authority (DMHCA). It is the responsibility of the clinical director and primary therapist to ensure the treatment plans are individualized and relevant to each youth's specific needs. Each youth is assigned to a treatment team upon arrival to the program. A review of seven youth mental health and substance abuse records validated the practice; however, the Treatment Team Designation form completed on the day of admission, did not initially include the residential living unit, vocational training instructor, and parent/guardian. The program provided an updated form during the annual compliance review week to include these treatment team members. An informal interview with the DMHCA indicated the program provides JSO specific treatment services and each clinician has obtained or maintained JSO certification in order to provide services to the youth. Seven reviewed youth mental health and substance abuse records found each contained an Initial Mental Health Substance Abuse Treatment Plan documented on a program-specific form which contained all elements as outlined on the Department's Individual Mental Health/Substance Abuse Treatment Plan form completed by the treatment team on the youth's date of admission. Each youth had a completed Individualized Treatment Plan (ITP) documented on a program-specific form containing all elements included in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Documentation reflected the youth, program administration, residential living unit, medical staff, mental health/substance abuse staff, and parent/guardian participated in the treatment team meetings. Each of the reviewed treatment team meeting documents indicated the treatment team addressed the progress of youth receiving individual, group, and family counseling. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form and the Sequel Authorization for Release of Health Information Pursuant to HIPAA (Health Insurance Portability and Accountability Act of 1996) form. Youth eighteen years of age and older sign a release form for specific information and to whom the information is shared. Four of

seven youth were identified with a substance abuse diagnosis and each youth record contained a signed Youth Consent for Substance Abuse Treatment form and a signed Youth Consent for Release of Substance Abuse Treatment Records form. A review of mental health and substance abuse treatment notes and group sign-in sheets during the annual compliance review period, verified group mental health therapy was limited to ten or less youth, substance abuse treatment groups were limited to fifteen or less youth, and individual counseling was conducted by the mental health clinical staff. Reviewed contract, group schedules, and documented practice found the licensed clinical staff conducted groups seven days a week. Coping with Stress: A Cognitive Behavioral Guide (CBT) Guide for Teens with Trauma, The Adolescent Coping Depression, Passport Program, and Living in Balance are conducted on Mondays. The Pathways group is conducted Tuesday, Wednesday, and Thursday. Skillstreaming the Adolescent and Animal Assisted Therapy is conducted on Friday. LifeSkills Training (LST) is conducted on Saturday and Sunday. A review of seven youth mental health and substance abuse weekly progress notes validated each youth received the prescribed services as outlined on the ITP. Three of seven reviewed youth records indicated the youth were on prescribed psychotropic medications and the ITPs incorporated the youth's psychiatric needs to include the medication and frequency of monitoring by the psychiatrist. Program practice is for the psychiatrist to review and sign the ITP for youth prescribed psychotropic medications. All seven reviewed youth mental health and substance abuse records documented the multi-disciplinary treatment team conducted a treatment plan review at least every thirty days. Three closed youth records were reviewed for the completion of a Mental Health and Substance Abuse Discharge Summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three reviewed Discharge Summaries were applicable for a youth being released on suicide precautions. Each reviewed summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference, as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by e-mail. Reviewed documentation supported this practice in each record. Seven interviewed staff indicated they did not facilitate or conduct any mental health groups or substance abuse groups. Seven interviewed youth found each indicated they are participating in individual counseling and three youth indicated they participate in family therapy. Three parents/guardians refused to participate and one youth was eighteen years of age and did not want to participate in family therapy.

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

The program maintains a policy and procedures ensuring mental health and substance abuse services are provided through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) with a specialized emphasis on juvenile sexual offender (JSO) treatment services. A review of the program's contract, clinical program description, and interview with the executive director (ED) indicated the program provides specialized JSO services. All youth with co-occurring substance abuse disorders receive substance abuse services by the licensed therapists. Treatment services are guided by an

Individualized Mental Health and Substance Abuse Treatment Plan addressing the youth's needs in accordance with Florida Administrative Code. At the time of the annual compliance review, the program's staff included six licensed mental health counselors (LMHC) and one licensed clinical social worker (LCSW). One licensed clinician position became vacant on February 1, 2022 and was filled on March 18, 2022. The licensed clinician was in pre-services training. One LMHC serves as the DMHCA and one LMHC serves as the assistant clinical director. A review of the clinician's credentials validated each met certification requirements to provide juvenile sexual offender (JSO) treatment at the program. Caseloads for each therapist did not exceed ten with a minimum of seven and maximum of ten. A review of seven staff pre-service training records supported each staff received an overview training in MHOS, SAOS, and JSO services prior to working with the youth. The licensed designated mental health clinician authority (DMHCA) is on-site at a minimum of forty hours a week and on-call for consultation twenty-four hours a day. The program's specialized treatment services include individual therapy, family therapy, and daily group therapy sessions. Each licensed clinician did not exceed ten youth on their case load. A review of the psychiatric visitor log for the past twelve months, confirmed the psychiatrist was on-site every week during the annual compliance review period and was available for emergencies and consultation twenty-four hours a day, seven days a week. The program maintains an agreement for professional services with a licensed psychologist with an expiration date of May 21, 2022. A review of the license verification on the Department of Health website confirmed the license was updated with an expiration date of May 31, 2024. According to the DMHCA, the program has not utilized the psychologist in the last twelve months. The agreement with the psychologist indicates they will complete assessments, Intelligence Quotient (IQ) tests, provide consultation to youth who may be experiencing crisis-related situations, and communicate with the DMHCA.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
<i>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.</i> <i>***Tele-psychiatry is not currently approved for use in Residential Programs. Residential must have given prior approval for the telehealth plan if services are not provided on-site. ***</i>	

The program maintains a policy and procedures ensuring psychiatric services shall be provided to youth in need of such services as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medications prior to, or subsequent to, admission to the program. Psychiatric services are provided by a licensed psychiatrist who is board certified in child and adolescent psychiatry or psychiatry by the American Board of Psychiatry and Neurology. The program's procedures outline the role of a contracted psychiatrist for the management and oversight of psychiatric care. The program's psychiatrist supervises the treatment and provides psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical, and psychiatric follow-up visits are conducted on an individualized basis. The program maintains an agreement for professional services with a State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist, with a specialty in child and adolescent psychiatry, and is scheduled to be on-site weekly. A review of the license reflected the psychiatrist's license was clear and active in the State of Florida with an expiration date of January 31, 2024. The program does not utilize an advanced practice registered nurse (APRN). A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site

weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave. State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist, with a specialty in child and adolescent psychiatry. A review of the back-up psychiatrist's license showed it was a clear and active in the State of Florida with an expiration date of January 31, 2023. The back-up psychiatrist is a member of the American Board of Psychiatry and Neurology with a specialty in child and adolescent psychiatry as well as forensic psychiatry. A review of psychiatrist sign-in sheets for the last twelve months supported the psychiatrist is on-site weekly, as required. Additional reviewed documentation supported the psychiatrist participates in the weekly clinical treatment team meetings with the program's designated mental health clinician authority (DMHCA) and the mental health therapists. Reviewed documentation supported the psychiatrist participates in formal treatment team meetings for all applicable youth prescribed psychotropic medications and signs the Individualized Treatment Plan (ITP) review documentation. The program's policy and practice are to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission. A review of seven youth mental health and substance abuse records verified there were three applicable youth receiving psychotropic medications, two of which entered the program with prescribed psychotropic medications, and one subsequently prescribed while in the program; however, the program's practice is to complete a psychiatric initial diagnostic interview within seven days of admission on all youth. During the intake screening process, the mental health therapists complete a Psychiatric Referral form identifying the referral information and the services requested. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. Each reviewed record documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form and each contained page number three of the CPPN. Each applicable youth received a comprehensive psychiatric evaluation within thirty days of admission. Subsequent to the comprehensive psychiatric evaluation, each youth prescribed psychotropic medications is evaluated at least monthly and discussed during the treatment team. A review of the three applicable youth records found each was evaluated by the psychiatrist every thirty days. Each completed assessment was documented on the Department's CPPN, including page three, and was completed in full. There were no documented lapses in psychiatric services for the records reviewed. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. A review of the applicable psychiatric progress notes verified the psychiatrist included the youth's identifying data, diagnosis, target symptoms of each medication, and description of effect of prescribed medication on target symptoms. In addition, the psychiatrist included the name of the prescribed psychotropic medication, quantity of medication, normal dosage range, ordered dosage, frequency and route administration, reasons for any changes in medication, and/or dosage and side-effects. The CPPN included the youth's adherence to the medication regime, vital signs, notification to the parent/guardian, signature and date of the psychiatrist, and applicable monitoring for Tardive Dyskinesia for two of the three youth; one youth did not require monitoring. An interview with the psychiatrist indicated every youth is evaluated with a diagnosis and applicable psychiatric disorders are treated with medications and other modalities. Youth who are not currently receiving psychiatric care are referred and seen promptly. The psychiatrist indicated they work with the mental health clinicians and nursing staff to implement the full range of treatment recommendations. The psychiatrist validated meeting with the DMHCA and clinical staff to staff the youth each week before a youth is evaluated. Open communication with the DMHCA and executive director is maintained. When there is a medication refusal, nursing staff documents the refusal on the Medication Administration Record

(MAR) and on the Refusal of Treatment form. If there are three refusals in a row, nursing staff notify the psychiatrist. Before each weekly clinic, nursing staff and the psychiatrist discuss any pertinent medical issues with the youth.

3.10 Suicide Prevention Plan (Critical)	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures outlining the development and implementation of a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The suicide prevention plan was last updated and approved by the executive director and the designated mental health clinician authority (DMHCA) on August 1, 2021, and the psychiatrist on September 7, 2021. The plan outlines the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. An interview with the DMHCA indicated the program provides suicide prevention training throughout the year and conducts mock emergency mental health drills to include emergency response to suicide attempts and/or self-inflicted injury.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance
<i>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.</i>	
<i>Any youth exhibiting suicide risk behaviors shall be placed on suicide precautions (precautionary observation or secure observation), and a minimum of constant supervision.</i>	
<i>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.</i>	

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. Any youth exhibiting suicide risk behaviors shall be placed on suicide precautions and at a minimum of constant supervision. All youth identified as having suicide risk factors by screening, information obtained regarding the youth, and staff observations shall be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. The program maintains five complete suicide response kits located in the medical clinic, master control, dormitory one, dormitory two, and dormitory three. Seven interviewed staff found each indicated the program maintains the suicide response kits in master control, six indicated the kits are in the dormitories, and three staff indicated in the medical clinic. An interview with the designated mental health clinician authority (DMHCA) and observations during the annual compliance review confirmed the kits contained a knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct the ASR on each youth during the admission screening process. A review of seven youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. All seven reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. Subsequent to admission, two of the seven youth were placed on Precautionary Observation (PO) determined by staff observations. One

additional applicable youth record was provided by the program for review. A review of the three applicable youth placed on PO found each youth remained on PO until the licensed clinician completed a Follow-Up ASR at which time the youth was transitioned to Close Supervision. While on PO and Close Supervision, mental health staff provided supported services. Program practice is to complete an additional Follow-Up ASR to determine if the youth is ready to transition to Standard Supervision. Reviewed documentation supported the youth's juvenile probation officer (JPO) and parent/guardian was notified of the youth potential suicide risk. The program maintains a policy and procedures outlining the use of secure observation; however, interviews with the DMHCA and executive director (ED) validated the program does not utilize secure observation and there has been no documented practice in the last twelve months. The program documents the referral on the Department's Mental Health and Substance Abuse Referral Summary form. Reviewed documentation supported the authorization of PO status, the completion of Suicide Precautionary Observation Logs, and youth received supportive services from the mental health clinical staff. Each reviewed youth was allowed to participate in select activities while under increased supervision. The program utilizes Gracepoint Crisis Center for youth seventeen years of age or younger and Gracepoint Adult Emergency Services for youth eighteen years of age and older. Six of seven interviewed staff each indicated if there is a youth expressing suicidal thoughts, they would notify mental health staff. Five staff indicated they would place the youth on constant sight and sound, two indicated they would notify the supervisor, and one would document the supervision.

3.12 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
<i>Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff 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.</i>	

The program maintains a written suicide prevention plan ensuring staff assigned to observe a youth placed on suicide precautions shall provide the appropriate level of supervision and record the observations of the youth's behavior at intervals not to exceed thirty minutes on the Suicide Precaution Observation (SPO) Logs for the duration the youth is on suicide precautions. A review of seven youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's Assessment of Suicide Risk (ASR) form. All seven reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. All seven reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. Subsequent to admission, two of the seven youth were placed on Precautionary Observation (PO) determined by staff observations. One additional applicable youth record was provided by the program for review. A review of the three applicable youth placed on PO found staff completed SPO logs for each event. Program practice is to complete the Department's SPO Log form. The reviewed SPO Logs and Close Supervision Visual Checks (CSVC) Logs were documented in real time and were completed by the direct care staff. The SPO Logs documented visual checks at least every thirty minutes and the CSVC Logs documented visual checks every five minutes. All three youth reviewed logs were not applicable for behavioral warning signs while the youth were placed on PO. Each reviewed SPO Logs documented the shift supervisor's signature and the clinical mental health staff signature. At the time of the annual compliance review, there were no youth placed on PO.

3.13 Suicide Prevention Training (Critical)**Limited Compliance**

All staff who work with youth shall be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.

The program maintains a policy and procedures ensuring 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. All direct-care and clinical staff will be trained annually on suicide prevention and implementation of suicide precautions, which includes quarterly suicide drills for all staff who come in contact with youth on each shift. A review of seven pre-service staff training records supported each staff received training on suicide prevention and implementation of suicide precautions. A review of the Department's Learning Management System (SkillPro) and seven in-service staff training records supported none of the staff received the required six hours of suicide prevention training. The program was placed on an outcome based corrective action plan (OBCAP) for an identified major deficiency regarding suicide prevention training and it was closed on April 8, 2021. The training consists of a thorough review of the program's suicide prevention plan and includes detection techniques, behavioral cues, and recommended responses. At the time of the annual compliance review period, the program ran three eight-hour shifts (A, B, and C). A review of suicide drills for the last twelve months showed each staff participated in suicide drills at least quarterly. There were thirty-nine staff applicable for participation in suicide drills at least semi-annually. Reviewed documentation supported thirty-eight staff exceeded participation in at least one drill semi-annually with one staff having only participated in one drill at least semi-annually. Reviewed drills included the use of life saving measures including the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED). Each reviewed drill documented a description of the incident, a synopsis of the response, involved staff, and any applicable deficiencies and/or corrective action. An interview with the executive director validated all staff participate in quarterly drills to ensure staff are trained in suicide prevention and implementation of suicide precautions. Seven interviewed staff indicated participation in drills and five staff indicated the drills are conducted monthly, one indicated every other month, and one staff reported they are not sure how often they participate in drills; however, the staff attends the drills when they are held. The program maintains five suicide response kits located in the medical clinic, master control, dormitory one, dormitory two, and dormitory three. Observations during the annual compliance review confirmed the kits contained a knife-for-life, wire cutters, and needle nose pliers.

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 maintains a policy and procedures ensuring the program responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the program. The program maintains a policy and procedures to establish a method of crisis intervention services to be provided to all youth. The plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and the executive director (ED) on August 1, 2021, and the psychiatrist on September 7, 2021. The

program's Crisis Intervention Plan included a process for notification and alert system, means of referral, communication, supervision, documentation, and review ensuring the safety and security of youth and staff.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
<i>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 (LMHP), or by a non-licensed mental health clinical staff working under the direct supervision of a LMHP, to determine the severity of a 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 interventions, the program director or designee shall be notified of the crisis and need for a 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.</i>	

The program maintains a written crisis intervention plan, which includes provisions for crisis intervention, suicide prevention, and emergency services. The plan states crisis intervention will be provided as needed in a one-to-one setting for youth who require immediate processing relating to the specific incident. The program's crisis intervention services include anger control issues, depressive symptoms, maladaptive coping mechanisms, and impaired impulse control. In the event a youth exhibits out of control behaviors, the program's direct-care staff place the youth on mental health alert and refer to a qualified mental health professional for a crisis assessment. A review of seven youth mental health and substance abuse youth records found one youth was applicable for a Crisis Assessment. The designated mental health clinician authority (DMHCA) provided two additional applicable youth records for review. A review of the three applicable Crisis Assessments found the program utilized the Department's Crisis Assessment form. The Crisis Assessment documented completion immediately following the determination the youth was in crisis. The Crisis Assessments was completed in full by a licensed therapist. Each youth was screened and determined to be placed on standard supervision. Two of the three Crisis Assessments were for an alleged Prison Rape Elimination Act (PREA) event and one was for a death in the family. The alleged victims in the PREA incidents received mental health treatment services and the PREA case was on-going at the time of the annual compliance review.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures ensuring an emergency response plan for mental health and substance abuse emergencies shall ensue the highest quality of care, safety, and management of the youth. The policy was approved by the designated mental health clinician authority (DMHCA) and executive director (ED) on August 1, 2021, and the psychiatrist on September 7, 2021. The plan includes procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for

emergency Marchman Act, documentation, training, and review. The purpose of the plan is to outline mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment; receive emergency mental health or substance abuse services. The program utilizes Gracepoint Crisis Center for youth seventeen years of age or younger and Gracepoint Adult Emergency Services for youth eighteen years of age and older for crisis stabilization for both Baker Act and Marchman Act proceedings. The program transports youth in need of emergency mental health evaluation and treatment to a Baker Act and Marchman Act receiving facility located in Tampa, Florida. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency.

3.17 Baker and Marchman Acts (Critical)	Non-Applicable
<i>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.</i>	

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

3.18 Safety Planning Process for Youth	Satisfactory Compliance
<i>A 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.</i>	

The program has a policy and procedures outlining the guidelines for the creation and review of safety plans for all youth and designed to identify stimuli which have both positive and negative effects on the youth. Each plan shall identify warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. The plan incorporates any recommendations from previous or current clinical assessments and is updated every thirty days. A review of seven youth mental health and substance abuse records was conducted in reference to a safety planning process for each youth. Each of the reviewed youth records documented the Trauma-Informed Individualized Safety Plans were completed on the day of admission. Reviewed documentation found the program has developed a safety plan form to help youth identify stimuli which cause positive and negative reactions from the youth. The program's Trauma-Informed Individualized Safety Plan form included an initial and a review planning process. The safety plans are jointly prepared by the youth, parent/guardian, case manager, and clinical staff. Reviewed documentation supported the youth were involved in the development of the safety plan and participated in the safety plan reviews as evidenced by their signatures, interviews, and observation of treatment team meetings. Each contained the required elements and incorporated recommendations from previous or current clinical assessments. When a parent/guardian was not able to participate in the development of the safety plan, the program sent the Trauma-Informed Individualized Safety Plan – Guardian Response Form to the parent/guardian for their review. The program's Trauma-Informed Individualized Safety Plan form included all required elements. The youth's safety plan shall be reviewed and updated every thirty-days to include signatures of the youth and staff as documented on the Safety Plan Monthly Review. All seven youth safety plans were updated every thirty days. The program maintains a safety plan on each youth and is securely located in the master control rooms which are easily accessible to staff. In addition, the safety plans were maintained in the youth's mental

health and substance abuse record. Six of the seven interviewed youth stated they were involved in the development of their safety plan and one of seven youth indicated no one talked to them about their triggers or how to calm down. Five of seven interviewed staff indicated the youth's safety plans were located in master control, two of seven indicated they were displayed on the walls of the dormitory, and one of seven staff indicated in the youth record. Seven staff were interviewed as to what is the process for reviewing the safety plans and one indicated whenever necessary or just to review for self-motivation to keep up on their own knowledge. One staff indicated usually monthly staff will review them by going over them during the monthly meeting where staff are allowed to ask questions. One staff indicated the plans were maintained in master control and it is good to look at what the youth's triggers are and their coping skills. One staff indicated during shift report, the therapist will come and tell the staff to watch for specific behaviors from the youth. One staff indicated if it is something new or a need to know basis, it is mainly discussed in the mental health department. If it is something case management can assist in, then the mental health therapists will let staff know. One staff indicated the plans can be reviewed any time and if any assistance is needed, they would talk to the director of case management.

Standard 4: Health Services

4.01 Designated Health Authority/Designee (Critical)

Satisfactory Compliance

The designated health authority (DHA) shall be clinically responsible for the medical care of all youth at the facility.

The program maintains a policy and procedures ensuring a health authority shall be responsible for the healthcare services provided and maintaining a designated medical clinic. The program maintains a written independent contract agreement with a State of Florida board-certified licensed medical doctor (MD) to serve as the designated health authority (DHA) who holds an unrestricted license which expires on January 31, 2023, and meets all requirements for independent and unsupervised practice in the State of Florida. The MD has specialty training in internal medicine and with no disciplinary action. The MD serves as the program's DHA and is clinically responsible for the medical care of all youth. A review of the program's contract indicates the DHA shall be on-site each week conducting periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. An interview with the DHA supported this practice. The program does not utilize an advanced practice registered nurse (APRN) or physician's assistant (PA). The DHA is scheduled to be on-site a minimum of two hours a week. In the event the DHA is on vacation or scheduled absences, the program maintains a back-up DHA with a State of Florida board-certified licensed MD who has a clear and unrestricted license which expires on January 31, 2024. The program's director of nursing reported the back-up MD's services were not required or needed in the past twelve months. Reviewed Physician Weekly Clinic Logs since the last annual compliance review found the DHA was on-site each week, as required. The DHA is on-site on Tuesdays for a minimum of two hours and is available twenty-four hours a day, seven days a week for consultation. On-site nursing coverage is provided seven days a week from 7:00 a.m. to 7:00 p.m. The DHA is responsible for communication with center staff regarding youth medical needs and participates in weekly DHA meetings with the program's administration and nursing staff. Reviewed attendance logs supported nursing staff also participated in the meetings.

4.02 Licensed Medical Staff

Satisfactory Compliance

The designated health authority (DHA) is clinically responsible for all healthcare services provided 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 to the Department's Rule, as well as the program's facility operating procedures and nursing protocols approved by the DHA.

The program maintains a policy and procedures ensuring the orientation, communication, and licensure/credential process of all healthcare providers. Procedures outline licensed nurses are practicing within the Florida Nurse Practice Act and the applicable Florida Board of Nursing Rules. The program provides on-site nursing coverage seven days a week from 7:00 a.m. to 7:00 p.m. The program had two full-time registered nurses (RN) positions and one part-time RN nursing position and at the time of the annual compliance review. The program has one RN providing services pro re nata (PRN). One RN serves as the director of nursing. All reviewed nursing staff maintained a clear and active license in the State of Florida. The program had one vacant medical records clerk position which became vacant in February 2022; however, a candidate has been selected and was in the background screening process at the time of the

annual compliance review. Reviewed training records supported each RN maintained current cardiopulmonary resuscitation (CPR) certification.

4.03 Facility Operating Procedures	Satisfactory Compliance
<i>The program shall have facility operating procedures (FOP) for all health-related procedures and protocols utilized at the program.</i>	

The program maintains facility operating procedures (FOPs) for all utilized health-related procedures and protocols. Reviewed documentation reflected the designated health authority (DHA) and the program's executive director reviewed, signed, and dated the FOPs on September 13, 2021 and the psychiatrist documented their review of applicable FOPs on September 7, 2021. Reviewed documentation validated nursing staff documented their reviews of the program's healthcare FOPs and protocols on a cover page on August 30, 2021, September 7, 2021, September 9, 2021, September 19, 2021, and September 20, 2021. The program has an established comprehensive clinical orientation for all newly employed healthcare staff which includes the Department's healthcare policies and procedures. Training records supported all newly employed healthcare staff received the clinical orientation conducted by a registered nurse.

4.04 Authority for Evaluation and Treatment	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to the youth. A review of seven youth Individual Healthcare Records (IHCR) reflected six were applicable for requiring a signed Authority for Evaluation and Treatment (AET) and each applicable reviewed IHCR contained the signed AET. One of the reviewed youth was eighteen years of age or older and there was a signed consent to release information in the youth's IHCR. The center had no applicable youth who required a Limited Consent for Evaluation and Treatment (LCET) and none of the youth were involved with the Department of Children and Families. Each applicable signed AET clearly documented, "Copy" on the form. Each AET was obtained prior to providing medical services.

4.05 Parental Notification/Consent	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures outlining requirements for parental notification and written consent from the parent/guardian. The program notifies the parent/guardian of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of seven youth Individual Healthcare Records (IHCR) found each had significant changes to existing medications and/or changes in chronic conditions or was taking over-the-counter (OTC) medication not covered by the Authority for Evaluation and Treatment (AET). Six reviewed records were applicable for new OTC medication and all seven were applicable for new prescribed medication. Reviewed chronological notes and the Parental Notification of Health-Related Care form documented the parent/guardian was notified, as required. Written parental notices were sent regardless of telephone notifications. Four youth

were prescribed psychotropic medications and parental consent was documented in page three of the Clinical Psychotropic Progress Note. None of the review records were applicable for emergency off-site care. An interview with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review. Seven reviewed youth IHCRs found nursing staff and the DHA documented a review of vaccinations of each youth within thirty days of the youth's admission. Each reviewed IHCR documented receipt of the youth's vaccination history on the day of admission. Each reviewed record further supported a copy of the Department's Immunization Tracking Record and a copy of the Florida Shots immunizations record. The program documents vaccination/immunization consent on the Department's Parental Notification of Health-Related Care Vaccinations/Immunizations form. An interview with nursing staff confirmed when a youth's vaccination/immunization record is not included in the youth's IHCR upon admission or in the electronic commitment packet in the Department's Juvenile Justice Information System (JJIS), it will be obtained through the Department of Health or Florida Shots website on the day of admission. Five of the seven reviewed youth IHCRs received vaccinations for influenza or COVID-19 and each IHCR contained the required parental consent.

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

The program maintains a policy and procedures ensuring at the time of admission, each youth will receive a healthcare admission screening utilizing the Department's Medical and Mental Health Admission Screening form. A review of seven youth Individual Healthcare Records (IHCR) found each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form on the date of admission. Each screening was completed by a registered nurse (RN). An interview with nursing staff confirmed the program's practice. None of the reviewed records were applicable for a change in physical custody since the youth's admission date. The RN notifies the designated health authority (DHA) with the youth's history and identified chronic condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. Youth are not placed in general population until any identified healthcare need is deemed to not require immediate medical attention and/or a referral for further assessment. None of the seven reviewed youth were applicable for a FEPHS re-screening; therefore, an additional applicable IHCR was reviewed. The one applicable youth had one change in custody and reviewed documentation supported a new FEPHS re-screening was completed by the RN upon returning on the date after a change in custody occurred. An interview with the nursing staff reported admissions screenings are usually conducted within fifteen minutes of a youth's admission and any time there is a physical custody change, healthcare staff complete a new admission screening utilizing the FEPHS form. The program had no other applicable youth for a change in custody requiring a FEPHS re-screening during the annual compliance review period.

4.07 Youth Orientation to Healthcare Services/Health Education	Satisfactory Compliance
<i>All youth shall be oriented to the general process of healthcare delivery services at the program.</i>	

The program maintains a policy and procedures ensuring all youth are oriented and have access to all healthcare services through discharge. A review of seven youth Individual

Healthcare Records (IHCR) supported each contained a completed Healthcare Education form documenting youth orientation to the program's healthcare services. Each youth received a general healthcare orientation within twenty-four hours of admission to the program during the intake process and during an individual session with nursing staff. Reviewed documentation supported each youth's orientation included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process and side effect monitoring, the right to refuse care and how it is documented, and what to do in the case of a sexual assault or attempted sexual assault. In addition, each youth was oriented to the non-disciplinary role of the healthcare providers, availability of healthcare staff, dental hygiene, sexually transmitted infections, personal hygiene, immunizations, infection control, nutrition, self-examinations, standard universal precautions, and a review of healthcare contacts.

4.08 Designated Health Authority (DHA)/Designee Admission Notification	Satisfactory Compliance
<i>The DHA or designee is notified when youth admitted require emergency care or routine notification in accordance with Department requirements.</i>	

The program maintains a policy and procedures ensuring the designated health authority (DHA) is notified when youth admitted require emergency care or routine notification in accordance with Department requirements. A review of seven youth Individual Healthcare Records (IHCRs) supported the DHA was notified within twelve hours of admission for each youth, regardless of the medical condition. Notification was documented on the nursing admission chronological notes for each of the seven reviewed records. Five of the seven youth were admitted with medication or possessed a chronic condition. The director of nursing reported the program's practice is to document all youth with chronic conditions on the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up. Four of the reviewed youth were admitted with psychotropic medication and the psychiatrist was notified, as required. An interview with the nursing staff indicated the DHA is notified by nursing staff within twenty-four hours or less of any youth being admitted, regardless of their condition, either through a telephone call or email.

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

The program maintains a policy and procedures detailing the process for conducting or reviewing admission history. The program utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the physical custody. A review of seven youth Individual Healthcare Records (IHCR) found each contained a HRH form completed electronically by a licensed nurse within seven days or less of the youth's admission to the program. Each reviewed HRH was reviewed by the designated health authority (DHA) and was maintained in the youth's IHCR. Each HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA) for each youth and reflected the most current admission into the program. The program's practice is to complete a new HRH and CPA within seven days of admission and annually, thereafter. An interview with the program's director of nursing confirmed the practice of completing the HRH upon admission or at least within seven days of the youth's admission and prior to the completion of the CPA and if applicable, annually thereafter.

4.10 Comprehensive Physical Assessment/TB Screening**Satisfactory Compliance**

The standardized Comprehensive Physical Assessment (CPA) form shall be used for all youth admitted into the physical custody of a Department program.

The program maintains a policy and procedures ensuring each youth admitted shall receive and/or shall have on record a current Comprehensive Physical Assessment (CPA) and Health-Related History (HRH) no later than seven calendar days of admission into the program. The program's policy and procedures ensure each youth receives a physical health evaluation after admission and prior to youth engaging in strenuous exercise or being subjected to extreme outdoor weather conditions. The program's policy and procedures ensure each youth shall be screened upon admission for Tier I Tuberculosis (TB) utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. If the screening indicates the youth has symptoms suggestive of active TB, the youth is not permitted to be placed in the general population until medically assessed by the designated health authority (DHA). A review of seven youth Individual Healthcare Records (IHCR) supported the program utilizes the Department's CPA form. All CPAs were completed by the DHA within seven days of each youth's admission. All sections of the CPA were completed in full utilizing "O" applicable "X" markings. All youth received an initial medical grade. Each of the seven youth refused the genital portion of the examination as "Refused by Youth" was documented on the CPA and each signed the refusal on the CPA and the Refusal of Treatment form. A review of seven youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to TB. Reviewed documentation found the results of the TST were also documented on the Department's Infectious and Communicable Disease (ICD) form and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. An interview with the program's director of nursing stated healthcare staff reviews the youth commitment packet for TB screening prior to arrival to ensure there is a current TST/PPD. A screening is completed upon admission utilizing the Department's FEPHS form. Another TST/PPD is not required if the youth remains in custody; however, a rescreen is completed one year from the initial TST/PPD. There were no current youth with symptoms suggestive of active TB and there were no youth prescribed anti-TB medications during the annual compliance review period.

4.11 Sexually Transmitted Infection/HIV Screening**Satisfactory Compliance**

The program shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (STI) and human immunodeficiency virus (HIV) risk factors.

The program maintains a policy and procedures in place ensuring all youth entering the program are clinically screened, evaluated, and treated, if necessary, for sexually transmitted infections (STI) and human immunodeficiency virus (HIV). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of seven youth Individual Healthcare Records (IHCR) indicated each youth was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infectious Screening (STIS) form regardless of if the youth was or was not sexually active. Two of the seven STISs indicated the youth required referral for further evaluation. A review of the two applicable IHCRs found each youth was tested and the results were filed in the laboratory section of the IHCR. Reviewed practice found the results were also documented on the Department's Infectious and Communicable Disease (ICD) form.

There were no applicable youth who were out of the Department's custody for over thirty days and/or requiring a rescreening due to presenting symptoms. The program maintains a policy

and procedures ensuring all youth at risk for HIV infection are offered counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. A review of seven youth IHCRs validated each youth was provided the opportunity to receive counseling and testing for HIV. The program utilizes the Department's HIV Antibody Test Youth Consent form. One of the seven youth consented for testing; therefore, an additional two youth IHCRs were reviewed and each youth consented for testing. All three applicable youth were tested by the local County Health Department and the test results were sealed in an envelope, marked, "Confidential" with the youth's name on the envelope. The program's nursing staff maintained a HIV Testing Tracking Log and pre-testing and post-testing was also documented on the applicable youth's Health Education Record form. An interview with the program's director of nursing reported youth are screened for STIs and offered testing at the time of admission. At admission, the youth signs whether they do or do not consent to HIV counseling/testing on the HIV Antibody Youth Consent Form and they are placed on the HIV Testing Tracking Log to determine who has consented or declined and when counseling/testing was completed. Youth are able to request and receive counseling/testing at any time if they initially declined. All HIV testing results are kept in a sealed envelope, marked, "Confidential", in the youth's IHCR and are given to the youth upon discharge from the program. The Hillsborough County Health Department comes to the program every few weeks to perform testing and to provide pre-test and post-test counseling. They also provide educational groups to youth in the program. Six interviewed youth each indicated they can ask and receive a confidential HIV test. One youth stated they did not know if they could request a confidential HIV test.

4.12 Sick Call Process	Satisfactory Compliance
<i>All youth in the program shall be able to submit sick call requests and have 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.</i>	

The program maintains a policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the sick call system. The sick call process responds to a youth's complaint of illness or injury of a non-emergent nature which requires a professional nursing assessment and possibly, a nursing intervention. The program provides sick call seven days a week, two times daily on weekdays from 10:30 a.m. to 11:30 a.m. and from 3:00 p.m. to 4:00 p.m., and from 9:45 a.m. to 10:00 a.m. and 4:30 p.m. to 5:30 p.m. on the weekends. Nursing staff reported youth are usually seen immediately after submitting a sick call request, regardless of the time of day. A review of seven youth Individual Healthcare Records (IHCR) indicated five youth submitted a sick call request. The youth complete a Sick Call Request form and places it in the mounted/designated sick call box in the dormitory and nursing staff check the sick call box at regular intervals no longer than two-hour intervals. Sick Call Request forms were observed in each dormitory during the annual compliance review week. Each youth was seen by the registered nurse (RN) for the sick call within twenty-four hours. None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick call complaint three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar. The program maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on September 13, 2021. According to an interview with the DHA, they will conduct sick calls while at the center, if necessary. All five applicable sick call events were documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms documented the nature of the complaint, assessment, and plan to include subjective, objective,

assessment, and plan format (SOAP). There were no sick call requests submitted during the annual compliance review week; therefore, there were no sick calls to observe. The medical clinic was observed to have an examination area and table to conduct confidential sick calls. The program has not utilized restricted housing since the last annual compliance review. Seven interviewed staff indicated sick call is conducted by nursing staff. Seven interviewed youth found four indicated they can be seen by medical staff immediately should they submit a sick call request. Two youth stated they may be seen within one day and one youth reported never having to submit a sick call request.

4.13 Episodic/First-Aid and Emergency Care

Satisfactory Compliance

The program shall have a comprehensive process for the provision of episodic care and first-aid.

The program maintains a policy and procedures ensuring a comprehensive process of episodic care, first-aid treatment, and emergency care. The program utilizes an Episodic Care Log to document episodic care and first-aid treatment. The log contains information to include the date, name of youth, the youth's Department of Juvenile Justice Identification Number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. A review of seven youth Individual Healthcare Records (IHCR) found three were applicable for receiving episodic care conducted by nursing staff. Each applicable IHCR documented problem-oriented elements which were used to capture pertinent information pertaining to the nature of the youth's ailment including identification of the subjective, objective, assessment, and plan (SOAP) to address the complaint for each incident. The program had no applicable episodic care events conducted by non-healthcare staff. Seven interviewed youth stated they could see a doctor or a dentist, if needed.

The program maintains nine first-aid kits which are located in master control, dormitories one, two, and three, the kitchen, the front desk, and two which are used for the program's vans utilized for transportation of youth. A random review of three first-aid kits, including one utilized in a van used for the transportation of youth, found each contained the required items identified on the designated health authority (DHA) inventory list. The program's nursing staff conducts weekly reviews of the first-aid kits and items are replenished upon use and/or expiration date. Nursing staff seals and dates the first-aid kits after replenishment and review. A review of the first-aid kits inventory log since the last annual compliance review validated the program's practice. The program has one automated external defibrillator (AED) located in master control. The AED procedures were located in the AED box as well as audio instructions. Nursing staff check the AED batteries and pads weekly to ensure the AED is operational and document their review on a tracking sheet. A review of tracking sheets since the last annual compliance review confirmed this practice. The AED was self-tested in front of the annual compliance review team to ensure it was operational. The batteries and the pads in the AEDs expire on March 30, 2024. The batteries were replaced on February 2, 2022 and the pad was replaced on February 14, 2022.

A review of seven staff training records found each was trained in cardiopulmonary resuscitation (CPR), first-aid, and AED and each held current certifications. All non-healthcare staff and nursing staff are required to maintain certifications. Reviewed documentation supported the DHA and all nursing staff maintained current certifications in CPR and AED. Emergency contact numbers were observed to be posted in the medical clinic, in administration, and in master control to include the number for the statewide Poison Information Center and nursing

interviews validated this. Only healthcare and trained non-healthcare staff can administer the epinephrine auto injector for youth requiring administration, when indicated. The program's executive director, assistant facility administrator, four supervisors, three youth care workers II, the business manager, and one youth care worker I are trained to administer the epinephrine auto injector. A review of seven training records supported each staff received the required training on the center's Emergency Care Plan and the applicable staff received training on epinephrine auto injector. There were no episodic care events during the annual compliance review week; therefore, an observation could not be conducted.

The program's policy and procedures indicated emergency drills are conducted for each shift on a quarterly basis at minimum, and life saving techniques such as CPR must be demonstrated at least once a quarter each year. A review of quarterly mock emergency drills since the last annual compliance review supported drills were conducted at least once a month on each shift and documented use of life saving techniques such as CPR at least semi-annually. Documented drills included the type of medical event, time the drill/event occurred, time 9-1-1 was called, name of the direct care staff involved, healthcare provider in charge, healthcare provider response time, type of medical care rendered, time the event concluded, clinical manager/medical staff review, and critique. In the event a drill was missing certain elements, nursing staff documented recommended suggestions. Seven staff were interviewed to determine if they can call 9-1-1 if necessary and each stated they can call, if needed. Each indicated they would call from a program cellular telephone or a telephone in the dormitory.

4.14 Off-Site Care/Referrals	Satisfactory Compliance
<i>The program 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.</i>	

The program maintains a policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of seven youth Individual Healthcare Records (IHCs) found two were applicable for off-site medical care with one of the youth having two separate incidents. The designated health authority (DHA) was notified for each of emergency event. Each of the applicable youth's IHCs contained a Summary of Off-site Care. Each reviewed applicable IHC contained discharge documentation, and instructions. The DHA documented a review of the off-site care findings, instructions, and information. Each of the youth required an additional referral for follow-up testing or appointment and documentation validated the referral was entered on the Sick Call/Referral Log for tracking and the follow-up was conducted, as recommended. An interview with the program's director of nursing indicated all off-site care incidents and follow-up appointments are documented and tracked on a calendar and the DHA reviews each incident upon their next on-site visit.

4.15 Chronic Conditions/Periodic Evaluations	Satisfactory Compliance
<i>The program shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.</i>	

The program has a policy and procedures to ensure youth identified with chronic conditions receive regularly scheduled evaluations and necessary follow-up care. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. Youth are screened during the intake process for medical

conditions warranting periodic evaluations and follow-up care. A review of seven youth Individual Healthcare Records (IHCs) found three were applicable for the existence of a chronic condition. Documentation reflected each applicable youth was classified with a medical grade between two and five. None of the youth were applicable for taking anti-tuberculosis medication or were pregnant. Treatment orders were written so they are clearly distinguishable for clinical staff. Each of the three youth were applicable for a periodic evaluation and there were no indications of lapses in care. All three youth were placed on the chronic conditions roster. In addition, reviewed records reflected each Department Problem List was updated as required. The program's executive director and healthcare staff meet daily during management meetings and as needed to address any medical issues. Additionally, the designated health authority (DHA) debriefs with the executive director each week prior to exiting the program after their on-site visit. In an interview, the DHA reported nursing staff provides them with a list of youth to be seen at each site visit and periodic evaluations are conducted as needed. There were no youth in the program requiring an off-site periodic evaluation.

4.16 Medication Management	Satisfactory Compliance
<i>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.</i>	

The program has a policy and procedures ensuring all medication and pharmaceutical products are procured, dispensed, administered, and stored safely, accurately and in accordance with state, federal, and industry standards. The program's practice is for nursing staff to verify all medications will have a current, valid order and are given according to a current prescription or practitioner's order. The Medication Receipt, Transfer, and Disposition Form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed. A review of seven youth Individual Healthcare Records (IHCs) identified five youth were taking prescribed medication upon admission and were applicable for medication management. Four of the five applicable youth were taking psychotropic medication. Each applicable IHC documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) or the psychiatrist to resume the applicable medication and all orders were signed by the practitioner. There were three applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered and proper consent was obtained. The program maintains a contract with a private pharmacy for procurement of medications and a Modified Class II Type B Pharmacy Permit with an expiration date of April 28, 2023. All medication is delivered to the program in blister packs. The program utilizes the standard Department Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications. Reviewed documentation reflected the staff initialed each administered medication entry and the five applicable youth documented their initials on the MAR. No youth refused the medication administration; therefore, the Refusal of Treatment Form was not required. The program maintains a policy and procedures to ensure the usage of the MAR by licensed healthcare staff and non-licensed staff. Each reviewed MAR clearly documented the youth's name, Department of Juvenile Justice Identification Number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. The MAR clearly indicated medication start and stop dates and nursing staff documented weekly side-effect monitoring. There were no lapses or errors noted. One youth required parenteral medication for diabetes which was stored appropriately.

The program has a secure refrigerator in the medical clinic which contained Tuberculin vaccinations and insulin during the annual compliance review. Nursing staff track daily temperatures of the refrigerator. The program has authorized and trained the executive director, the assistant facility administrator, four supervisors, three youth care workers II, the business manager, and one youth care worker I to assist youth with self-administration of medication. The program's practice is to have licensed nursing staff on-site until 7:00 p.m. seven days a week, thereby having only nursing staff to administer medication. Trained non-licensed staff are permitted to provide OTC medications when nursing staff are not on-site. The program did not have any standing orders for psychotropic medications, no pro re nata (PRN) orders for psychotropic medications, or emergency treatment orders for psychotropic medications. Four of the five reviewed youth records found the youth were admitted on prescribed psychotropic medications. The DHA and the designated mental health clinician authority (DMHCA) were notified of each admission. The psychiatrist was notified when the medication was received to obtain an order for continuation. Observations of medication administration of one youth found the program's executive director escorted the youth to the medical clinic door. The registered nurse (RN) utilized medication cart to block the medical clinic doorway. The youth provided verbal consent prior to observation and approached the RN. The youth introduced themselves, confirmed their date of birth, what medications they were prescribed, and what were the side effects. No medications were observed to be pre-poured. The RN verified the Six Rights of Medication Administration (right youth, right medication, right dosage, right time, right route, and right documentation) for the youth. The Six Rights were also posted on the medical clinic door. Seven staff were interviewed and each stated medication is administered by the nurse. Two of the staff were supervisors and reported they are trained in medication management and will administer OTC medication in the event nursing staff are not on-site. Seven interviewed youth found four who stated medication is administered by the nurse and three who were not applicable for taking medication.

4.17 Medication/Sharps Inventory and Storage Process	Satisfactory Compliance
<i>Any medical equipment classified as sharps, as well as stock medications shall be secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed of or when the medication is administered.</i>	

The program maintains a policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations during the annual compliance review found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. Nursing interviews indicated the medication usually maintained in the refrigerator is for anti-tuberculosis and insulin for diabetes. Nursing staff conducted daily temperature checks and documented on the Temperature Log. The program securely stored sharps and syringes separate from medications. The program maintains a policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN) or a registered nurse and a supervisor. A review of

three controlled substances validated this practice. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a private vendor pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist's license expires February 28, 2023. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. The program maintains procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nursing staff to dispose of the medication by placing the medication in an All Purpose RX Destroyer System bag and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. All non-controlled medications are sent back to the pharmacy for credit. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. A review of the program's counts since the last annual compliance review validated no discrepancies were identified. The program maintains a current agreement with a private vendor for biomedical waste treatment with a certificate of exemption issued on October 1, 2020 with the State of Florida, Department of Health.

4.18 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
<i>The program shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as according 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 regarding infection control shall also be provided at the time of intake and subsequently when the need is identified.</i>	

The program maintains a policy ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. Additionally, the center maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority, the program's executive director, and nursing staff on January 4, 2022 indicating a review. Documentation in seven youth Individual Healthcare Records reflected each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control. Reviewed documentation supported the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan also addressed common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. The program ensures Hepatitis B immunization is made available for staff and staff have access to protective equipment. The program's executive director (ED) stated a copy of the plan is maintained in the medical clinic, master control, and the assistant facility administrator's office and accessible to all staff. Additionally, the ED stated the plan is reviewed annually. The local

county health department, CDC, and the Department's Central Communications Center (CCC) were notified of all incidents related to the COVID-19 pandemic. An interview with the program's director of nursing reported staff are trained on the infection/exposure control process during pre-service and annually, thereafter. A review of seven staff training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

This is an all-male program; therefore, this indicator shall be rated non-applicable.

Standard 5: Safety and Security

5.01 Youth Supervision	Satisfactory Compliance
<i>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.</i>	

The program has a policy and procedures regarding youth supervision. The program requires a staff-to-youth ratio of one-to-eight during daytime activities and one-to-twelve when youth are asleep. Observations of staff supervising youth were made during the annual compliance review in person and by reviewing video of staff and youth interactions, ten-minute checks, searches, recreation, and participation in school. The observations of school, recreation, meals, breaks, and line movements confirmed staff were actively supervising youth within ratio with three exceptions. On day one, a youth was observed going to utilize the restroom out of sight and sound of supervision and a classroom was observed to be out of ratio 11:1. On day two, a review of ten-minute checks found the staff left the dormitory for eighteen minutes on the evening of March 26, 2022. Staff were observed each day interacting positively with youth. Three staff were asked how many youth they were supervising, one of three staff was not immediately knowledgeable of the youth in their care and counted the youth. The program's policy and procedures were reviewed for active supervision. The program considers active supervision to be closely observing youth and changes in behavior, maintain ratio, and implement the behavior management system (BMS). The posted daily schedule was observed in the living areas the youth occupy. Youth were observed to be engaged in a full schedule of activities. Staff were closely monitoring youth behavior and changes in behavior, as well as consistent application of the BMS by staff. Seven staff were interviewed and each was able to explain the process of what to do in case of a discrepancy in the head count.

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

The program has a comprehensive behavior management system (BMS), which is clearly written and incorporated in the youth handbook. The program has a jointly combined BMS agreement between the program and the school. The executive director (ED) trained the education staff in the jointly combined BMS plan to include use of the BMS during school. Observations were made of the BMS posted in the living units of the program clearly visible to the youth. Seven youth case management records were reviewed and included orientation of the program's BMS. Four pre-service staff records were reviewed and all four received BMS training on day four of the approved training plan. Rules governing conduct and positive and negative consequences for behaviors are documented in the youth handbook. The BMS was observed to be posted on the each of the three dormitories. The program's BMS includes maintain order and security, promote and protect youth rights, positive and negative consequences, constructive disciplinary actions, opportunities for positive reinforcement,

recognition of accomplishments and positive behaviors exceeding a four-to-one ratio, promote socially acceptable means for youth to meet their needs, process for explaining to youth the reason for any sanction imposed, youth have the opportunity to explain their behavior, opportunity for staff and youth to discuss the impact of the behavior on others, reasonable reparations for harm caused to others, discussion of alternate behaviors, promotion of positive dialogue and peaceful conflict resolution, separation of youth from population is minimized, coordination with any individual behavior plan, and consistent implementation and treatment through oversight. The program's BMS does not include increasing length of stay, denial of basic rights or services, group punishment, punishment of youth by other youth, or disciplinary confinement. On-site observations throughout the annual compliance review week supported staff were adhering to the BMS and recognition of accomplishments and positive behaviors at a four-to-one ratio. A daily meeting is held with the treatment team and the youth to discuss the number of points earned for the day as well as any inappropriate behavior. The program provides a variety of rewards such as extra canteen items, extra dietary items, restaurant options for menu, bi-weekly movie night, pancake breakfast, game room, outings, and extra meals. Seven staff were interviewed, all seven advised receiving training on the BMS and all seven were able to explain the BMS. Seven youth were interviewed and were able to provide consistent examples of consequences. Examples included not being allowed to play in the game room, write up, time out, or losing a day of privileges. The ED was interviewed and explained the monitoring system according to policy. The youth have a point system and points are earned each day calculated for the week for extra privileges. The consequences are based on rule violation and daily meetings are conducted to explain and evaluate the process with the treatment team and the youth.

5.03 Behavior Management System Infractions and System Monitoring	Satisfactory Compliance
<i>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.</i> <i>Supervisors shall monitor staff implementation of the BMS and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.</i>	

The program has a policy and procedures to include a protocol where staff are provided feedback regarding the implementation of the behavior management system (BMS). A sample of position descriptions was reviewed which specified the required qualifications of staff whose job functions includes implementation of the program's BMS. A review of seven separate program staff job descriptions found the responsibility of implementing the BMS was included in the position descriptions. A daily phase meeting is held with the treatment team and the youth to discuss the number of points earned for the day as well as any inappropriate behavior. The program does not utilize room restriction. There were no observation or video of room observation during the annual compliance review period. Seven youth were interviewed and all seven were able to explain the BMS and phases of the point system. All seven advised no youth can punish another youth. One youth advised the system is fair, two youth advised very good, and four advised the system is good. Seven staff were interviewed and were able to explain the process for the BMS for youth. All seven staff explained supervisors are in constant communication regarding the BMS and the implementation. The executive director (ED) interview confirmed staff are evaluated on the BMS within the performance evaluation and the

assistant facility administrator (AFA) conducts fidelity checks on staff to ensure appropriate implementation.

5.04 Ten-Minute Checks (Critical)	Limited Compliance
<i>A program shall ensure staff observe youth at least every ten minutes while youth 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.</i>	

The program maintains a policy and procedures to ensure visual checks for safety and security of each youth are conducted anytime youth are placed in their sleeping rooms, including rest periods. Staff conduct and document ten-minute checks anytime youth are in their sleeping rooms and throughout the sleep period. The program has a total of thirty-two video cameras capable of recording thirty days of video footage. At the time of the annual compliance review, twenty-four cameras were reported as operational. A review of documentation and two video recordings for each of the three dormitories was conducted. Reviewed documentation and observed video review confirmed nineteen of twenty-four checks were completed, as documented, at least every ten-minutes with most staff conducting the checks every eight minutes. There were five separate ten-minute reviews whereby staff documented their review and the observed video review showed the review was not conducted. One staff member was observed leaving the dormitory three times for a total of eighteen minutes on third shift on March 26, 2022. The program reported the incidents to the Department's Central Communications Center during the annual compliance review, and the incident was accepted. Ten-minute checks were documented in real time, indicated youth status, and were initialed and signed by the staff member conducting the check. Seven staff were interviewed and advised room checks were conducted every eight-minutes when a youth is placed in their room for sleeping or non-punishment reasons. An interview with the executive director (ED) indicated the program security cameras can store video footage for thirty days; however, some of the cameras are currently inoperable.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
<i>The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.</i>	
<i>The program shall conduct and document youth counts, minimally, at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.</i>	
<i>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.</i>	
<i>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 youth counts and census information, the program reconciles immediately and takes follow-up action, as needed.</i>	

The program maintains a policy and procedures regarding census, counts, and tracking. The program requires counts to be conducted minimally at the beginning of each shift and several times daily, to include after each outdoor activity, during emergency situations, escape incidents, and program disturbances. The program's Continuity of Operations Plan (COOP) was approved by the Department on March 30, 2021. Observations made during the annual

compliance review week indicated it is the program's practice to conduct formal hourly youth counts and informal youth counts during any type of youth movement or change in scheduled activities. The program tracks daily census information in the logbook, including, at a minimum, the daily total census count, new admissions, releases, direct discharges, transfers, and youth temporarily away from the program. A review of randomly selected dates and times in the logbooks since the last annual compliance review validated head counts were conducted at the beginning of each shift, after outdoor activities, and during emergency situations. The program logbooks included documentation of new admissions, releases, and youth temporarily away from the program. There were no applicable transfers documented during the annual compliance review period. Seven staff were interviewed and all seven were able to explain when counts are conducted and when emergency counts are conducted. All seven staff were able to provide the daily census of youth.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance
<i>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. The program ensures direct care staff, including each supervisor, are briefed when coming on-duty.</i>	

The program maintains a policy and procedures outlining the maintenance of a permanent bound logbook to record routine information, program activities, events, incidents, and emergency situations. The program maintains a master control logbook to document and pass all vital information between shifts, bound with numbered pages. Logbook entries include the date and time of the incident, name of staff and/or youth involved, brief statement of occurrence, and signature of staff making the entry. The program uses a highlighting system to identify headcounts, searches, drills, youth movement, and incidents. Observations and a review of logbooks since the last annual compliance review found logbook entries were documented in ink with no erasures or white-out areas. Errors were struck through with a single line, dated, and initialed by the person correcting the error. Reviewed documentation indicated each entry included the date and time of the event, the name of the staff and youth involved, a brief description of the event, and signature of the staff making the entry. Logbooks included entries for emergency situations, population counts, searches, drills, law enforcement access to youth, perimeter checks, and youth movement. In addition, admissions, releases, and applicable transports away from the program were documented. Logbook entries and other pertinent information is reviewed during each shift briefing. Each staff signs the logbook to acknowledge reviewing the information from the previous shift. Reviewed logbooks reflected the program consistently documented internal incidents reported to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC).

5.07 Key Control**Satisfactory Compliance**

The program has a system in place to govern the control and use of keys including the following:

- *Key assignment and usage including restrictions on usage*
- *Inventory and tracking of keys*
- *Secure storage of keys not in use*
- *Procedures addressing missing or lost keys*
- *Reporting and replacement of damaged keys*

The program has a policy and procedures regarding key control which includes the control and use of keys. The policy 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. Distribution and collection of keys by master control was observed. The key inventory was reviewed and the inventory matched the actual key rings in use. Personal keys are surrendered upon entry into the facility with the staff at the front desk. The keys are secured in a locked box and a key identification is provided to visitors to the program. Program keys are stored in master control. The key storage area was secure. An interview with the master control operator indicated the process for restricting usage of keys such as medical, youth and staff records, and youth property keys are position-specific and kept in a separate lock box accessible only by the master control. The daily tracking and reconciliation of keys is maintained on the key control log. There have been no incidents of missing or lost keys in during the annual compliance review period. Permanent key assignment was observed and include human resource, executive director (ED), health service administrator (HSA), and assistant facility administrator (AFA). Three sets of keys were randomly checked and master inventory is conducted weekly. The three samplings of key rings were observed and compared to the inventory; all three staff had the appropriate number of keys and knew each function. There were no incidents of lost or damaged keys reported to the Department's Central Communications Center (CCC) during the annual compliance review period. An interview with the master control operator and staff interviews validated the process for key restriction, inventory, and issuance. Seven staff were interviewed and all seven were able to explain the process for key issuance, inventory, and the process for missing or damaged keys.

5.08 Contraband Procedures**Satisfactory Compliance**

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, lighters or matches, electronic or vaporless cigarettes, any unauthorized article of food or clothing, any intoxicating beverage or any beverage which causes or may cause an intoxicating effect, any controlled substance, any prescription or non-prescription drug which has a hypnotic, stimulating, or depressing effect, any firearm or weapon of any kind or any explosive substance, non-facility issued electronic equipment or devices to include smartwatches, 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 both staff and youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the youth's case record. If a confiscated item is not illegal or prohibited, the program director or designee has the discretion to discard of 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 or prohibited contraband, the program shall turn the item over to local law enforcement and a criminal report must be filed.

The program has a system in place to prevent contraband from entering the facility. This system includes the program defining what items or materials are considered contraband, as well as exemptions. Youth are provided with a list of contraband upon admission which include sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, electronic equipment or devices, lighters or matches, any intoxicating beverages, metals, personal cellular telephones, unauthorized money, and non-facility issued keys. Youth are informed of consequences if found with contraband. To prevent contraband, searches are conducted of the physical plant, facility grounds, youth, incoming mail, and outgoing mail. The program's policy and procedures address any staff who is found in possession of contraband will be subject to disciplinary action up to and including dismissal and law enforcement shall be contacted if any item found would be considered illegal. The program maintains a log related to contraband searches. When contraband is discovered, it is listed as well as the disposition. The executive director (ED) reported any youth, staff, or visitor having contraband shall be dealt with immediately to ensure the safety and security of the program. All discovered contraband shall be destroyed, disposed of, sent to the youth's home, or kept as evidence to submit to law enforcement, as indicated for illegal contraband. Youth are made aware of contraband discovered and plans for disposition. Possession of contraband presumed illegal shall require notification to law enforcement, establishment of chain of custody to include documenting when, where, and who discovered the item. If the nature of the contraband requires notification to law enforcement or filing criminal charges, the contraband shall be considered evidence and must not be altered in any way. Discovery of illegal contraband shall require an internal incident report and reporting to the Department's Central Communications Center (CCC). A review of CCC's found none related to youth contraband in the last twelve months. During the annual compliance review, two staff were observed wearing smartwatches which are considered contraband. The ED was notified and a CCC was documented. The program immediately conducted a retraining regarding the prohibited items, documented on April 7, 2022 by the assistant facility administrator (AFA). An interview with the ED confirmed the program did have

a list of staff positions authorized to use electronics while in the facility, signed by the ED and dated January 5, 2021.

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

The program has a policy and procedures related to searches and full body visual searches. Throughout the annual compliance review, there were several observations made of youth being searched before and after movements to class, group, and recreation. Searches were conducted by the appropriate gender, were done thoroughly, and youth were treated with dignity and respect. Observed searches appeared to be within Protective Action Response (PAR) guidelines and completed with the appropriate number of staff. Seven interviewed youth reported searches occur after outdoor recreation, when items are missing, after visitation, after every movement, and after meals. Seven staff were interviewed and reported youth searches are conducted between every movement.

5.10 Vehicles and Maintenance	Satisfactory Compliance
<i>The program ensures any vehicle used by the program to transport youth is properly maintained and documentation regarding the use and maintenance of each vehicle is maintained. Each vehicle used for transporting 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 transports, and youth are not attached to any part of the vehicle by any means other than the proper use of a seat belt.</i>	

The program has one transport van to transport youth. A review of documentation confirmed the vehicle had an annual inspection and the program maintains documentation demonstrating the vehicle maintenance. The transport van was secured when not in use and had the required number of seat belts. A transport was not observed during the annual compliance review week. The transport van had a fire extinguisher secured, a seat belt cutter, a window punch, and road hazard kit. An assigned and approved first-aid kit is maintained in master control for use during transports. A random check of ten vehicles in the parking lot found all doors secure.

5.11 Transportation of Youth	Satisfactory Compliance
<i>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.</i>	

The program has a policy and procedures in place detailing driver eligibility and requirements according to the Department's policy. The program maintains a cellular telephone for all youth transports. The program's transport ratio is one staff to five youth; however, the practice is for two staff, one of the same gender as the youth, to conduct youth transports. According to policy and procedures and an interview with the executive director (ED), assistance facility administrator (AFA), and seven staff indicated all youth and staff are required to wear seat belts while in the vehicle. There were no transports conducted during the annual compliance review week; therefore, observations were not possible. Seven staff were interviewed and all seven advised a program cellular telephone is issued for transports along with the safety equipment.

Seven youth were interviewed and all seven advised no contraband has been in the transport van and all feel safe during a transport.

5.12 Weekly Safety and Security Audits

Satisfactory Compliance

A program shall maintain a safe and secure physical plant, grounds, and perimeter.

The program maintains a policy and procedures outlining the inspection process and maintenance of a safe physical plant, grounds, and perimeter. The program's executive director (ED) or designee conducts weekly safety and security audits which are submitted to the Department. Identified deficiencies were documented on the reviewed reports and included the status and due date of any needed corrective action. A review of the Safety and Security Inspection forms since the last annual compliance review indicated inspections were completed, as required. Additionally, the program's maintenance staff completes a weekly preventative maintenance checklist and documents the check of faucets, drains, flush valves, shower heads, wiring, meter readings, and additional items noted. Observations during the annual compliance review showed many plumbing and repair issues. The program offered documented efforts supporting quotes were obtained and parts were on back order. The Department currently has a major maintenance request for a refrigerator and eight cameras. The interviewed ED verified the weekly safety and security audit process and explained the needed repairs are verbalized to the maintenance staff and documented on the weekly report. The ED reported the dormitory bathroom repairs were being coordinated and overseen by the Department's facility services. The shower area bathrooms on each of the three dormitories are undergoing improvements. During the annual compliance review the bathroom within dormitory one was under construction, the bathroom for dormitory two was completed, and the bathroom for dormitory three was reportedly next in queue for renovations. The completed bathroom had new fittings, paint, tile, grout, and counters. The interviewed ED reported in addition to the weekly audits, needed items are discussed with the Department during a regional monthly meeting.

5.13 Tool Inventory and Management

Satisfactory Compliance

The program shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.

The program maintains a policy and procedures outlining the strict control of all tools and secure storage. The policy identifies the maintenance manager as the designated tool control manager. The program classifies tools into three categories which include Class A, Class B, and prohibited tools. Class A tools have sharp edges and/or have the potential to be used as a weapon. Observations of Class A tools showed each was secured within the maintenance managers office on a shadow board, inaccessible to youth. Tools were observed to be numbered and documentation reflected they were inventoried daily. A review of five randomly selected tools showed each was labeled and securely stored in the correct location. An interview with the maintenance manager reflected tools are signed-in and signed-out when used. All kitchen tools are securely stored and inventoried perpetually and daily. Kitchen knives are maintained in a locked cabinet on a shadow board to ensure easy identification and tracking. A review of three randomly selected kitchen tools reflected inventories were accurate and reviewed logs verified daily inventories. Class B tools including mops, brooms, and buckets are maintained in a locked closet which is inaccessible to youth. The program considers these tools to be housekeeping tools and the items are used by staff and youth when performing daily cleanup activities. Staff are required to complete a sign-out and sign-in log when items are used and are returned to the designated storage room. A review of Class B storage reflected

inventories were accurate and tools were secured when not in use. The program's dietary manager is currently assisting with Class B tool tracking and storage due to a housekeeping vacancy. The maintenance manager, executive director, and dietary manager reported there were no instances of missing or lost tools since the last annual compliance review. Additionally, the program has a process for broken tools requiring disposal and replacement, which is overseen by the maintenance manager. The maintenance manager reported there have been no tool purchases or disposals since the last annual compliance review. Program policy and informal interviews during the annual review revealed if a tool is missing, staff will notify administration, the program will stop all youth movement, and the program will be searched until the tool is found. Prohibited tools include machetes, bowie knives, and other long bladed knives. A review of five pre-service and seven in-service staff training records reflected each staff member received tool training. A review of seven youth case management records indicated staff complete a Youth Risk Assessment prior to approving Class B tool use. Youth are not permitted to use Class A tools. Seven interviewed staff reported youth are allowed to handle scrub brushes, mops, and brooms.

5.14 Youth Tool Handling and Supervision

Satisfactory Compliance

There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.

The program maintains a policy and procedures for the strict control of tools and youth use of Class B tools. A review of the program's procedures verified staff are required to complete a sign-out and sign-in log when Class B tools are used and are returned to the designated storage room. A review of seven youth case management records indicated staff complete a Youth Risk Assessment prior to permitting youth to use Class B tools. The assistant facility administrator (AFA) reported all youth permitted to handle Class B tools attend a training on proper tool usage and reviewed youth records verified tool usage is part of the youth orientation process. The AFA reported any youth who inappropriately use a tool will immediately be suspended from tool use. The program staff-to-youth ratio during Class B tool use is one staff to five youth. The ratio during disciplinary work assignments is a minimum of one staff to every three youth. Program staff search all youth after work projects have been completed. Observations of youth cleaning was conducted during the annual compliance review. Youth were properly supervised while mopping and/or sweeping and searched after the job was completed. Seven interviewed youth stated they are permitted to use scrub brushes, mops, and brooms. One youth reported youth are also allowed to use a rake when working in the garden area.

5.15 Outside Contractors

Satisfactory Compliance

The program shall establish guidelines required for outside contractors, which includes information about tool control and restrictions.

The program has a policy and procedures outlining the rules for when tools are brought in by contractors. Contractors are required to sign the visitor log upon entry and are provided a contract agreement form which indicates a list of unauthorized items. The contractor signs the form confirming notification of what items are considered to be unauthorized and documenting any tools being brought into complete repairs. A review of the contractor binder verified this practice. If any unauthorized items are needed by the contractor while in the program, approval is obtained by the executive director or designee. A review of the sign-in sheets, contractor agreement forms, and five randomly chosen work invoices verified the contractors were on-site on the same date the documents were signed. Reviewed documentation and a review of the

Department's Central Communications Center incidents since the last annual compliance review reflected there were no instances of missing contractor tools. An informal interview with the maintenance manager indicated when contractors are on-site, youth are not allowed near the work area and maintenance staff are responsible for ensuring supervision of all work projects. Observations of contractor escorts and sign-in logs during the annual compliance review period verified the program's practice.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures to ensure the continuation of basic care and custody of youth in the event of an emergency or disaster, while ensuring safety of staff, youth and the public. The program policy requires drills to be completed semi-annually on the assigned topics of weather, flood, hostage situations, chemical spills, disturbances, bomb, and terrorist threats. The program completed Continuity of Operations Plan (COOP) drills monthly, exceeding the required frequency; however, was missing one weather, two chemical spill, and two flood drills. The program's policy was updated during the annual compliance review to coincide with the Continuity of Operations Plan (COOP) which only requires drills to be conducted for a variety of topics on a rotating basis. The program's COOP was approved by the Department on March 30, 2021 and was last reviewed on April 5, 2022. Drill documentation included the type of drill, date and time, participants, a brief scenario description, deficiencies identified during the drill, and applicable corrective actions. The program reviews each drill and debriefs staff on how well drills were conducted during all staff meetings. Observations reflected fire evacuation routes and egress plans were posted in common areas throughout the program. The program received its annual fire marshal inspection in March 2022. Cited corrections were implemented and approved by the fire marshal during the annual compliance review week. A review of fire drill documentation supported the program practice was to conduct a monthly fire drill on each shift. The program is equipped with sixteen fire extinguishers which were last inspected April 8, 2022. The interviewed executive director reported program drills are completed monthly on each shift. Seven interviewed staff reported participating in weather, major disturbance, hostage situation, chemical spill, flood, escape, fire, medical, and mental health drills in the last twelve months. Seven interviewed youth reported knowing what to do in the event of a fire and participating in fire drills at least monthly.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
<i>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.</i>	
<i>The program shall establish and maintain critical identifying information, as well as a current photograph of each youth, which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.</i>	

The program maintains a policy and procedures to ensure the development of a Continuity of Operations Plan (COOP) outlining the basic care and custody of youth in the event of an emergency or disaster, while ensuring safety of staff, youth, and the public. The program's

COOP was approved by the Department on March 30, 2021 and was last reviewed on April 5, 2022. The COOP addresses phases of a disaster plan, as well as emergency management including preparedness, response, and recovery. The COOP addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. Reviewed documentation confirmed the program maintains critical identifying information in hard-copy binders including case management, mental health, and medical information. The COOP requires the program to bring all records with the youth in the case of an evacuation and a review of seven hardcopy records found each documented the youth's name, Department identification number, admission date, date of birth, gender, race, detailed parent/guardian contact information, emergency contacts, assigned juvenile probation officer contact information, name of committing judge, committing offense, jurisdiction specific information, applicable victim notification information, a physical description of the youth, medical information, and a photograph of the youth. A review of the plan indicated alternative housing has been identified should the program require evacuation due to an emergency or disaster. Observations during the annual compliance review showed the program maintains needed equipment and supplies within the kitchen in the event of an evacuation. An informal interview with the maintenance manager verified there is a generator which powers the program for continuous operation and services during emergency or disaster situations. A review of generator inspection logs verified the generator is checked monthly. The interviewed executive director indicated the COOP is available to all staff and is located in the administrative offices and in master control.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures to ensure the strict control of flammable, poisonous, and toxic items used. The program required all flammable, poisonous, and toxic items and materials to be securely stored and perpetually inventoried. Youth are prohibited from locations where toxic items and chemicals are stored. Toxic and flammable items are stored in the maintenance office and within a room within the program. Toxic items are only accessible by the maintenance manager. Cleaning chemicals are stored in a locked room within the program. A list of staff who are authorized to handle these chemicals is posted on the back of the door. A Safety Data Sheet (SDS) binder was located with both toxic and cleaning materials. A perpetual chemical inventory list is maintained, and the chemicals are checked daily. A review of three separate toxic items and three separate cleaning chemicals were compared against inventories. All inventories were accurate, and each product had a corresponding SDS. A review of the inventory lists since the last annual compliance review verified the inventory practices. An interview with the dietary manager and the maintenance manager verified the controlled storage and tracking of flammable, poisonous, and toxic items and materials.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
<i>The program shall maintain strict control of flammable, poisonous, and toxic items and materials.</i> <i>Youth shall not be permitted to use, handle, or access 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.</i> <i>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).</i>	

The program maintains a policy and procedures prohibiting youth from handling any flammable, poisonous, and/or toxic items or materials. Youth are not to clean, handle, or dispose of any toxic materials, bio-hazardous bodily fluids, or human waste. Youth are strictly prohibited from the maintenance area where toxic items and chemicals are stored. The program practice is to have the dietary supervisor or maintenance manager issue cleaning supplies to the shift supervisor, who then pours and/or sprays the chemical. Observations of cleaning during the annual compliance review supported the program practice of spraying the cleaning chemical and having the youth wipe. Seven interviewed youth revealed they do not handle chemicals at the program. One youth reported they do help paint and three youth reported when youth achieve a certain level, they can do their own laundry. Youth revealed the staff will then scoop laundry soap into the washing machine. The interviewed youth confirmed youth do not handle any toxic, flammable, or caustic items.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
<i>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.</i>	

The program maintains a policy and procedures to ensure the strict control and disposal of flammable, poisonous, and toxic items used. The policy requires adherence to procedures in accordance with Occupational Safety and Health Administration (OSHA) federal regulations. An interview with the maintenance manager indicated the program utilizes the local county disposal drop off for any disposal needs. A review of the Chemical Disposal Log indicated there were no materials requiring disposal since the last annual compliance review. The program has a contract with a vender to dispose of used kitchen grease and waste on a quarterly basis. The program maintains strict procedures regarding chemical spills. The policy dictates all spills are reported immediately to the shift supervisor and the direct shut down of the air handler and ventilation system is performed. Next, an evacuation of the affected area is conducted and a determination is made by the executive director (ED) whether to contact outside assistance to contain the spill. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional. The assistant facility administrator (AFA) and maintenance manager revealed the program has not had a chemical spill since the last annual compliance review. An interview with the ED reported the maintenance manager is ultimately responsible for the inventory and disposal of toxic materials and the program uses a local community site for needed disposals.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable
<i>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.</i> <i>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:</i> <i>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;</i> <i>Type of water, such as pool or open water;</i> <i>Water conditions, such as clarity, turbulence, and bottom conditions;</i> <i>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.</i> <i>Lifeguard-to-youth ratio and positioning of lifeguards;</i> <i>Other staff supervision; and</i> <i>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.</i> <i>Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.</i> <i>Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.</i>	

This program does not participate in any water-related activities; therefore, this indicator is rated non-applicable.

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

The program maintains a policy and procedures to ensure staff and visitors are provided with a safe environment through the effective application of communication and visitation requirements. Youth are provided the opportunity to receive visitation and communication with approved family members. During admission, each youth is provided with the program's visitation, telephone, and mail policies and guidelines through the youth handbook. Parents/guardians are informed of the visitation and communication guidelines upon admission through a welcome letter and parent/guardian handbook. The program contacts the youth's juvenile probation officer (JPO) to verify the youth's parent/guardian and other family members are not under current or past investigation for youth with a history of human trafficking. Visitation is scheduled for Saturdays and Sundays for one hour increments for each dormitory from 1:00 p.m. to 4:00 p.m., extended visitation is held once each month from 1:00 p.m. to 4:00 p.m. for all

youth, and the program organizes an extended weekday visitation from 11:30 a.m. to 12:30 p.m. by appointment. Due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control and Prevention (CDC), on-site visitation was limited during times of high risk. The interviewed executive director and telephone logs confirmed extra telephone contact was made available to youth during these instances. Reviewed chronological notes and visitor sign-in sheets verified special visitation and face-to-face visits were occurring. Youth can write letters or make telephone calls at least once a week to approved family members. An interview with the director of case management revealed all incoming and outgoing mail is checked for contraband in the presence of the youth with case management or administrative staff. Seven interviewed youth reported they communicate with their families by telephone and mail.

5.23 Search and Inspection of Controlled Observation Room	Satisfactory Compliance
<i>The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.</i>	

The program has a policy and procedures regarding searching and inspecting the controlled observation room, prior to placing a youth on controlled observation. The program did not place any youth into controlled observation since the last annual compliance review; therefore, there was no documentation to review for compliance.

5.24 Controlled Observation	Satisfactory Compliance
<i>Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.</i>	

The program maintains a policy and procedures regarding controlled observation. Program staff are authorized to temporarily place a youth in a controlled observation room if there is an imminent risk to the youth harming themselves or others, or if the youth is causing major damage to the program which may cause a security risk. If a youth is placed in controlled observation for any of these reasons, a Controlled Observation Report is to be completed upon the youth's placement. The program had no controlled observation placements since the last annual compliance review. An interview with the executive director confirmed the program only uses controlled observation after exhausting all resources and as a last resort. Seven youth were interviewed and four reported never being placed in their room for getting into trouble. Two youth reported they were placed in their rooms right at bedtime and one youth stated being placed in their room to cool down and knocked on the door to notify staff they were ready to rejoin the group.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
<i>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.</i>	

The program has a policy and procedures regarding controlled observation which addresses safety checks and release procedures. The program did not place any youth into controlled observation since the last annual compliance review; therefore, there was no documentation to review for compliance.