State of Rhode Island and Providence Plantations
OFFICE OF THE CHILD ADVOCATE

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Jennifer Griffith, Esquire
Child Advocate

Eric Gaboriault, Regional Director
Rhode Island Residential Programs
623 Atwells Avenue
Providence, Rhode Island 02909

January 17, 2020

Dear Mr. Gaboriault,

The Office of the Child Advocate (OCA) has completed an investigation with respect to Communities for People (CFP) homes. Please find the below report and findings issued by the OCA. Please note names of youth, staff members and/or community agencies have been redacted from this report to protect confidentiality. The period under review is August, September and October of 2019.

Background:

The OCA received numerous Child Protective Services (CPS) reports regarding homes within the CFP community. The OCA received additional concerns from outside agencies, program staff, youth and family members of children placed through CFP. Upon receipt of the information, this office conducted an investigation that encompasses information from a variety of sources including public information, conversations with youth, program staff, family members, community agencies and a review of program records and youth files.

Investigative Actions:

The OCA requested copies of incident reports and staff log books from Program Director, Debra Jean Laurent all of which were provided for review. Members of the OCA visited each home operated by CFP and spoke with staff and youth. Onsite review of log books, medication books and youth files were completed. All CPS reports were reviewed and are documented throughout this report to indicate areas of concern that emerged throughout the CFP facilities.

OCA Findings: 81 Washington Avenue House and 380 Hope Street House:

CFP Program Director, Debra Jean Laurent provided a program Fact Sheet for 81 Washington Avenue and 380 Hope Street. A brief description is provided below:

> "The Intensive Supervised Living Program is a community-based residential program serving adolescent boys who are exhibiting acute emotional and/or behavioral dysregulation. While the program provides a high degree of supervision, support, and structure, it utilizes positive behavioral approaches and provide supports in the least restrictive, least intrusive manner possible.
>
> The program provides assessment, stabilization, treatment, and skills instruction to youth step-down from hospitalization or diversion and re-entry into the community from the Rhode Island Training School.
>
> The program provides youth with psychosocial, educational, and vocational training. The program uses a wide range of diagnostic and treatment services, including daily living and social skills training, to improve each youth's functioning" ...

> **CPS Report for 81 Washington Ave:** Information was called into the CPS Hotline to report three youth, two biological males and one transgender male were found in bed together, with the lights off and "kissing noises" could be heard through the door. This report was classified as an IR and DCYF did not complete an investigation. The OCA requested an investigation based on the information and concerns with supervision however no investigation was initiated.

The OCA expressed concerns regarding the details of this report due to two of the youth involved having a history of sexual trauma. Upon review of the Incident Report provided by CFP it remains unclear how long the youth were alone in the bedroom before staff entered the room and made the children get out of the bed. The incident report was clear the three youth were in bed together and when the door was opened the youth were in the dark on top of one another. A review of the program log book documents three residents were "caught in a sexual act."

Program Staff changed the rooms for all youth in order to monitor them more closely. Youth reported to staff they were "watching a makeup movie".

The OCA expressed concern with the supervision level of these youth as they have a history of sexual trauma, as victims and offending behaviors. Additionally, one of the residents involved is over twenty-one and residing in the home on a variance. The OCA raised concerns regarding this twenty-one-year-old sharing a room with a seventeen-year-old trauma victim. The OCA was informed these residents were provided single rooms after this incident and at the time of this report, the twenty-year-old has been discharged and moved into the adult system.

The OCA remains concerned with the level of supervision and combination of youth based on their individual needs and treatment goals.

> **CPS Report for 81 Washington Avenue:** Information was reported to the CPS Hotline reporting a fight between two residents with staff intervening. The reporter states another staff member intervened and was heard advising one of the residents, "Don't do it up here do it outside where there are no cameras." Reporter states staff member was also saying things to resident un French/Haitian Creole which could not be understood. Reporter states, staff member looked at the youth and said, "he is going to get you and get you good." Reporter states another staff member was a witness to the incident and heard what the staff member said to the youth.
>
> This report was classified as an Information Referral therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions were taken by CFP.

The house log was incomplete and none of the records reviewed met the standards set in the licensing regulations. The log book was missing entire shift entries making it impossible to know what is happening during a shift and where each resident is located. Additionally, it is unclear who the staff are on each shift and who is entering information into the log book. Entries do not indicate AM or PM making it difficult to discern the time of day and youth are listed as being on community time, also making it impossible to determine where youth are located while in the community. One entry indicates roommates engage in a physical altercation between 12:00am and 1:00am leading to one of the residents being hospitalized. There is no information as to how this youth is transported to the hospital and if this resident was injured and required hospital attention. It is noted at 6:15am DCYF calls the home to inquire about this resident being hospitalized. Sometime between 7:00am and 8:00am the log indicates this resident arrives at the house with hospital staff. On this same day an AWOL youth arrives at the home requesting money for a haircut. Staff reportedly give youth $20.00 and youth leaves the program, remaining on AWOL status. Documentation in the log book indicates youth requesting a ride to work from staff and being denied, despite the program Fact Sheet stating... "coordination of and transportation to appointments;"...

All files were incomplete and sub-standard. Youth files were incomplete and lacked pertinent information. The program does not have a medication log with each youth's information. Medication sheets and files are kept in the individual youth files, not in a separate medication binder. Upon review of the medication sheets most were incomplete and missing entries, primarily from the second shift. None of the medication records met appropriate standards.

Other safety concerns were observed throughout the house, including but not limited to; exposed electrical outlets, an electrical cord running across the floor, not properly mounted or securely attached. The kitchen and refrigerator did not show adequate food for the residents and there was no food menu. No one in the home could advise when food shopping is done and whose responsibility it is to ensure food is in the home.

Although the program Fact Sheet indicates, … "care coordination and case management; educational and vocational" … There is no evidence of program staff assisting with employment, teaching basic life skills and individuals within the home verified this does not happen on a regular basis if at all.

OCA Findings: 380 Hope Street:

CPS Report for 380 Hope Street:
Information was reported to the CPS Hotline by a resident of the home. Youth reported staff denied him extra food. This information was classified as an IR therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what action was taken by CFP.

CPS Report for 380 Hope Street:
Information was reported to the CPS Hotline by CFP staff. Staff reported one of the residents was receiving unsolicited pictures from a former resident. These pictures are reportedly of the youth's penis. A report was made to the Providence Police. This information was classified as an IR therefore DCYF did not complete an investigation. The matter was referred to the DCFY Licensing Division. It is unclear what action was taken by CFP.

CPS Report for 380 Hope Street:
Information was reported to the CPS Hotline by CFP staff. Staff report two youth flipped the mattress over of a third youth while he was sleeping. The youth in bed received a small bruise. This was reported to be horseplay and not intended to cause the resident harm. This information was classified as an IR and therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions were taken by CFP.

Upon arrival to the home OCA staff were greeted by a youth sitting on the front porch and no staff on the premises. Resident explained he was currently AWOL and was returning to the program. OCA members contacted the program manager to inform of youth's return and waited for staff to arrive at the home. Additional conversations within the program report program staff treat youth unfairly. It was reported to the OCA; CFP staff treat residents differently and some youth receive preferred treatment. Youth indicate wanting to be treated with the same respect as the other residents within the home. It was reported staff tell the youth due to their tenure within the agency and personal relationship with the Program Director, staff will not receive a consequence. According to source, this information has been called into the hotline and allegedly addressed to no avail. It was also noted the Program Director is a relative of program staff.

All youth and medication files were incomplete and sub-standard.

OCA Findings: 136/138 Knight Street House and 24 Tappan Street House:

CFP Program Director, Deb Jean Laurent, provided a program fact sheet for 136/138 Knight Street and 24 Tappan Street. A brief description is provided below:

> "The Transitional Treatment Program is a community-based residential program serving older Adolescents with chronic and/or severe mental health needs. The program serves as both a diversion to psychiatric hospitalization, and/or as a step-down option for youth who are leaving the hospital or out of state residential treatment centers and who are not able to return to living with their family.
>
> The program provides youth with consistent psychiatric consultation as well as psychosocial, educational and vocational training. The program uses a wide range of diagnostic and treatment services, including daily living and social skills training, to improve each youth's functioning.
>
> The TTP Model provides youth and their families with consistent psychiatric consultation and medication monitoring, emergency therapeutic intervention, routing and emergency evaluation, and psychiatric assessment through our contractual partnership with Gateway Healthcare.
>
> Staff work with the youth, birth parents and natural resources using evidence based and trauma informed treatment models, including Dialectal Behavioral Therapy, Trauma Focused Cognitive Behavioral Therapy, and Motivational Interviewing" ...

CPS Report for 136 Knight Street:
Information was reported to the CPS hotline a resident of the home went AWOL (physically left the building) and climbed through the window of another resident's bedroom window from outside of house in order to engage in sexual activity with the other resident. The roommate of the youth was asked to be a lookout for the residents while they had sex. This reportedly occurred throughout the night and was reported by the roommate the following day. DCYF classified this report as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. The OCA is unclear what steps or actions were taken by CFP.

CPS Report 136 Knight Street:
Information was reported to the CPS hotline by a DCYF social worker indicating CFP staff spoke inappropriately about a youth in front of the youth's mother. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. The OCA is unclear what steps or actions were taken by CFP.

CPS Report 138 Knight Street:
Information was reported to the CPS hotline by a CFP Staff. Staff reported upon coming into work at midnight there was a situation wherein two girls who have a room on the second floor were on the first floor. Reporter indicates the youth were talking

sexually. Reporter remained in the doorway of the room until approximately 2AM when the girls returned to their respective rooms. One of the residents is red flagged as sexual abuse perpetrator. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. OCA is unclear what steps or actions were taken by CFP.

The staff house log was incomplete and none of the records met the standards set in the licensing regulations. The log was missing entries from all shifts. Log entries fail to note where youth are located, and what is happening throughout a shift.

Individual medication sheets were incomplete and none of the records met the standards set in the licensing regulations. There is not an independent medication log. The medication sheets were missing entries from all shifts and the program does not have a medication log, consisting with individual pages for each youth. Each individual medication sheets are stored in youth binders. The Food menu was not posted.

OCA Findings: 24 Tappan Street:

CPS Report for 24 Tappan Street:
Information was reported to the CPS Hotline by CFP staff. Staff reported a resident made threats to hurt another youth with a knife. Providence Police responded to the house and conducted a room search. A knife was found under the resident's bed. The knife was secured by staff, police cleared the home however it was reported the resident continues to make threats of harm towards the other youth. This information was classified as an IR therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what steps or actions were taken by CFP.

CPS Report for 24 Tappan Street:
Information was called into the CPS Hotline by a resident reporting another resident had stolen her radio from her room and staff would not take it from the resident and return it to reporter. Youth reported the radio is her only coping skill and it is program violation for youth to go in one another's rooms. Reporter also stated when she attempted to retrieve her radio the other resident hit her with a purse and broke her radio. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what steps or actions were taken by CFP.

CPS Report for 24 Tappan Street:
Information was reported to the CPS hotline by a resident of the home. Youth reported a staff member left the house, leaving one staff with six (6) residents. Reporter further stated the staff member also took the house keys with her that have the medication key attached. Youth reported being concerned of a fight breaking out as the youth in the home do not get along. The report was classified as an IR and DCYF did not complete

an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions or steps were taken by CFP.

CPS Report for 24 Tappan Street:
Information was reported to the CPS Hotline by CFP staff. Staff report a youth was found in possession of an alcoholic beverage. Reporter states it is unclear how the youth obtained the alcohol but reports youth recently returned from being AWOL. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions were taken by CFP.

CPS Report for 24 Tappan Street:
Information was reported to the CPS hotline by CFP staff. Staff report a youth missed her medication dose by an hour and the youth was upset she was not allowed to take the medication late. This information was classified as an IR therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions were taken by CFP.

OCA Findings: 244 Washington Ave House:

CFP Program Director, Deb Jean Laurent, provided a program fact sheet for 136/138 Knight Street and 24 Tappan Street. A brief description is provided below:

"The Short Term Assessment & Reunification Program (STAR) provides immediate access to safe, structured, community-based residential setting providing; family support, rapid assessment and stabilization for youth exhibiting an array of mental health needs and behavioral presentations including self-harm and aggressive behavioral episodes and who need assessment and stabilization.

The program immediately engages parents/caretakers with the goal of rapid reunification. The STAR program provides youth with a full range of supportive case management and educational continuity, including transporting the youth to the school where he most recently attended.

Staff work with the youth, birth parents and natural resources using evidence based and trauma informed treatment models including, Trauma Focused Cognitive Behavioral Therapy and Motivational Interviewing.
Programmatic services for youth include: crisis prevention, stabilization and intervention needed, brief, acute, residential care in a safe, secure and supportive community-based setting, the involvement of caregivers and family members in all aspects of treatment, including service planning, family therapy and trauma focused psycho-educational opportunities, service planning with permanency goals and timeframes for attainment, development and implementation of youth safety or crisis management plans; coordination of and/or access to educational groups; programming focus and enhancing independent daily living skills,

medication management, educational and vocational coordination and support; case management and court advocacy"...

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline. Caller stated he often sees youth smoking marijuana in front of the house and sees the youth playing basketball at 5:30AM. Caller is concerned about the level of supervision by the staff. This information was classified as an IR and therefore DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what actions were taken by CFP.

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline. Caller was identified as clinician from CFP. Reporter stated three (3) youth in one-bedroom and were playing on the "Monkey App." Reporter advised the Monkey App is a video chatting app where people communicate with strangers.

One youth reported the boys were "fooling around" one of the other boys in room got uncomfortably close to him, touched him on the butt and grabbed his testicles. Reporter stated he had not spoken with the other youth in the room and this incident happened on either Friday or Saturday.

Reporter stated staff would be notified of the incident and would keep a close eye on the resident and the youth were separated. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear if any additional action was taken by CFP.

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline by a CFP staff. Reporter stated he was upstairs in the office when he heard what sounded like a slap come from downstairs. When he came downstairs, he observed a resident looking like he was getting ready to punch a neighborhood girl who was standing in the doorway of the home with a belt in her hand. Youth reported she hit him with the belt.

Reporter stated youth did not have any visible injuries but was upset so he grabbed him and brought him into the house before he could do anything to the girl. The youth was upset and broke something in the home. Youth was charged by police with vandalism. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what action were taken by CFP.

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline by house clinician. Reporter stated while out in the community one resident slapped another resident across the face. This information was classified as an IR and DCYF did not complete an investigation.

The matter was referred to the DCYF Licensing Division. It is unclear what if any action was taken by CFP.

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline by CFP staff. Reported stated three (3) youth were AWOL from the program. Upon return to the program the three (3) youth smelled of marijuana and alcohol. Additionally, another youth who was not AWOL smelled of marijuana and alcohol.

Reporter is unclear where the youth obtained the marijuana and alcohol and none of the youth had substances on their person. One youth was unable to receive their morning medication due to being under the influence. All youth refused to be transported for medical attention and Providence Police were contacted to transport youth to be medically cleared. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what action were taken by CFP.

CPS Report for 244 Washington Ave:
Information was reported to the CPS Hotline by CFP Case Manager. Reporter stated two (2) residents were having a verbal argument. One youth attempted to take a phone and three (3) other residents jumped in and being hitting youth. Staff broke up the fight and contacted Providence Police. Residents have no injuries and do not require medical attention. This information was classified as an IR and DCYF did not complete an investigation. The matter was referred to the DCYF Licensing Division. It is unclear what action were taken by CFP.

The log books and files were incomplete and missing entries. Medications sheets were incomplete and missing entries from all shifts. Log books were incomplete, missing entries and fail to document where youth are located.

The OCA observed a youth not enrolled in an educational or vocational system despite being placed in the facility for over one month. The OCA was unable to confirm any of the information in the program description were taking place such as family therapy or evidence based, and trauma informed treatment models were prevalent in the day to living and structure.

OCA CONCERNS and RECOMMENDATIONS:

It was clear there is a disconnect between the mission of CFP and the staff members. Unprofessionalism amongst staff members was prevalent not only in reports reviewed by the OCA but with conversations and interactions at all homes and with other pertinent parties. Each program lacked an appropriate level of professionalism. It was difficult to determine a difference between youth and staff in each home as many staff are dressed in similar clothing to the youth living in the home. Staff speak to youth in a condescending manner, and with indifference. Some staff treat youth as "friends"

and boundaries are a concern at all levels of staffing including the Program Director. Within each program youth and staff discussed being treated differently by management and the Program Director as well as other program staff depending on your personal relationship with "higher ups". Concerns were logged by the OCA regarding the management and Program Director's boundaries with subordinates in front of other staff and youth in the program. Youth are privy to personal information of staff members. This is based on conversations reportedly overheard by management/supervisors as well as social media platforms. Staff and the Program Director were found to speak openly about other staff members on social media platforms, all of which was available to youth and families. The OCA is concerned with boundaries and what appears to be improper behavior on behalf of the Program Director. Additionally, it was reported to the OCA, staff complete significant training prior to starting their job, there is no consistency or follow through by the Program Director to ensure everyone including the house manager is following the protocols of the training and being provided adequate supervision.

Agency incident reports are a major concern. There is one system used to document incidents and the report does not provide adequate documentation and representation of the incident. The OCA reviewed numerous incident reports and were unable to determine the staff member writing the report. Several reports were completed days after the incident took place. Staff members are completing incident reports even though they were not involved in the incident. The OCA is concerned staff and or management are reporting on an incident they were not involved with or a party to and some contained names of staff that were no longer employees of CFP. Incident reports were not completed in full and did not contain the signature of the author of the report.

Additional Concerns and Recommendations

- The OCA noted agency back logs from June 2019 - Present for medication and daily logs were still stored in the office of each facility. It is unclear what the policy or procedure is for storage of these documents.

- During each review conversation with residents and staff, stated the agency struggles with consistent staffing which impacts relationship building with the staff.

- The OCA is concerned of the age range allowed for children at 244 Washington Avenue. The OCA does not recommend youth ages 12 through 18 years of age reside together in the same home.

- The OCA recommends CFP ensure agency incident reports contain signatures and ensure the staff member involved is completing the report prior to the end of their shift.

- The OCA recommends CFP conduct ongoing training and supervision to Program Director and House Managers to require professionalism and accountability.

- The OCA recommends that all staff be re-trained in medical protocol.

- The OCA recommends CFP ensures all employees follow proper protocol and guidelines and perform more frequent supervision and guidance.

- The OCA recommends that all staff be re-trained in written documentation procedures.
- During the process of this review at **24 Tappan St.**, the inspection of the physical site of a hallway there was a tile in the floor that was not in place causing a potential hazard.

Respectfully submitted,

Jacqueline Sanchez
Senior Planning & Program Development Specialist

Virawood "Jimmy" Vilayvanh
Senior Planning & Program Development Specialist

Kathryn R. Cortes
Special Projects Coordinator

Cc: Chief Judge Michael Forte
DCYF Acting Director, Kevin Aucoin
DCYF Chief Legal, Patricia Hessler
DCYF Chief of Staff, Aimee Mitchell
DCYF Associate Director, Deb Buffi
DCYF Chief of Licensing and Regulation, Veronica Davis
DCYF SCWII GinaMarie Dibartolo

CORRECTIVE ACTION ADVISED:

Thank you again for your time and attention. Violations were noted in each section of the below listed Childcare Regulations. Please review each section noted below and make the necessary corrective actions for these violations to ensure Communities for People residential facilities are in compliance with all licensing regulations. The corrective action shall be completed within thirty (30) days. The respective agency shall forward documentation of all corrective actions to the OCA and the Department to ensure completion of corrective action and compliance with the Residential Child Care Regulations for Licensure.

III. HEALTH, PRIVACY AND SAFETY

A. Physical Site

1. The Facility will be housed in a structure equipped and maintained to provide for the safety, health, privacy and physical comfort of all residents.

2. Any proposed changes to the site must be made in accordance with State and local laws and notice to DCYF in accordance with **SECTION THREE-LICENSING STANDARDS, I. ADMINISTRATION AND ORGANIZATION**, D. Notice Requirements above.

3. The Facility must maintain all structures and equipment on the premises in good repair, free from hazard or risk. Any power equipment will be stored appropriately.

4. All living areas of the Facility will be well-lighted and ventilated.

5. All areas must be clean and properly maintained at all times.

6. Each residential unit will contain interior space for the children's leisure, designed and equipped in a manner consistent with program goals.

7. There will be dining areas that allow children, staff and guests to eat together.

H. Medication for Residents

1. The Facility will maintain written protocols for dispensing over-the-counter (OTC) and prescription (RX) drugs.

1. Each medication will be properly labeled and stored in a separate container for each child, labeled with the child's name.

2. The Facility will maintain all medications under double lock (in a locked container stowed in a locked cabinet).

3. The Facility will maintain a sign-off sheet for the transfer of keys to the locked cabinet and container.

4. No prescriptions may be given to any child other than the child for whom it has been prescribed.

5. There will be at least one trained staff person per shift responsible for dispensing medication.

6. The Facility will maintain a medication log, consisting of individual pages for each child. The log will include the child's name, the name of the prescriber, the name of the RX or OTC drug, the dose, the date and time dispensed and the name of the staff person who dispensed each dose.

7. The medication log page for each child will conspicuously indicate any allergies.

8. Any medication requiring injection must be administered by a qualified medical practitioner. Subcutaneous medications may be administered by the child if the child has been properly trained. All self-injections are to be monitored by trained staff. If the child is permitted to, but is unable to self-administer a medication, trained staff, in accordance with the facility's written emergency medical procedures (refer to section G. Emergency Medical Procedures above) may administer the medication.

9. The Facility will maintain a written procedure for the disposal of expired and discontinued medications. All medical waste will be disposed of pursuant to the universal precautions for infectious disease and control.

J. Food Services

1. Food preparation and storage areas must be maintained in sanitary condition.

2. Menus, all meeting accepted nutritional standards, will be posted for the residents.

3. The Facility will provide every child with at least three (3) regularly scheduled meals a day and at least one (1) healthy snack, with no more than fourteen (14) hours between breakfast and dinner.

4. No child will be denied food for other than medical reasons. The reason, as recommended by the child's health care provider, will be noted in the child's Facility record.

V. FACILITY RECORDS AND SERVICE PLANS

A. Facility Service Plans

2. Individual service plan

a. Within thirty (30) calendar days of admission, a Facility will review the child's service needs and strengths in a manner that recognizes and respects the child's race, ethnicity, culture, sexual orientation and expression. The review must address the following issues:

v. Pre-vocational and vocational training
vi. Life skills development

E. Education

1. The Facility will arrange for residents to attend appropriate educational programs in accordance with State and Federal law.

2. No Facility will operate an educational program without the written approval of the Rhode Island Department of Education (RIDE).

3. The Facility will provide residents with appropriate space and supervision for quiet study and access to necessary reference materials.

4. The Facility will provide for vocational education and/or life skills training and services as appropriate to the child's age and abilities.

G. Employment and Money

5. The Facility will ensure that any child who is not involved in an educational or vocational program is gainfully employed.

6. The Facility will encourage age-appropriate, gainful employment for a youth in accordance with the youth's individual service plan.