STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Girls Academy

TrueCore Behavioral Solutions, LLC
(Contract Provider)
117 North East 39th Boulevard
Okeechobee, Florida 34972

Review Date(s): May 12-15, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tonya Gittens, Office of Program Accountability, Lead Reviewer ([Standard 1])
Camelia Daley, Office of Program Accountability, Regional Monitor (Standard 2)
Patrick Morse, Office of Program Accountability, Regional Monitor (Standard 3)
Maryann Sanders, Office of Program Accountability, Regional Monitor (Standard 4)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 5)
Sharon Wong, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Okeechobee Girls Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): May 12-15, 2020

MQI Program Code: 1209
Contract Number: R2103
Number of Beds: 32
Lead Reviewer Code: 160

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
5.11 Transportation of Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	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 *	Non-Applicable
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Non-Applicable
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 *	Non-Applicable
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	Non-Applicable
5.09	Searches and Full Body Visual Searches	Non-Applicable
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Limited
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Satisfactory

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Program Overview

The Okeechobee Girls Academy is a thirty-two bed program for thirteen to eighteen-year-old female youth, located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). In addition, the program offers youth with a substance abuse diagnosis substance abuse treatment through Seeking Safety, Living in Balance, Pathways to Self-Discovery and Change, and Project Towards No Drug Abuse. The program offers mental health treatment through Voices – A Program of Self-Discovery and Empowerment for Girls, The Teen Relationship, Skillstreaming, Anger Management for Substance Abuse and Mental Health, Anxiety Workbook for Teens and The Anger Workbook for Teens. The program provides Thinking for Change and Impact of Crime as the criminogenic and restorative justice curricula. In addition, SAVVY Sisters is offered as the program's gender-specific programming. Additional treatment services provided includes recreational therapy, individual, group, and family therapy. Program administration is comprised of a facility administrator, assistant facility administrator, and four shift managers. Case management services are provided by the transition services manager and two case administrators. Mental health staff at the program includes the director of clinical services serving as the designated mental health clinician authority (DMHCA), the contracted psychiatrist, a contracted psychologist, three master's-level therapists, and a recreation therapist. Medical services are offered seven days a week and are provided by the contracted designated health authority, a health services administrator, two licensed practical nurses, a contracted optometrist, a contracted gynecologist, and a contracted dentist. Educational services are provided by TrueCore Behavioral Solutions, LLC. Okeechobee County School District provides oversight of employed staff. The layout of the program includes two youth dormitories, two administrative buildings, a Home Builders Institute workshop and classroom, a library, a classroom building, a theatre room, a recreation building, a maintenance building, and a storage room formerly used as a shower room. The program shares a warehouse with the Okeechobee main campus, also managed by TrueCore Behavioral Solutions, LLC. The program has fifteen closed captioned cameras. All fifteen cameras were fully operational during the annual compliance review week. At the time of the annual compliance review, the program had two vacant positions which included one youth care worker and one non-licensed therapist. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of specific indicators or elements were unable to be completed, during this fiscal year. Off-site supplemental reviews were conducted as desk audits throughout the remainder of this fiscal year.

Strengths and Innovative Approaches

- The program had a Prom youth in the program. There were vendors from the community to help the ladies do their hair, make-up, and nails.
- Eight youth teamed up with American Cancer Society to participate in a walk. Youth helped with distributing water to the participants. Youth got a chance to speak with cancer survivors as well as family members who have lost loved ones.

Standard 1: Management Accountability

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

The program has a written policy and procedures requiring initial background screenings compliance with the Department's Background Screening (BSU)/Clearinghouse. The program had fourteen newly hired staff since the last annual compliance review. There were no new applicable contracted staff or volunteers. A review of documentation supported all fourteen newly hired staff received background screenings completed by the Department's BSU/Clearinghouse, before each staff's date of hire. There were no staff needing an exemption prior to working with youth. There was documentation in all reviewed staff records indicating the hiring specialist reviewed the Department's Central Communications Center (CCC) system, Staff Verification System (SVS), and the Florida Department of Law Enforcement's Automatic Training Management System (ATMS) as part of the pre-employment background screening process. The program requires all direct-care staff to complete a pre-employment assessment. As of September 2019, the program changed from using the Ergometric Pre-employment Assessment tool to using the Berke Assessment. The assessments are scored as low, medium, or a high fit for the role, and a job fit percentage is provided. Staff scoring at a medium or high may be provided a job offer. Nine of the fourteen newly hired staff were applicable for a pre-employment assessment. A review of the nine applicable direct-care staff records documentation showed each staff completed and assessment and scored the required medium or high score. The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards, along with the school board annual screening, to the Department's BSU on December 04, 2019, meeting the annual requirement.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.).	

The program has a written policy and procedures to address the five-year background re-screening process. A re-screening is required every five years, which is calculated from the staff's original date of hire with the program. All rescreening's are required to be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program's human resource manager tracks the five-year anniversary of hire dates and processes the five-year re-screenings for all staff. The program

had three staff applicable for a five-year background re-screening. Reviewed documentation confirmed the program completed a five-year rescreening for each staff. Each staff rescreening was completed and submitted to the BSU/Clearinghouse prior to the staff member's five-year hire date anniversary. There were no applicable contracted staff or volunteers requiring a five-year re-screening since the last annual compliance review.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.* • *The program shall complete or schedule a TRACE self-assessment.*	

The program maintains a written policy and procedures to establish an environment in which youth, staff, and others feel safe, secure, and without the threat of any form of abuse or harassment. Upon hire each staff electronically signs the employee code of conduct and handbook which is maintained in the agency's electronic system. A review of five staff records showed each staff signed a code of conduct. Youth are also provided with a handbook during the admission process. The handbook includes the youth's rights, the Department's Central Communications Center (CCC), and Florida Abuse Hotline telephone numbers. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of CCC and Florida Abuse Hotline postings was conducted through photographs, and validated they were located in the youth living areas, and throughout the program. The program had three abuse allegations reported to the CCC and/or the Florida Abuse Hotline since the last annual compliance review. All three allegations were reported by youth. One allegation was investigated and found to be unsubstantiated. Two allegations are still under investigation. At the time of the annual compliance review, the program received their Trauma Responsive and Caring Environment (TRACE) assessment survey results. The TRACE assessment action plan was completed on April 7, 2020. Five interviewed youth stated they feel safe while in the program, and they have never been stopped from reporting abuse to the Florida Abuse Hotline. All five youth stated staff are respectful when talking with youth and to other youth. Two of the five youth stated they never heard staff use profanity when speaking to them or other youth. One of the five youth

stated they occasionally hear profanity towards youth, and it was just through conversation, and two of the five stated it happens often, and is sometimes in a threatening manner but did not go into detail. Five interviewed staff explained the process for allowing staff and youth to call the Florida Abuse Hotline or CCC. Five staff stated they have not observed a co-worker telling a youth they could not call the Florida Abuse Hotline, or heard a co-worker using profanity when speaking with youth. An interview with the facility administrator stated the employee code of conduct enforces staff are expected to interact with youth in a manner promoting their emotional and physical safety. If staff use profanity towards youth they will be reported to the department and necessary disciplinary actions will follow to include immediate removal from youth contact.

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

The program maintains a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff member from youth contact, when necessary. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. A review of all incidents since the last annual compliance review found three incidents which involved a complaint against staff for physical abuse. Reviewed documentation of each report found management took appropriate and immediate action by initiating an internal investigation regarding staff on each allegation of abuse. Documentation confirmed two staff were removed from youth contact as required, and one staff was not removed from youth contact. The program's facility administrator (FA), at the time, did not remove staff from youth contact and was told by the Department of Juvenile Justice a staff must be removed from youth contact when there is an abuse allegation against a staff. One of the three reviewed reports was found to be unsubstantiated for abuse, two of the three reports are still under investigation. An interview with the FA stated youth are made aware of contacting the Florida Abuse Hotline and the Department's Central Communications Center (CCC) through facility postings, daily meetings, and Florida Abuse Hotline direct connect telephones placed in both housing units. Staff are made aware of their responsibility to ensure all youth requesting a call receive it and must complete an incident report and document it in the facility logbook. This information is communicated in staff briefings and all staff meetings. All abuse calls are tracked through incident reports and program logbook entries.

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

The program maintains a policy and procedures regarding the reporting of incidents to the Department's Central Communications Center (CCC). The program is required to notify the CCC within two hours of a reportable incident or within two hours of notification of the incident. The program had a total of nineteen CCC reports in the past six months. Five CCC reports were reviewed, and all five incidents were reported within the required two-hour time frame. Each incident was shown to be logged in the program's master control logbook. A review of the

program's internal incident reports found there were no incidents which meet the requirements for being reported to CCC and were not reportable. The program had an increase by two incidents in the number of reportable incidents to the CCC compared to the last annual compliance review.

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

The program maintains a written policy and procedures regarding Protective Action Response (PAR) physical intervention techniques in accordance with Florida Administrative Code. A PAR report shall be completed any time a PAR incident occurs. All PAR reports should include statements from every staff member involved and be completed by the end of the staff member's workday. A PAR certified instructor or a supervisory staff should review the report along with the review from the program's facility administrator (FA) or designee within seventy-two hours of the incident. The program had a total of six PARs in the past six months, which was lower than the last annual compliance review. There were no reported instances of excessive force since the last annual compliance review. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which are submitted to the Department monthly. A review of five PAR reports was conducted. Each report showed documentation of the report completion by the end of the staff member's workday, with each staff involved completing a statement. All five reports contained documentation of a review by a PAR certified instructor, which was completed within seventy-two hours by all required parties. There were no reports which required calls to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth requested or made a report to the Florida Abuse Hotline. The program's PAR rate during the annual compliance review period was 0.14, which is below the statewide Residential PAR rate of 2.28. An interview with the FA stated PAR reports are completed and filed in a binder by the month. An incident report is written in reference to the PAR report and logged in the program's logbook.

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

The program has a written policy and procedures regarding pre-service training. The program maintained a pre-service training plan for all newly hired staff which was approved and signed by the Department's Office of Staff Development and Training on February 17, 2020. A review of five pre-service staff training records indicated four staff were certified within 180-days of their hire date as required. The remaining staff took the written PAR test on September 6, 2019 with a score of seventy three percent. The Department requires a passing score of seventy five percent. The staff member retook the written PAR test on March 11, 2020 and received a passing score of 100 percent. Each of the five staff were certified in cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Each staff was trained in Protective Action Response (PAR), suicide prevention, professionalism and ethics,

emergency procedures, and child abuse reporting. Four of the five reviewed staff training records had documentation in the Department's Learning Management System (SkillPro) reflecting their completion of over 120 hours of pre-service training. The remaining staff member had eighty-one hours, which is less than the required 120 hours of pre-service training due to the written PAR not completed in the required ninety days. Reviewed documentation indicated all trainings were delivered by qualified trainers.

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

The program has a written policy and procedures regarding in-service training. The program maintains a written in-service training plan, which was reviewed and approved by the Department's Office of Staff Development and Training on February 17, 2020. Reviewed documentation validated the program has an annual in-service calendar which is updated as changes occur. Two supervisors and three direct-care staff training records, for a total of five records, were reviewed for completion of in-service training. All staff had current certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). All staff completed training in professionalism and ethics, as well as suicide prevention. A review of two supervisory staff completed eight hours of supervisor training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal. All training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The program maintains a policy and procedures regarding the youth grievance process. The program maintains a written pre-service training plan, which indicates all staff will be trained in the program's grievance process. All five reviewed training records documented each staff received training on the program's grievance process and procedures prior to direct contact with youth. The program's grievance process consists of informal, formal, and appeal phases. The program also uses "Chatty Cathy" forms before filling out a formal grievance, which allows youth first opportunity to voice an objection and informally resolve a complaint. All informal grievances must be responded to within forty-eight hours. The program maintains a binder of "Chatty Cathy" and grievance forms for at least twelve months. The program had a total of four grievances in the past year. A review of grievance documentation showed each form was filled out completely with the required signatures and responses. None of the reviewed grievances required an appeal. Five youth were interviewed regarding the ability to receive assistance when completing a grievance. One of the five youth stated they can request assistance with completing a grievance form, and four stated they cannot request assistance with completing a

grievance form, no additional information was given as to why. All five youth explained the program's grievance process. Five interviewed staff explained the program's youth grievance process. An interview with the facility administrator (FA) stated there is an informal phase where youth complete a "Chatty Cathy" and address it with the staff which can help them resolve the complaint or concern within seventy-two hours. The formal phase where the youth complete a grievance form addressing their complaints. Each grievance form is assigned a number and a written response is provided to the youth by the supervisor. If the youth disagree to the outcome, then they can appeal the grievance, send it to the next level, and it will be forwarded to the FA.

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

The program has a written policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract outlines Thinking for a Change (T4C) as the program's required evidence-based delinquency curricula. The program has three staff trained to facilitate T4C. Two facilitators hold a bachelors-level degree and one holds a high school diploma. All three have over ten years of experience working with youth and have completed T4C facilitator training. The program prescribes delinquency interventions to each youth based on identified needs. A review of the program activity schedule and sign-in sheets since the last annual compliance review showed groups were facilitated. The T4C group started on October 31, 2019 and ended May 6, 2020 with eight youth. A review of five youth records found three youth participated in T4C and three are awaiting to start the next T4C group. Each youth had goals in their performance plan to address their individualized delinquency needs. An interview with the facility administrator (FA) stated the program provides T4C as and intervention. Staff are trained to deliver the curriculum. Five interviewed youth stated they participate in groups. An interview with the FA stated youth are matched to case managers and intervention groups through a classification meeting which is conducted to identify the youth's physical and emotional safety needs through dormitory and room assignments, case manager and therapist assignments, and group assignments which will best meet their needs. This meeting includes participation of the designated mental health authority, assistant facility administrator, medical, living unit designee, case manager, youth, parent/guardian, and assigned juvenile probation officer.

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

The program has a written policy and procedures to address life skills training for youth. The program provides life skills training utilizing Skillstreaming the Adolescent, Living in Balance, Teen Relationship Workbook, Pathways to Self-Discovery and Change, and Anxiety Workbook for Teens curricula. The social skill intervention groups specifically address communication, interpersonal relationships and interactions, anger management, and critical

thinking. The program has a policy and procedures which determines how services are provided and how youth are placed in groups. A review of the activity schedule confirmed life skills training groups are provided to youth daily. A review of group sign-in sheets for the past six months verified youth are receiving life skills training as scheduled. Five interviewed youth all explained which groups they participated in and explained the skills developed while in the program. Youth reported some acquired skills included communication skills, patience, anger management, and coping skills.

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

The program has a policy and procedures for the provision of restorative justice awareness to the youth. The program's contract indicated Impact of Crime (IOC) is a required service provided to all youth in the program. A review of the program training records showed there were four staff trained to facilitate IOC groups. A review of the program's activity schedule showed IOC groups are facilitated. A review of five youth records indicated all five-youth completed the IOC group. A review of six months of IOC sign-in sheets determined the curriculum was delivered as designed. The program completed two cycles of IOC during the review period and one group which started on February 25, 2020 was currently in progress. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19 pandemic, this review was conducted off-site; therefore, observation of a restorative justice awareness group was not possible. An interview with the facility administrator stated youth receive IOC as their restorative justice group, and the primary goal of the curriculum is to assist youth offenders in accepting responsibility for the harm they have caused by their criminal actions and reducing the risk of future criminal activity. The IOC groups also help to educate offenders on the impact of crime on victims, their families, and their communities, increasing offenders' awareness, empathy, accountability for their actions, and to provide a safe and healthy forum for crime victims to share their experiences with offenders in a manner which is restorative. The groups provide direction for offenders in developing methods to restore their victims, families, and communities both inside and outside the residential commitment program.

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

The program's contract requires Savvy Sisters and Voices – A Program of Self-Discovery and Empowerment for Girls as the gender-specific curricula to be provided. The Savvy Sisters curriculum focuses on areas youth may need assistance on discovering in their lives. The Voices curriculum advocates a strength-based approach using a variety of gender responses and therapeutic approaches. A review of the program's activity schedule and sign-in sheets since the last annual compliance review confirmed gender-specific programing is provided to the youth. An interview with the facility administrator confirms all youth in the program receive the same gender-specific care.

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

The program has a written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. The program's alert board, which is located in the shift supervisor's office, identifies youth who are identified with an escape risk, special alerts, and/or gang affiliation alerts. The alert board also identifies youth placed on any type of mental health alert or sports/activity restriction. Documentation showed the program reviews the internal alerts during the shift briefings. A review of five youth records for medical, mental health, and case management alerts showed alerts were entered into JJIS. When comparing JJIS alerts to the program's internal alert list, there were no discrepancies. Alerts in JJIS matched the program's internal alerts. All reviewed internal and JJIS alerts were downgraded or discontinued by a licensed medical staff, the director of case management, and/or the licensed mental health staff. An interview with five staff stated they are notified of youth alerts by the alert board, medical and mental health staff, the program logbook, and during shift briefings. An interview with the facility administrator stated medical staff present information at all staff meetings when information needs to be reviewed or new information needs to be covered. Any direct-care, supervisory, or clinical staff may place a youth on alert status if the youth meets the criteria. All alerts are reviewed during the daily morning management meeting for any changes. The medical department maintains the daily tracker and alerts are added in the JJIS system when needed by each department.

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

The program has a written policy and procedures ensuring the management of all Individual Healthcare Records, mental health and substance abuse records, and case management records for each youth. A review of five youth healthcare, mental health and substance abuse, and case management records found each was marked confidential and documented the youth's name, Department identification (DJJID) number, the youth's date of birth, county of youth's residence, date of admission, and committing offense. All Individual Healthcare Records, mental health and substance abuse records, and case management records were secured in a designated locked room/office, which was not accessible to youth.

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

The program has a written policy and procedures ensuring youth have the opportunity to provide their input. The program has a youth advisory board in place, which allows youth to express their needs and themselves. Youth are allowed to discuss issues and ideas on behalf of themselves and other youth in their dormitories. A review of the program's advisory board binder documentation showed sign-in sheets and meeting minutes with the topics which were discussed for the past six months. The meetings were conducted at least once a month with the program's shift supervisor and available staff. The facility administrator (FA) stated the program also uses the youth grievance forms for addressing youth complaints. Youth participate in monthly student advisory board meetings, and also complete monthly surveys which are reviewed. Additionally, youth and staff participate in a daily meeting which allow the youth to give praises, discuss issues, concerns, and needed apologies. The FA also added, as youth provide input into the program operations, we discuss as a team and as long as we are in guidelines of our policies and procedures, we develop a plan to implement the youth's input. Five youth were interviewed regarding their ability to provide input at the program. All five youth stated the program has a process for allowing youth to provide input about what happens at the program.

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 a community advisory board, which serves all Department's residential programs located in Okeechobee County. The advisory boards were combined due to a limited amount of people living in this rural community and the number of boards and local representatives whom participate. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator (FA) mailing a letter, thirty days in advance of the scheduled meeting to increase attendance. Reviewed documentation for the past twelve months supported the program's community advisory board meets at least quarterly. The meeting minutes were documented with an agenda and sign-in sheets. The next quarterly meeting is scheduled for June 2020. The program maintains a list of thirty-eight community advisory board members consisting of representatives from local law enforcement officials, school board officials, the judiciary community, community partners, faith-based organizations, a mentoring agency, victim advocacy representatives, business community, and parents/guardians of former residents. Reviewed documentation supported the attendance of the advisory board members. An interview with the FA confirmed the community advisory board meetings are held quarterly, the time varies, and members are from local business/groups. The FA reported invitations are sent by mail, email and a telephone call for a reminder maybe conducted. The advisory board provides and receives feedback on how to improve services provided to our youth, along with systems successful with other programs.

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

The program maintains a written policy and procedures identifying service, employment recognition, and tuition reimbursement. The program conducts daily morning management meetings Monday through Friday, daily shift briefings, and monthly all staff meetings to discuss issues affecting the program's operation and to keep staff informed of important corporate information, and weekly meetings with the regional compliance manager. The program's daily morning management meetings follow a pre-set agenda and includes the discussion of Protective Action Response (PAR) incidents, calls to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), grievances, youth behaviors, admissions and discharges, and any upcoming events. The program administration conducts comprehensive quarterly youth and staff surveys. The results of the surveys are discussed in detail at the corporate office and subsequently, the results are reviewed and shared with staff during the all staff monthly meetings. The program has incentives for staff which include tuition reimbursement, employee appreciation, and staff celebrations. Five staff were interviewed regarding program planning. All five stated meetings are held monthly. Five staff stated meeting topics range from the drills, medical, education, operations, and policies. Four of the five staff stated they are briefed on annual reports and on youth and parent/guardian surveys. One of the five staff stated they are not briefed. Four of the five staff stated the communication in the program is good and one of the five stated it is very good. All five staff stated they are able to provide feedback and input into the program operations. An interview with the facility administrator (FA) stated the morale at the program has a lot to do with the program's changes in leadership. The changes were made due to the closing of other programs within the company. Once this was explained to staff, they understood and embraced the changes in a positive way. Staff are given awards on a monthly basis which include employee of the month, caught doing good, most improved staff, helping hand, above and beyond, and unsung heroes. The FA stated the program uses staff and youth surveys, outcome measurements of incident reports, grievances, CCC reports and the use of the positive performance system to develop an understanding in the culture of the program to ensure treatment services are provided. The FA stated the Department's Comprehensive Accountability Report (CAR) report is shared with staff during all-staff meetings. Additionally, management meetings are held during the weekdays, and briefings and debriefings are conducted on each shift daily to discuss all important information needing to be communicated timely.

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

The program has a written policy and procedures ensuring the evaluation of staff performance. The program conducts ninety-day performance evaluations for newly hired staff and annual evaluations for all staff completed during the fourth quarter October to December each year, which is a new process as of November 2019. A review of five staff performance evaluations documentation showed each were completed on time. All five staff performance evaluations were reviewed by the program's facility administrator (FA). The evaluations rated the staff's quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff's job-specific responsibilities. An interview with the FA reported each employee of the program shall be evaluated once annually, as well as the

completion of a ninety-day evaluation, after their introductory period. The FA reported the program strives to complete annual evaluations by the fourth quarter of each year.

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

The program has a written policy and procedures regarding recreation and leisure activities. A review of the program's contract indicated the contract requires a recreational therapist (RT) with a bachelor's-level degree in recreational therapy or a related field with at least one-year experience working with youth. A review of the program's recreational therapist's record confirmed the recreational therapist has met the required educational and work experience requirements for the contract. The RT maintained a master's-level degree in athletics administration. The program's contract indicated the RT is also required to have one-year related experience working with youth. The reviewed résumé indicated the RT had five years' experience working with youth. Documentation showed the program maintains a monthly calendar of indoor and outdoor recreation activities which consist of football, basketball, card games, and board games. Youth are provided at least one hour of activity daily. Documentation showed activities were planned to support social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. When the heat index is above the approved temperature, or when there is inclement weather, the youth are provided one hour of recreation time inside the program. A review of the program's logbooks found the program consistently documents recreation time. A review of five youth records documented recreational therapy activities are provided and are incorporated into goals on each youth's individualized treatment plan. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19 pandemic, this review was conducted off-site; therefore, observation of youth recreational activities was not possible. Four of the five interviewed youth stated they receive at least one hour of physical and leisure activities each day. The one remaining youth stated they do not receive at least one hour of activities, because some shifts do not want to go outside, therefore, the youth do not have recreation every day. All five youth stated they are provided with varying degrees of mental and physical exertion throughout the day. Five staff were interviewed, and each staff stated youth receive one hour of recreation and leisure activities daily, which consist of volleyball, kickball, jump rope, yoga, and ping pong.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures addressing initial contact to parents/guardians and the committing court upon each youth's admission. Five reviewed case management records found each parent/guardian or the Department of Children and Families (DCF) worker, if applicable, was notified by telephone and in writing of the youth's admission within twenty-four hours of arrival to the program. Each of the five reviewed records confirmed youth were provided a telephone call to the parent/guardian or DCF worker at the time of admission. Additionally, each record documented an admission letter and an input questionnaire sent to the parent/guardian or DCF worker within forty-eight hours of each youth's admission. One interviewed youth reported during orientation process a telephone call is given to call youth's parent/guardian. Five case management records were reviewed, and each record documented the program's practice of sending a notification letter to the committing court(s) and to each assigned juvenile probation officer within five working days of each youth's admission.

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

The program has a policy and procedures addressing youth orientation. A review of five case management records supported each youth was provided an orientation within twenty-four hours of admission. Each reviewed record documented a signed checklist and signed receipt of youth handbook acknowledging the youth received an orientation packet and information on the, program's daily schedule, expectations and youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, behavioral management system, zero-tolerance policy regarding sexual misconduct, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) number, contraband, dress code and hygiene procedures, community access, visitation, mail, the use of the telephone, grievance procedures, emergency procedures, and assigned living units. The orientation checklist documented each youth reviewed a map of the program and designated areas which are not accessible to youth. Five interviewed youth reported their orientation included program rules, procedures, schedules and all other pertinent information. Each interviewed youth confirmed the orientation was conducted on the day they were admitted to the program.

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Five case management records were reviewed, one record was applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. The reviewed record contained the required signed consent of the youth, who was eighteen years old at the time of admission to the program. The program had no other youth eighteen or older who met the required three records requirement.

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

The program has a policy and procures addressing the classification process. The policy outlines the effective delivery of treatment services based on determination of each youth's individual needs and risk factors. The program's policy addresses when reassessments are warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and behavioral concerns. A review of five case management records found each youth had a completed admission classification completed for the purposes of assigning youth to a living/sleeping area and staff advisor. Each reviewed admission classification form was completed on the date of admission for each youth. During an interview, the program's facility administrator reported all classification factors are taken into consideration when deciding where to place the youth. A classification meeting is conducted which includes the designated mental health authority, assistant facility administrator, medical, living unit designee, case manager, youth, parent/guardian, and juvenile probation officer. Case management assigns group assignments which will best meet the youth's needs. Five admission classification forms were reviewed, and none were applicable for having an alert entered into the Department's Juvenile Justice Information System (JJIS) at time of admission. The program has an internal alert system. During an interview, the program's staff reported all program alerts are maintained and updated as needed on an alert board which is accessible to all staff, there is also a daily debriefing. The program's policy and procedures addressing reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other actives which involve the use of tools, and a youth's participation in any off-campus activities. Each reviewed record documented the completion of a reassessment which included review of the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. Documentation confirmed reassessment results were discussed at

treatment team meetings. It is the program's practice to complete a reassessment each month for each youth and documentation supported this was completed in each of the five youth case management records reviewed.

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

The program has a policy and procedures addressing gang identification which includes notification to law enforcement. The program assesses each youth at admission for suspected gang involvement. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS). Five case management records were reviewed, and one was applicable for gang involvement or association. The program did not have an additional youth applicable. Documentation validated the program notified the local law enforcement's gang liaison by electronic mail of the youth admitted to the program who was identified as a gang associate or gang member. The gang information is also shared with the educational staff at the program, the youth's juvenile probation officer, and the post-residential services counselor, when applicable.

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

The program has a policy and procedures addressing gang prevention and intervention activities. Five youth case management records were reviewed for participation in gang prevention and intervention activities and one was applicable. The program indicated they did not have an additional youth applicable. Documentation supported the applicable youth was documented as associated with or a member of a gang and had a performance plan which included gang prevention and intervention strategies. The program utilizes the Gang Resistance and Drug Education (GRADE) curriculum. The GRADE curriculum includes eight lessons and gang agreement for after discharge. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities.

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

The program maintains a written policy and procedures to address assessments. A review of five case management records found each contained a Residential Assessment for Youth

(RAY) completed within thirty days of the youth's admission to the program. Each RAY was completed in the Department's Juvenile Justice Information System (JJIS) and was used to identify criminogenic risk and protective factors and prioritized the youth's criminogenic needs. A copy of the RAY assessment overview report was maintained in each youth's case management record. Five reviewed case management records found each was applicable for a RAY Reassessment. Documentation supported two of the five RAY Reassessments were completed within ninety-days of the initial RAY Assessment. One RAY Reassessment was one day late. Two RAY Reassessments were two days late. Each RAY Reassessment was maintained in the youth's case management record. There were other updates or reassessments deemed necessary by the intervention and treatment team.

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

The program maintains a written policy and procedures regarding the completion of Youth Needs Assessment Summary (YNAS). Five case management records were reviewed, and each contained a YNAS completed within thirty days of the youth's admission to the program. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in each youth's case management record.

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

The program has a policy and procedures addressing performance plan development. The treatment team, including the youth, meet and develop the individualized performance plan (IPP), based on the findings of the initial assessment of each youth within thirty days of the youth's admission. Five youth case management records were reviewed, and each documented the IPP was developed within thirty days of the youth's admission. The treatment team members who participated in the development of the IPP for each youth included the case management representative, youth, administration representative, living unit representative, mental health treatment staff, and education staff and was verified by each member's signature and date on the IPP. One youth case management record indicated no signature on the IPP for education since school was not in session due to holiday break. The reviewed performance plans for each youth was developed after the initial assessment. The IPP is a document developed by the treatment team, including the youth, which stipulates goals the youth must

achieve prior to release from the program. The goals are measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include delinquency interventions, targeted court-ordered sanctions, and identifies transition activities. Five youth IPPs were reviewed and each included individualized goals based on prioritization needs. All goals included specific interventions which were measurable, included youth and staff responsibilities to complete the goals, and included projected target dates for completion. All five reviewed records indicated each youth was enrolled in education and career programing. Each of the five reviewed IPPs addressed the top three criminogenic needs of the youth. Five youth case management records were reviewed for documentation of transition activities and each applicable IPP documented transition activities. Five interviewed youth reflected each youth was familiar with their IPP goals and explained the treatment process. Each interviewed youth confirmed they received a copy of their initial IPP. The IPPs are signed by each youth and treatment team leader, as well as all parties with significant responsibility in goal completion. Within ten working days of completion of the IPP, the program sends a transmittal letter, and a copy of the IPP to the committing court, each youth's juvenile probation officer (JPO), and each parent/guardian. Five youth case management records were reviewed, and each indicated a transmittal letter and a copy of the performance plan was sent within ten working days to the committing judge, JPO, parent/guardian, and Department of Children and Families (DCF) worker, when applicable. All five IPPs were signed by the youth, treatment team leader, and all significate parties responsible for the goal completion. The program mailed all five IPPs to the parents/guardians or DCF worker to sign and return to the program. Reviewed documentation indicated one of the signature pages were returned to the program.

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

The program has a policy and procedures addressing performance plan revisions. Five youth case management records were reviewed, and each was applicable for a revision to the individual performance plan (IPP). Documentation supported each IPP was revised based on the Residential Assessment for Youth (RAY) Reassessment results, newly acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and completing a goal. Documentation found IPPs were updated with recommendations from the treatment team. Three closed youth case management records were reviewed, and documentation found each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

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

The program has a policy and procedures addressing performance plan summaries and transmittals. Five case management records were reviewed, and each was applicable for requiring a performance summary. Documentation validated each performance summary was completed every ninety-days following the signing of the initial performance plan. All performance summaries included the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peer and staff, the status of each goal, and significant positive or negative events. Each reviewed performance summary was signed by each youth and included comments, and each original performance summary was filed in the youth's case management record. Each of the five reviewed case management records contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and the parent/guardian or Department of Children and Families worker, when applicable. Three closed youth case management records were reviewed for completion of a release summary. Documentation supported a release summary was completed and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least ninety-days prior to each youth's planned release. Each of the three applicable closed case management records contained a judicial electronic mail stating the judge will neither approve or deny the PRN and is aware of the Department's policy. Three applicable closed case management records contained signed PRNs in each youth's record.

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

The program maintains a written policy and procedures to address the encouragement of parent/guardian involvement in case management services. Five case management records were reviewed for documentation of parental involvement. Four records found documentation the parent/guardian was encouraged to participate in the assessment, performance plan development, progress reviews, formal treatment team meeting, and transition planning for their youth. One youth was under the supervision of the Department of Children and Families (DCF) and documentation reflected the DCF worker was invited to participate. Documentation in the five reviewed records indicated the parent/guardian either participated by telephone or had the opportunity to give verbal/written input on the program's Parent/Guardian Input form.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19 pandemic, this review was conducted off-site; therefore, observation of the center's treatment team meeting was not possible. Furthermore, there were no treatment team meetings conducted during the annual compliance review week. Parents/guardians are invited to participate in the youth's formal treatment team meetings. Documentation in the five reviewed records indicated the program reach out to parents/guardians to facilitate involvement by mailing an admission letter within forty-eight hours of admission which includes the dates of upcoming treatment team meetings. An interview was conducted with the facility administrator to determine how the program encourages parental involvement in the case management processes. It was reported parents/guardians are invited to participate in youth treatment team meetings, weekend visits, and family activities. Five interviewed youth each confirmed their parents/guardians are involved in their case management services.

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 maintains a written policy and procedures to address treatment team and its members. A review of five youth case management records found each youth participated in an initial treatment team meeting. Treatment team members included the case manager who serves as the treatment team leader, the transition service manager who also serves as the gang liaison, youth, administration representative, living unit representative, treatment staff, educational staff, Department of Children and Families representative when applicable juvenile probation officer (JPO), parent/guardian, medical staff, and mental health/substance abuse staff. There were no applicable youth receiving services form the Agency for Persons with Disabilities (APD). All required staff provided information to the treatment team meetings verbally when required, as well as written input when not in attendance. Reviewed documentation confirmed the youth's JPO, parent/guardian, and any other pertinent parties were invited and were encouraged to participate through advance notification to participate in treatment team meetings and if participation cannot be arranged, let them have the opportunity to provide input verbal/written.

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.	

The program maintains a written policy and procedures to ensure treatment teams reference or incorporate each youth's treatment plan into the youth's performance plan. Five youth case management records were reviewed. Each had separate academic and mental health treatment plans which were incorporated into the performance plan for all five youth. One youth was under the supervision of the Department for Children and Families; however, there were no behavior support plan. In addition, Agency for Persons with Disabilities (APD) behavior support plans were not applicable for the five youth records reviewed or any youth in the program.

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

The program maintains a written policy and procedures pertaining to formal and informal treatment team meeting. Each youth participates in a formal treatment team meeting at least every thirty-days. A review of five youth case management records documented each was applicable for receiving a treatment team meeting. A review of each youth's formal performance plan included the youth's name, date of review, any comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, and progress on performance plan goals. The formal review also included, positive and negative behaviors, and behaviors resulting in physical interventions. Each youth is provided an opportunity to demonstrate skills acquired in the program, their treatment progress, and a review of the Residential Assessment for Youth (RAY) Reassessment results. A review of each youth's informal performance reviews is documented and conducted biweekly in the case records which includes the youth's name, date of review, any comments from treatment team members, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, and behaviors resulting in physical interventions. Each youth is provided an opportunity to demonstrate skills acquired in the program, their treatment progress, and the RAY Reassessment results were also reviewed. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19 pandemic, this review was conducted off-site; therefore, observation of the center's treatment team meeting was not possible. There were no treatment team meetings conducted during the annual compliance review week. A review of the Department's Juvenile Justice Information System (JJIS) also reflected the anticipated release date and documentation updates every ninety days and at the sixty-day transition conference. Five interviewed youth indicated they are provided the opportunity during treatment team meetings to demonstrate any skills learned in the program. Five interviewed youth each confirmed the staff review their performance to include progress on performance plan goal, positive and negative behavior, and treatment progress.

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

The program maintains a written policy and procedures relating to career education. A review of three closed youth case management records indicated employability skills goals were added to each youth's education plan. All three reviewed closed records included a sample employment application, a résumé summarizing education, work experience, and/or career training. All three reviewed closed records also contained appropriate documents essential to obtain employment, documentation to validate the youth and parent/guardian, when applicable, were aware of the youth's vocational plan for the youth. The skills are designed to be both age and intellect appropriate. The education program is appropriate for the educational abilities and goals of the youth in the program. The career education program is appropriate for the length of stay and custody characteristic of the youth in the program. The program provides the vocational

competency development programing at the following levels. Residential juvenile justice education program with a contracted minimum length of stay of nine months shall provide Career and Professional Education (CAPE) courses leading to pre-apprentice certifications and industry certification. Each youth closed case management record documented the program education, career, and professional. The program provides Type 2 which include Type 1 program content and an orientation to the broad scope of career choices based upon personal abilities, and aptitudes, and interest. Exploring and gaining knowledge of occupation option and the level of effort required to achieve them are essential prerequisites to skill training. Also, the program includes content and the competencies, or the prerequisites needed for entry into specific provide occupation. Each youth is also provided career education programming includes communication, interpersonal, and decision-making skills. An interview was conducted with the program director to determine what career education services are offered to youth in the program. It was reported youth are provided employability skills, carpentry, hospitality, and tourism. Virtual job shadow where the youth explore career options and complete a variety of other career related assessments. An interview was conducted with the lead teacher to determine what career education services and assessments are offered to youth in the program. It was reported all youth complete the O'Net Interest Profile after they enter the program. The lead teacher indicated they are a type 2 program offering some type 3 programing. The program provides CAPE services in the areas of hospitality and tourism and building construction technologies through Home Builders Institute (HBI). All high school youth are enrolled in one or more vocational courses leading to an Occupational Completion Point (OCP). Employability skills are the primary focus. The youth are afforded the opportunity to complete the SafeStaff Food Handler program. The lead teacher provided documentation of ten culinary certificates awarded to youth as part of the hospitality and tourism class. In April 2020, youth participated in an employability skills course provided for free by Careersafe. This was documented in each applicable youth's student cumulative file.

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

The program operates an educational program in partnership with the Okeechobee County School District on a year-round basis. The youth are required to participate in educational and vocational career-related instruction for a minimum of 250 days distribute over twelve months with a minimum of twenty-five hours of weekly instruction. Also, within this schedule are ten days set aside for teacher planning and professional development. A review of three closed youth case management records indicated the youth received credits for the educational and training experience. A review of the activity schedule and logbook documentation supported there is minimal interference of educational instruction. Five interviewed youth stated there was minimal disruptions during school instruction. An interview with the program's lead educator indicated the educational instruction schedule is from Monday through Friday starting at 7:55 a.m. to 1.55 p.m. with a lunch break from 11:03 a.m. to 12:03 p.m

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

The program maintains a written policy and procedures outlining transition, release and discharge. A review of three closed youth records confirmed each contained a detailed transition plan. Each plan was developed based upon the youth's post-release goals, beginning at the youth's admission to the program as required. Each reviewed plan documented the key personnel related to transition activities included the youth, parent/guardian, education staff, assigned juvenile probation officer, and personnel from the post-release school district. Each transition plan was developed with the youth, program, education staff, and aftercare staff with specific education plans for continuation of education. There were no applicable youth who had a plan for employment in place of continued education. Each reviewed closed record had an education transition plan which included services and interventions based on the youth's assessed educational needs and post-released education plans. All three reviewed records indicated each youth completed a sample employment application, a résumé summarizing education, work experience, career training, and a valid Florida identification card. In all three reviewed youth records, there was documentation indicating the location and business hours of a local Career Source Center, and appropriate documents essential to obtaining employment upon leaving the program. All three closed records documented each youth's case manager and parent /guardian were made aware of the plan, documents, and post-release discharge plans.

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

The program has a written policy and procedures addressing transition planning, conferences, and Community Re-entry Team (CRT) meetings. Three closed youth records were reviewed, and each indicated the youth had a transition conference held at least sixty days prior to the targeted release date. Documentation indicated all treatment team members included the youth, treatment team leader, facility administrator, and other team members participated in each transition conference meeting. All three reviewed youth records documented the youth's juvenile probation officer (JPO), parent/guardian, education staff, and any other pertinent parties participated in the transition conference. During the transition conference, participants reviewed

the transition activities outlined on each youth's performance plan. There were no applicable revisions to the performance plans reviewed. Documentation supported target completion dates and persons responsible for completion were identified at each completed conference. The treatment team leader obtained an attendance log with the date and signatures, representing each participants acknowledgement of the transition goals and accountability for completion. A copy of the plan was sent with a request for return with signature to the youth's parent/guardian who was not in attendance. Supporting documentation indicated the case manager electronically transmitted a copy of the plan to the assigned JPO, and the return JPO e-mail acknowledgement was printed and filed with the plan in the youth record. Three closed youth records were reviewed for documentation of CRT and there was evidence for participation in the meeting. Each case management record documented a CRT meeting was conducted prior to the youth's release. The youth and case manager participated by telephone.

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

The program maintains a policy and procedures ensuring the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program. The program assembles an exit portfolio for each youth to assist the youth upon release back into the community. A review of three closed case management records found the exit portfolios were discussed and signed by each youth during the transition conference. Reviewed documentation in all three close records found each exit portfolio included the youth's State of Florida identification card, copy of the youth's transition plan, a calendar with all dates, time, and locations of upcoming community appointments, Social Security card, birth certificate, all educational documentation, school transcripts, résumé, and a completed sample employment application. All three exit portfolios documented they were discussed and signed by each youth at the exit conference. Documentation indicated upon release from the program each youth was provided a copy of their exit portfolio and the information was forwarded to the youth's juvenile probation officer (JPO). In addition, each youth had a Plan for Success which contained identified goals, contact person, location, and appointment dates. A review of the provider's contract validated met all requirements outlined.

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

The program maintains a written policy and procedures pertaining to exit conference. Reviewed documentation found each exit conference was conducted after the program notify the juvenile probation officer of the release. Three closed case management records were reviewed for completion of the exit conference at least fourteen days prior to each youth's release. The program staff noted the date, signatures, and telephone participants on the signature line, when applicable. The date of admission and the date of termination documented in the youth record correlated with the dates entered in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation supported the status of transition activities was discussed in each youth's exit conference.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the director of clinical services and the program's designated mental health clinician authority (DMHCA). The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:00 p.m. and is on-call and available to provide emergency consultation twenty-four hours a day, seven days a week. The current DMHCA was promoted into the position on August 12, 2019. The previous DMHCA left the program on July 1, 2019 and moved into the DMCHA position in another program on the Okeechobee campus. During the period of July 1, 2019 through August 12, 2019, TrueCore's regional clinical director was serving as the interim DMHCA. An interview with the current DMHCA indicated they are responsible for providing oversight to the clinical department and ensure the Positive Performance System is consistently applied. In addition, the DMHCA ensures group sign-in sheets are current and the clinical team has the materials needed to facilitate groups, individual therapy, and family sessions. The DMHCA ensures youth receive group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required Mental Health Overlay Services (MHOS), Substance Abuse Treatment Overlay Services (SAOS), and supplemental specialty services for dual diagnosed youth ensuring each youth's clinical needs are addressed. The DMHCA indicated they provide individual, group, and family therapy. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and also participates in bi-weekly meetings with the psychiatrist and treatment team members to discuss each youth receiving services. A review of the DMHCA's position description validates the services provided and serving as the program's mental health and substance abuse authority. The DMHCA is responsible for ensuring the proper completion of documentation and integration of the mental health delivery system and for directing the program's psychological and treatment services to include technical and administrative duties, testing, therapeutic activities, research, and participation in the overall programming and administration.

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

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

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

The program has three non-licensed therapist positions. At the time of the annual compliance review the program had one vacancy. The therapist position became vacant on August 12, 2019 when the therapist became licensed in the State of Florida and was promoted into the designated mental health clinician authority (DMHCA) position. The non-licensed therapist position was vacant until April 27, 2020 and the new therapist was in training at the time of the annual compliance review. A review of the two current therapist's credentials found each maintained a master's-level degree in social work and mental health counseling, respectively. Since the program is required to provide on-site clinical services seven days a week, the licensed mental health counselor, who also serves as the director of clinical services and designated mental health clinician authority (DMHCA), works on Sundays to ensure adequate coverage and Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS) are provided. The non-licensed therapists work under the direct supervision of the DMHCA. A review of the clinical supervision logs from December 2019 through May 2020 found the non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA each week. The reviewed documentation found the program utilized a clinical supervision log which included all required elements, as outlined in 63N-1. The reviewed forms reflected a review of the clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations. An interview with the DMHCA indicated they provide weekly supervision for all clinical staff ensuring program issues are addressed. The DMHCA indicated clinical staff communicate daily with each other and assist each other ensuring clinical services are provided as required. Training records for the two non-licensed therapists validated each completed the required twenty-hours and supervised experience in assessing suicide risk mental health crisis intervention and emergency mental health services. The training included the administration of five Assessments of Suicide Risk or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk. One completed the training in March 2018 and the other completed the training in October 2019. The program is licensed through the Department of Children and Families (DCF), under Chapter 397, F.S. for outpatient treatment with an expiration date of April 7, 2021. Each non-licensed therapist works under the direct supervision of the licensed DMHCA when providing mental health and substance abuse services.

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

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

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. In addition, the program maintains a written comprehensive plan for mental health and substance abuse services ensuring all youth receive clinical services. The program's practice is to complete a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation regardless of identified needs for each new admission. A review of five youth mental health and substance abuse records found each youth was assessed utilizing the Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Adolescent Psychopathology Scale – Short Form (APS-SF), Trauma Symptom Checklist for

Children (TSCC), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), American Society of Addiction Medicine (ASAM), and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). The results of the assessments are utilized for the completion of the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. Reviewed documentation supported all five Bio-Psychosocial Evaluations were completed within thirty calendar days of the youth's admission and the program practice is to complete a new evaluation annually. Four of the five reviewed evaluations were completed by non-licensed, master's-level therapists, and one was completed by the licensed mental health counselor (LMHC). The LMHC documented their review within ten days of completion, as required. All reviewed Bio-Psychosocial Evaluations contained all required elements as outlined in Florida Administrative Code.

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

The program maintains a written policy and procedures ensuring all mental health and substance abuse treatment services are available to each youth who is determined to meet clinical criteria to receive services. Mental health and substance abuse treatment is steered by an individualized treatment plan addressing all of the youth's needs in accordance with Florida Administrative Code. A review of five youth mental health and substance abuse records and five case management records found each youth was assigned to a multidisciplinary treatment team upon admission into the program. Each reviewed mental health and substance abuse record identified treatment team members to include the youth, program administration, residential living unit representative, therapist, case manager, and parent/guardian, when applicable. A review of five youth case management records validated the education, vocation, and medical staff were also identified as treatment team members. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each youth record had a signed Youth Consent for Substance Abuse Treatment, a signed Youth Consent for Release of Substance Abuse Treatment Records form, and a Youth Consent for Substance Abuse Treatment in a Department Substance Abuse Overlay Services (SAOS) or Integrated Substance Abuse Treatment Program form. Weekly progress notes were documented in the format outlined in Florida Administrative Code and the Department's Counseling/Therapy Progress Note form. Each youth was determined to be in need of individual, daily group, and monthly family therapy. Reviewed documentation supported the program provided groups to include Voices – A Program of Self-Discovery and Empowerment for Girls, Girl Matters Savvy Sister, Skillstreaming the Adolescent, Living in Balance, Teen Relationship, Criminal Conduct and Substance Abuse Treatment for Adolescents, Seeking Safety – A Treatment for Post-Traumatic Stress Disorder and Substance Abuse, and Anger Management for Teens. The program was also providing The Passport Program which ended on June 9, 2019, and The Anxiety Workbook for Teens which ended on May 6, 2019. Reviewed youth records supported each youth received an initial psychiatric evaluation and three youth were determined to be in need of psychiatric medication management. All five youth were determined needing mental health treatment and four of the five youth were determined needing substance abuse treatment. All five reviewed youth records determined each youth required mental health and/or

substance abuse treatment and found goals outlined on the individualized mental health and substance abuse treatment plan. Each youth received the services as outlined. A review of treatment team documentation validated the meetings were held, as required, and the treatment team members were in attendance. There was no treatment team conducted during the annual compliance review week; therefore, the team could not participate by telephone. The program is licensed through the Department of Children and Families (DCF), under Chapter 397, F.S. for outpatient treatment with an expiration date of April 7, 2021. According to Florida Administrative Code, mental health groups are limited to ten or fewer youth and substance abuse group are limited to fifteen or fewer. Reviewed group documentation and attendance logs found all groups were ten or less. The DMHCA indicated, as the director of clinical services they are responsible for coordinating and implementing all aspects of mental health and substance abuse services in the program. The DMHCA oversees the monitoring and tracking of clinical service delivery and documentation, including daily group therapy, individual therapy, family therapy, and weekly progress note documentation. According to the DMHCA, they provide individual, group, and family therapy, assist in facilitating mental health groups when needed, and conduct fidelity monitoring. The DMHCA is responsible for ensuring communication with the clinical staff occurs daily. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this annual compliance review was conducted off-site; therefore, observation of a group could not be conducted in person. Five youth were interviewed and each reported participating in clinical groups. Five staff were interviewed regarding who facilitates mental health and substance abuse clinical groups and all five indicated groups are facilitated by the program's clinical staff.

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

The program maintains a written policy and procedures outlining responsibilities and required elements of mental health and substance abuse treatment services and planning. All mental health and substance abuse treatment services provided at the program are provided by a licensed therapist or a non-licensed master's-level therapist working under the direct supervision of the licensed clinician. Each youth released from the 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. Five reviewed mental health and substance abuse records supported the multidisciplinary treatment team developed an initial treatment plan on each youth's date of admission to the program. Each initial plan was signed by treatment team members participating in the development of the plan. The initial treatment plans were documented on a form containing all required elements, as outlined in Florida Administrative Code 63N-1, and on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed plan contained mental health and substance abuse planning for the youth. One of the five reviewed youth records was applicable for admission on prescribed psychotropic medications. All five applicable youth reviewed treatment plans

documented each youth was referred for psychiatric evaluation. Reviewed documentation supported all five youth's individualized treatment plans were completed within thirty days of admission and documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form which contained all elements outlined in Florida Administrative Code 63N-1. Each reviewed plan documented the designated mental health clinician authority (DMHCA) reviewed and signed the plan within ten days of completion, as required. Each reviewed plan contained the required signatures of all treatment team members who participated in the development of the plan with the exception of one whereby the living unit representative did not sign the plan; however, documentation supported the living unit representative submitted information to the multi-disciplinary treatment team to utilize in the development of the treatment plan. Three youth were currently on prescribed psychotropic medications, one admitted with medications and two subsequent to admission were prescribed psychotropic medications, and the individualized treatment plan included psychiatric services, including psychotropic medication and frequency of monitoring. Each reviewed plan documented the prescribed services the youth receives daily, weekly, and monthly. All five reviewed youth records required monthly treatment team reviews, and each was completed, as required. Reviewed group schedules, attendance sheets, weekly progress notes, and an interview with the DMHCA indicated groups were scheduled and conducted as required. Three closed records were reviewed, and each contained the appropriate discharge plan documentation. None of the applicable discharges were applicable for youth released on suicide precautions/suicide alert. All three records applicable for an exit conference documented the juvenile probation officer (JPO) and parent/guardian participated in a discussion regarding the discharge plan. All three reviewed records documented a copy of the discharge plan was provided to the parent/guardian and assigned JPO. Each reviewed discharge plan contained clear treatment recommendations for continuing mental health and applicable substance abuse services.

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

The Okeechobee Girls Academy is a non-secure program serving female youth. A review of the program's contract and clinical program description indicated mental health and substance abuse treatment services are available through the provision of Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The program is licensed through the Department of Children and Families (DCF), under Chapter 397, F.S. for outpatient treatment with an expiration date of April 7, 2021. The program provides SAOS by utilizing Living in Balance, Seeking Safety – A Treatment for Post-Traumatic Stress Disorder and Substance Abuse, Pathways to Self-Discovery and Change, Criminal Conduct and Substance Abuse Treatment for Adolescents, and Towards No Drugs. The program provides MHOS by utilizing Voices – A Program of Self-Discovery and Empowerment for Girls, Skillstreaming the Adolescent, The Teen Relationship, and Anger Management for Substance Abuse and Mental Health, Anxiety Workbook for Teens. The program provides Thinking for Change and Impact of Crime as the criminogenic and restorative justice curriculums. In addition, Girl Matters SAVVY Sisters is offered as the program's gender-specific programming. The program offers group counseling seven days a week. The program was also providing The Passport Program which ended on June 9, 2019, and The Anxiety Workbook for Teens which ended on May 6, 2019. Individual therapy is provided to all youth at least monthly. A review of five youth mental health and substance abuse records indicated one youth was receiving individual therapy bi-weekly and four youth were receiving individual therapy monthly. Family therapy sessions are

scheduled at least monthly. The program's therapeutic services include psychosocial skills training, psycho-education, and supportive counseling tailored to each youth's identified needs. The psychiatrist is on-site bi-weekly and participates in a clinical meeting with the designated mental health clinician authority (DMHCA) and the non-licensed master's-level therapists to discuss each youth receiving services. The program maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services as needed. According to the DMHCA, no youth were referred to the psychologist since the last annual compliance review. At the time of the annual compliance review, the clinical department had one non-licensed therapist vacancy. The therapist position became vacant on August 12, 2019 when the therapist became licensed in the State of Florida and was promoted into the designated mental health clinician authority (DMHCA) position. The non-licensed therapist position was vacant until April 27, 2020 and the new therapist was in training at the time of the annual compliance review. There were fourteen youth in the program at the time of the annual compliance review with ten youth identified as MHOS and four youth identified as SAOS. The master's-level therapists were assigned a caseload of approximately seven youth each. Interviews completed with the DMHCA and facility administrator confirmed the program's participation in the specialized MHOS and SAOS clinical services. Five interviewed youth each indicated they are participating in specialized clinical therapy.

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

The program maintains a written policy and procedures ensuring the provision of psychiatric services to youth in the program. The program maintains an independent psychiatrist agreement with a State of Florida licensed medical doctor to provide psychiatric services. The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The psychiatrist holds certifications from the American Board of Psychiatry and Neurology for psychiatry and child and adolescent psychiatry. The program's psychiatric services include psychiatric evaluations, psychiatric consultation, medication management, and medical supportive counseling. As part of the initial admission screening assessment, each youth is assessed utilizing the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). An interview with the designated mental health clinician authority (DMHCA) indicated each youth is assessed by the psychiatrist within thirty days of admission. In addition, the DMHCA reported the program uses a referral form for youth who may be exhibiting signs or symptoms indicating an updated psychiatric evaluation is needed. The program's practice is to complete a psychiatric evaluation for all newly admitted youth. An interview with the psychiatrist validated they provide psychiatric evaluations on all youth admitted to the program within two weeks if the youth was admitted on prescribed psychotropic medications and within thirty days or sooner if the youth was not prescribed psychotropic medications. In addition, the psychiatrist indicated they provide medication management for all youth on psychotropic medications at least one time each month, if not more frequently. The psychiatrist indicated they review each youth healthcare and mental health and substance abuse record to include any prior psychological and psychiatric evaluations, medical reports, and laboratory results. Included in medication management is prescribing and adjusting medication regimens, as well as ordering lab tests,

electroencephalogram (EEG) tests, electrocardiogram (ECG) tests, medication levels, administering Abnormal Involuntary Movement Scale (AIMS), referring to specialists as deemed necessary depending on the particular medication each youth is prescribed and their specific medical and neurological condition. Five reviewed mental health and substance abuse records indicated each contained a psychiatric initial diagnostic interview completed within fourteen days of admission. Each diagnostic interview documented youth history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medications, explanation of medications, and frequency of medication monitoring. Each reviewed record documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN). Each contained a page number three of the CPPN, clearly documenting a treatment plan discussion with the youth and the parent/guardian. One reviewed mental health record indicated the youth was admitted to the program with prescribed psychiatric medication and two youth were subsequently prescribed psychiatric medication. Each of the three reviewed records documented an initial diagnostic psychiatric interview included all required elements and was completed within fourteen days of admission as required. The applicable youth records for psychotropic medications documented the justification for medications and frequency of monitoring on page three of the CPPN. Each documented parent/guardian consent was obtained and witnessed on the CPPN. The program does not utilize a psychiatric advanced practiced registered nurse (APRN). Documentation supported the psychiatrist was on call twenty-four hours a day, seven days a week, and reviewed logs supported they were on-site bi-weekly. The psychiatrist participates in bi-weekly meetings with the program's clinical staff. An interview with the psychiatrist validated this practice indicating they work closely with the treatment team regarding each youth progress and treatment recommendations. As part of the meeting, nursing staff are also participating in order to update the psychiatrist on each applicable youth's potential medical issues and side effects. The psychiatrist indicated they contact each parent/guardian when a psychotropic medication is considered and obtains appropriate consent. The program does not have standing orders or pro re nata (PRN) orders for psychiatric medications. A review of the three applicable youth records indicated medication management was conducted for each youth at least every thirty days or sooner, as required.

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

The program maintains a comprehensive plan for mental health and substance abuse (MHSA) services and a suicide prevention plan with detailed procedures. The suicide prevention plan was updated and approved by the designated mental health clinician authority (DMHCA) on January 29, 2019. and then by the new DMHCA on May 4, 2020. The program's written plan included all required elements, as outlined in Florida Administrative Code. The plan outlined the identification and assessment of youth at risk of suicide through the screening or alert process and any time subsequently, as well as suicide precautions and the levels of supervision. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and to recognize verbal and behavioral cues. The plan included the referral process, communication, notification, documentation, immediate staff response, and review process. An interview with the facility administrator (FA) validated the program conducts monthly mock drills for staff which include emergency response to suicide or self-inflicted injury and also discusses emergency response during the monthly all-staff meeting.

In addition, suicide prevention training is conducted for all pre-service staff and then annually for all in-service staff.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a suicide prevention plan to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. All youth admitted into the program are screened for suicide risk factors as part of the initial intake and admission classification meeting process. The clinical therapists' complete screenings immediately upon intake and ensure the constant supervision of the youth throughout the intake process. A review of five youth mental health and substance abuse records validated each youth was screened for suicide risk utilizing the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR), regardless of the MAYSI-2 results. Two ASRs were completed by the licensed mental health counselor and three were completed by the master's-level non-licensed therapist. A review of both non-licensed master's-level therapist's staff training records validated each therapist completed the required twenty hours of ASR training and five supervised assessments under the direct supervision and within the physical presence of a licensed clinician. All assessments documented a conference with the licensed mental health professional and the program director or designee prior to lowering the supervision level, as required. None of the five reviewed ASRs were identified with an elevated risk of suicide. An interview with the designated mental health clinician authority (DMHCA) indicated the program had two youth placed on precautionary observation (PO) in the last twelve months with one youth placed on PO twice. The program provided the three PO examples for review. Both applicable youth were placed on precautionary observation (PO) due to staff observations. The juvenile probation officer and parent/guardian notification were documented as required. A review of the Department's Juvenile Justice Information System (JJIS) validated suicide risk alerts were initiated and removed, as required. Suicide Precaution Observation Logs were completed for each youth while on PO. Supervision was documented on each log to include mental health staff supportive services. Reviewed documentation supported each applicable youth received a Follow-Up ASR. Discontinuation of Close Supervision was documented in accordance with the program's suicide prevention plan. The program does not utilize secure observation as outlined in policy and interviews with staff. The program maintains one complete suicide response kit located in the administration building in the shift supervisor's office. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observation of the program's suicide response kit could not be observed. Five interviewed staff indicated the suicide response kit is located in the supervisor's office. One staff indicated a knife-for-life is also located in the medical clinic.

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

The program maintains a written comprehensive plan for mental health and substance abuse services detailing suicide prevention procedures. The suicide prevention plan establishes a method in which suicide prevention services shall be provided to all youth. Two applicable youth mental health records were reviewed for youth with elevated suicide risks and placed on Precaution Observation (PO) for a total of three separate events. All three applicable Suicide Precaution Observation Logs were documented on Department's Mental Health and Substance Abuse form and contained all applicable elements. Each reviewed Suicide Precaution Observation Log was documented in real time and did not exceed thirty-minute intervals. There were no applicable youth with warning signs documented. Each reviewed log documented the safe housing requirements and was reviewed and signed by the shift supervisor and by the mental health clinical staff.

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

The program maintains a comprehensive mental health and substance abuse plan outlining all staff will receive intensive training on suicide prevention. The training consists of a thorough review of the suicide prevention plan and includes detention techniques, behavioral cues, and recommended responses. During pre-service training, staff are provided a module on mental health and adolescent behavior, and within the module, the typical behaviors of youth with mental health needs, as well as the strategies for working with the youth, are outlined. Staff are provided with an overview of recognizing signs and symptoms of emotional disturbance and mental health illness in children and adolescents. Lectures and practical application are utilized to address suicide precautions, levels of supervision, crisis response, and documentation. Training includes signs, symptoms, and stages of suicide. Six hours of suicide precautions and prevention is provided as part of the annual in-service staff training. Mock drills in response to suicide attempt and/or serious self-injurious behaviors are conducted once a quarter on each shift. A review of five staff training records and two non-licensed mental health therapists found each staff completed two hours of suicide prevention training in the Department’s Learning Management System (SkillPro) and four hours of instructor-led training. The program has two shifts, A and B, which operate from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m., respectively. Reviewed mental health drills reflected clinical drills simulating a youth suicide attempt and/or self-harm were conducted on each shift approximately each month. Reviewed documentation supported direct-care staff participated in drills during the last twelve months. Documentation presented for review supported direct-care staff, including the maintenance staff, participated in a semi-annual suicide drill. Reviewed documentation supported the use of cardiopulmonary resuscitation (CPR) was conducted seven times on A-shift and eight times on B-shift in the last twelve months. Each reviewed drill documented the description of the mock incident, a synopsis of the response, any applicable deficiencies identified, and any applicable

corrective action required. Reviewed documentation supported mock drills which demonstrated life saving techniques such as CPR and use of the automatic external defibrillator (AED) were conducted at least two times each quarter. Participating staff signed the Facility Emergency Drill Log indicating their understanding and compliance with the procedures. An interview with the facility administrator indicated the program also discusses emergency response during the monthly all-staff meeting.

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 written comprehensive plan for crisis intervention services in order to respond to youth in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the program. The crisis intervention plan was updated and approved by the facility administrator on September 16, 2019, corporate office on July 24, 2019, and the designated mental health clinician authority (DMHCA) on May 4, 2020. The plan detailed crisis intervention procedures to include notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and the review process. Low level crisis intervention is typically provided by the program's direct-care staff and/or supervisor staff through interventions within the positive performance system (behavior management system). Youth demonstrating acute emotional, psychological distress, or behavioral issues are referred immediately to the mental health clinical staff for crisis intervention, assessment, and counseling. A youth can be placed on a mental health alert by direct-care staff and/or clinical staff when a youth is identified as having a mental disorder or acute emotional distress which may pose a safety/security risk. All mental health alerts are entered into the Department's Juvenile Justice Information System (JJIS) and documented on the program's alert communication board and in the program's logbook.

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

The program maintains a written comprehensive plan for crisis intervention services in order to respond to youth in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the program. The

program's policy and procedures ensure when a youth is in crisis, the program utilizes the Department's Crisis Assessment form completed by the clinical staff and approved by the licensed clinical staff. When a youth is determined to be in crisis, the youth is placed on Precautionary Observation and a Crisis Assessment is completed by mental health staff. The Crisis Assessment documents the reason for the Mental Status Examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, and treatment recommendations. In addition, the Crisis Assessment documented the recommendations for follow-up and/or further evaluation and documented the notification by telephone and time to the parent/guardian. A mental health alert is placed in the Department's Juvenile Justice Information System (JJIS) and is removed when the youth is no longer determined to be in crisis. A review of five youth mental health and substance abuse records found none were applicable for a Crisis Assessment. An interview with the designated mental health clinician authority (DMHCA) indicated the program had one applicable youth who required completion of a Crisis Assessment in the last twelve months. Reviewed documentation supported the Crisis Assessment was immediately completed by the trained master's-level non-licensed therapist on October 4, 2019 on the date the youth was determined to be in crisis, since this was an alleged Prison Rape Elimination Act (PREA) incident. The DMHCA documented their review on October 6, 2019. The youth was not determined to be in crisis and was placed on standard supervision. A review of the JJIS found the program placed the appropriate alert and removed the alert as required. The youth's parent/guardian was notified by telephone and written correspondence. The program had no youth applicable for an off-site Crisis Assessment during this review period.

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

The program maintains a written comprehensive emergency mental health and substance abuse services plan. The plan was updated and approved by the facility administrator on July 5, 2018 and by the designated mental health clinician authority (DMHCA) on January 29, 2019 and on May 4, 2020 by the new DMHCA. The emergency care plan included procedures for immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. In addition, the plan outlined documentation requirements and staff training requirements to include recognizing signs and symptoms of emotional disturbance and signs and symptoms of substance abuse and mental health illness. Staff training specific to emergency care needs is provided within each staff member's orientation and pre-service training and staff participate in mock training drills at least semi-annually. Mock drills are utilized to review procedures for emergency responses to include suicide attempts and serious self-inflicted injury situations. The emergency care plan is reviewed with each staff member to ensure staff are aware of emergency identification and responses necessary to ensure the safety of the youth. On-site training includes egress plans and the location of all safety equipment to include the suicide response kits, suicide rescue tools, first aid kits, and automated external defibrillator (AED). The program utilizes New Horizons of Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Raulerson Hospital in Okeechobee, Florida for Marchman Act.

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

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

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on September 4, 2019. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of May 31, 2021 and is an osteopathic physician with specialty training in family practice. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly, as required. In the event the DHA cannot be on-site, duties have been delegated to a medical doctor who holds a clear and active license in the State of Florida which expires on January 31, 2021 to act on behalf of the DHA. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical conditions. Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans as needed. Interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and reviews healthcare policies and procedures and nursing protocols. An interview with the DHA confirmed this practice. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2021 and the certificate of insurance expires July 31, 2020. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2022. The optometrist license expires February 28, 2021.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on January 14, 2020, and the facility administrator documented a review on January 22, 2020. The program maintains two full-time licensed practical nurses (LPN) and one part-time LPN. One LPN is the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by HSA. Reviewed training curricula and plan reflected a new nursing staff would

receive the required pre-service and orientation training to include on-the-job training. The program hired two new nursing staff since the last annual compliance review and reviewed documentation supported, they completed the require training. The program maintains a nursing protocol manual developed and approved by the DHA on February 25, 2020. Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures on various dates throughout the annual compliance review period. Treatment protocols were reviewed by the DHA on February 25, 2020 and remained effective without change to include admission standing orders, non-licensed medical and emergency protocol guide, body mass index protocol, and approved first aid kit content and designee.

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

The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent(s) who have legal custody or by the legal guardian and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. A review of five youth Individual Healthcare Records found three were applicable for a signed AET. Each of the three reviewed youth Individual Healthcare Records contained a copy of the signed AET and the word, “Copy” was clearly stamped on each. One youth was under the supervision of the Department of Children and Families where parental rights have been terminated and the healthcare record contained a signed Order of the Court authorizing treatment. One youth was eighteen years old upon admission to the program and the youth’s healthcare record contained the required signed consent. Each reviewed AET and/or Release of Information form or court order was filed in each youth’s healthcare record in the appropriate section. There were no original AETs reviewed. An interview with nursing staff indicated the licensed practical nurses review all admissions in the Department’s Juvenile Justice Information System (JJIS) and validates the AET. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth’s medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five reviewed Individual Healthcare Records supported three were applicable for parental notification. Reviewed documentation supported each parent/guardian was notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic

condition. Each of the three reviewed youth records required parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) and documentation supported parental notification was sent. One reviewed youth Individual Healthcare Record was applicable for off-site emergency care and reviewed documentation supported the parent/guardian was notified. Verbal parental/guardian consent is obtained as soon as possible after an order is written. Verbal consent is obtained for any over-the-counter medication which has not been previously approved. For new prescriptions, significant dosage change, or for discontinuing a medication, a parental notification is also completed. All attempts are made to verbally contact the parent/guardian prior to a youth leaving for the emergency room (ER). The parent/guardian is also contacted upon the youth's return with the results of the ER visit. Written notification is completed after the return from the ER. Nursing interviews indicated parental/guardian notifications are written and sent the same day as the event to include off-site appointments, new intake, seen on-site by the designated health authority, and/or any other pertinent medical event. Three of the five reviewed youth Individual Healthcare Records supported each youth was prescribed a psychotropic medication. Documentation supported the required parent/guardian consents were obtained for each youth. The reviewed Individual Healthcare Records documented a telephone consent conducted by the psychiatrist and witnessed by the nurse. The parents/guardians received a written follow-up of a copy of the Department's Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Copies of all correspondence were maintained in the applicable youth Individual Healthcare Records. There were no applicable youth requiring immunizations; however, policy and procedures outline the AET provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian shall be provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. When the parent/guardian does not consent to the vaccinations, the Parent Notification of Health-Related Care: Vaccination/Immunizations form is sent with the required VIS to obtain consent. There were no applicable reviewed Individual Healthcare Records of the parent/guardian not consenting due to religious reasons. Program practice is for the nursing staff to pull each youth's immunization record from the Florida Shots website within the first week of admission and have the designated health authority document a review of the record. This practice was confirmed by the nursing staff in an interview.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth Individual Healthcare Records supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). Reviewed Chronological Progress Notes documented consent and results of a pregnancy screening for each of the five youth who were sexually active. An interview with nursing staff indicated a nursing assessment is conducted immediately following the initial search, shortly after the youth's arrival. The licensed practical nurse notifies the designated health authority (DHA) by telephone, by text, or verbally, if on-site, 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. The DHA Notification form is filed in the youth's Individual Healthcare Record in the practitioner's chronological note section. Referrals are documented in the physician's log. None of the five reviewed Individual Healthcare Records were applicable for a change in custody.

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

The program maintains a written policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The health education shall be provided by the healthcare staff, in writing and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. For youth with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review of five youth Individual Healthcare Records supported each youth received a healthcare orientation on the day of admission as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for female adolescents. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay, which is documented in the healthcare record. Five reviewed Individual Healthcare Records validated this practice.

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

The program's practice is for the designated health authority (DHA) to be notified by telephone, text message, or verbally, if on-site, of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of five youth Individual Healthcare Records reflected the DHA was notified by telephone and the Notification of Admission form was filed in the practitioner's section of each healthcare record. In addition, the nurse documents the DHA notification on the Nursing Chronological / Notification Progress Note – Female Admission form and the form is filed in the nursing chronological notes section of the healthcare record.

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

The program maintains a written policy and procedures ensuring nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth Individual Healthcare Records supported a new HRH was completed for each youth within seven days of the youth's admission. Reviewed practice

validated the HRH was completed on the same day of each admission. The nursing staff provided their electronic or written signature on the HRH. The DHA documented a review of the HRH on the completed CPA. An interview with nursing staff confirmed the practice and indicated the HRH is also completed whenever any new significant medical event or change occurs and then annually, thereafter.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. The program also maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of five youth Individual Healthcare Records reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. All five reviewed CPAs did not complete sections numbers twenty-three, twenty-four, twenty-five, and twenty-six (pelvic and rectum examination) and each documented deferred by clinician due to age on the CPA. Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout their stay, when applicable. A review of five youth Individual Healthcare Records reflected each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening. All tier I tuberculosis screenings were conducted on the day of admission for each youth. 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. Nursing interviews indicated nursing staff also review the Department's Juvenile Justice Information System to ensure there is a documented TST and to ensure the TST is current and documented as required. The nursing staff also utilizes a tracking log to monitor TST/PPD due dates. There were no youth in the program with symptoms suggestive of active TB. The program's procedures outline if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the DHA.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). 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 five youth Individual Healthcare Records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and was performed for each youth. Test results were filed in the lab section of the

healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all five youth. Each youth identified as sexually active also receive a pregnancy test and results were documented in the healthcare record. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing staff interviews confirmed the program's practice. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth Individual Healthcare Records supported each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. A reviewed of five youth Individual Healthcare Records reflected three consented for testing. The program utilizes the designated health authority (DHA) to provide pre and post-counseling. Reviewed youth Individual Healthcare Records validated when youth received pre-counseling, testing, and post-counseling, the youth's Health Education Record form was updated. The results were placed in a sealed envelope marked 'Confidential' with the youth's name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff also maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, post-testing date, and provider name. Five interviewed youth indicated they can request HIV testing. Each interviewed youth also indicated they can receive gynecological services if necessary.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make Sick Call Requests and have their complaints treated appropriately through the sick call system. The program identifies Sick Call as the official method for a youth to request healthcare services for an illness or injury. Sick Call care, including dental complaints, shall be available to all youth. Sick Call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The Sick Call Process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's Sick Call Process upon admission. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2022 and the optometrist license expires February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist is on-site one time a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program offers youth the opportunity to make a Sick Call Request, seven days a week, once daily, conducted by the licensed nursing staff. Each day sick call is conducted from 12:00 p.m. to 2:00 p.m. A review of five youth Individual Healthcare Records found four youth completed a Sick Call Request form at least one time during their stay. The licensed practical

nurse (LPN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. The program's procedures outlined the healthcare staff will automatically refer the youth to the designated health authority (DHA) for an evaluation and treatment. Reviewed Individual Healthcare Records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff supervisors and youth care worker II staff received medical technician training delivered by the LPN. An interview with the LPN indicated refresher training is provided annually. The program maintains sick call boxes mounted to the wall located in each of the two dormitories and in the cafeteria. The box is monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore; observation of the program's sick call process could not be observed. Five interviewed staff indicated nursing staff conducts sick call. Five youth were interviewed and each reported being seen within one day of submitting a Sick Call Request. Five interviewed staff stated sick call is conducted by nursing staff.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth Individual Healthcare Records found three youth requiring episodic and/or first aid care during their stay in the program. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic / First Aid / Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews validated the program's practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log. The program maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains one automated external defibrillators (AED) located in the supervisor's office. Nursing staff ensure the AEDs are functioning adequately and include the inspection of the batteries and pads to ensure they are in working order. The AED procedures are audio as described by the nursing staff. Reviewed documentation supported AED batteries expire on December 30, 2023, and pads expire on July 16, 2022. The batteries were last changed on December 30, 2019 and the pads were changed

on April 2, 2020. Reviewed documentation for twelve first aid kits, including two kits used during youth transport, supported each contained the required items and all items were current and within their expiration period. A list of the items contained in each first aid kit were maintained on an inventory log with the date of the weekly inspection along with nursing staff initials. The program also maintains one full suicide response kit located in the supervisor's office and documentation found it contained a knife-for-life, wire cutters, and needle nose pliers. The first aid kits are checked weekly and the AED and suicide response kits are checked monthly by nursing staff to ensure each are adequately supplied and in operating order. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore; observation of the program's AED, first aid kits, and suicide response kit could not be observed. Reviewed training records found all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current certifications in CPR and AED. Reviewed training records supported shift supervisors, youth care worker II staff and the facility administrator have been trained in the administration of the Epinephrine Auto Injector. The program conducts announced and unannounced mock emergency medical drills monthly on each shift. Reviewed documentation supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR / AED demonstration at least quarterly. In compliance with the CDC guidelines regarding COVID-19, this review was conducted off-site; therefore; observation of postings informing staff of their right and responsibility to call 9-1-1 could not be observed. The program reported emergency telephone numbers were located in each office and the medical clinic accessible to staff but inaccessible to youth. Five interviewed staff indicated they are able to call 9-1-1 when a youth is identified with a medical emergency.

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

The program maintains a written policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth Individual Healthcare Records found two youth requiring off-site care and/or emergency care including one youth who was seen off-site for dental care and one youth who had two off-site care incidents. Each of the three off-site care events was documented in the Individual Healthcare Records. The reviewed youth Individual Healthcare Records indicated each youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care form and discharge paperwork as evidenced by signature and date. One youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call/Referral Log form.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth Individual Healthcare Records indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All three youth were classified with a medical grade of two through five. Each youth were currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records reflected each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more often. An interview with nursing staff indicated youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth. In addition, the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. In an interview, the psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. One youth was not in the program for ninety-days; however, documentation reflected they were scheduled for a periodic evaluation on May 19, 2020. The program did not have any youth taking anti-TB medication or who were pregnant. Reviewed documentation supported the Department's Problem List was updated as required.

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

The program maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and documented. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. An interview with nursing staff indicated only a licensed practical nurse completes the admission and any applicable medications are verified with the youth's medical records and the youth's parent/guardian. A review of five youth Individual Healthcare Records indicated one was admitted into the program on prescribed medication and two were prescribed medication subsequent to admission. Nursing admission notes documented the youth's current medication and the designated health authority (DHA)

Notification of Admission documented current prescribed medication and verbal notification or telephone was noted. The program's practice is to notify the DHA for all youth admissions. Reviewed documentation reflected the DHA or psychiatrist resumed the prescribed medication for the youth. Reviewed Medication Administration Records (MARs) validated the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Each of the three applicable reviewed youth Individual Healthcare Records reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications. Three reviewed youth Individual Healthcare Records found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All three youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Nursing staff reported the medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two licensed practical nurses (LPNs). If there is only one LPN on-site, the inventory is completed by the LPN and a shift supervisor. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff maintain locked cabinets in the medical clinic with OTC medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on- site. Opened OTC medication is stored in the locked medication cart. Closed and unopened OTC medication is stored in a locked cabinet in the medical clinic. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. Three youth were applicable for a refusal of medication and it was clearly documented on each MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore; observation of medication administration could not be observed. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program's procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. In compliance with the CDC guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore; storage of controlled substances and other medication could not be observed. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the

temperature is monitored daily. Five interviewed staff and five interviewed youth reported medication is administered by nursing staff.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications are not stored with injectable or topical medications. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore; medication inventory was unable to be observed. The program maintains a written 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) are inventoried at least weekly. The program's 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 licensed practical nurses (LPN). The program reported no controlled substances on-site at the time of the annual compliance review. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. 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 written procedures for the disposal of narcotics and other controlled substances. The program's 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 1st Choice Pharmacy for credit. 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 from the past six months validated no discrepancies were identified with the counts. The program maintains a current agreement with Stericycle, Inc. for biomedical waste – treatment with a certificate of exemption issued on October 19, 2019 with the State of Florida, Department of Health. Stericycle, Inc. picks up medical waste weighing less than twenty-five pounds monthly for proper disposal.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on September 10, 2019, and designated health authority (DHA) on April 6, 2020. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outlines outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program had no instances in which the Okeechobee County Health Department, CDC, and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility/occupational exposure. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The plan includes risk assessment and methods of compliance. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program had one youth who was placed in quarantine pending test results for COVID-19; however, the test results were negative, and the youth was returned to general population. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. The plan is accessible to all staff and is maintained in the medical clinic, master control, and in the administrative offices.

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

The program has not had any pregnant youth during this review period; therefore, this indicator rates as non-applicable.

Standard 5: Safety and Security

5.01 Youth Supervision	Non-Applicable
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.	

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be rated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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

The program maintains a written policy and procedures which indicates all consequences and sanctions for the violation of program rules. Consequences shall be directly related to the seriousness of the inappropriate behavior exhibited, consistent with the sanctions detailed in the youth handbook, and applied immediately. The program's behavior management system (BMS is known as the growth and change positive performance system (GCPPS), which was designed to help youth manage their behavior and learn ways to deal with situations. The program's GCPPS is a multi-level system designed to increase desired behaviors using reinforcements and decrease unwanted behaviors through a menu of appropriate consequences. The written description is provided to each youth within the youth handbook provided at orientation, to allow easy access for youth, and includes rules governing conduct, and positive and negative consequences for behavior. In five reviewed youth records documentation of acknowledgement receipts was found confirming each youth received the youth handbook at orientation. The GCPPS is reviewed with the youth by the staff completing the orientation phase. The youth handbook includes a list of behavioral infractions and rewards they can earn for positive behavior. The GCPPS is a level system and rewards are generated through a point system which youth earn daily. The program has an annual in-service and pre-service training plan, which includes the GCPPS for all staff. A review of five staff in-service and five staff pre-service training records found staff are trained on the GCPPS. Five interviewed youth explained the GCPPS and what rewards could be earned with positive behavior. The youth indicated a variety of rewards are provided to them which consist of purchases from the program boutique store, extra hygiene products, daily incentives, weekly incentives, and monthly incentives. Due to COVID-19 pandemic this review was conducted off-site; therefore, observation of staff implementing the GCPPS during interactions with the youth was unable to be conducted. Three of the five interviewed youth reported staff give rewards and consequences correctly and on a consistent basis, and two youth reported are not consistent. According to the youth interviews, four youth rated the GCPPS good and one youth rated the GCPPS as poor. Five staff were interviewed regarding types of rewards provided to the youth

as part of the BMS. Each staff described different types of rewards provided to youth which includes daily and weekly incentives, extra snacks, off campus outings and church services, and birthday reward. According to the facility administrator interview the program uses five levels within the GCPPS based on youth positive days, daily performance base on point card, and weekly incentive pass which includes a risk assessment for participate in off campus activities.

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

The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline, positive and negative consequences, and to encourage youth to meet behavior expectations. The program's BMS known as the growth and change positive performance system (GCPPS). The program's GCPPS requires all staff to be responsible for monitoring and addressing behavior. Case managers are responsible for tracking the youth violations and utilizing the GCPPS when confronting the youth about their behaviors. The youth handbook informs each youth of the program's responsibility to the youth and the youth's responsibility and expectations to the program. According to the facility administrator interview, the GCPPS reminds the youth of their responsibility to follow all rules, exhibit appropriate behavior at all times, and ensure all staff having direct contact with youth are trained. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of youth and staff interactions, and exchange of open communication could not be observed. The program does not use room restrictions for any infractions as part of the GCPPS. Youth length of stay is not increased subsequent to engaging in negative behavior, nor are youth denied basic rights or services. The program has an annual in-service and pre-service training plan, which includes the GCPPS for all staff. A review of five staff in-service and five staff pre-service training records found staff are trained on the BMS. Youth grievances and the "Chatty Cathy" process are mechanisms through which youth may voice their concern regarding the fair and consistent implementation of the GCPPS. The program's facility administrator reviews youth level and points, grievances, and youth feedback at the team daily meetings as a means of monitoring fair and consistent application of the GCPPS. Five interviewed youth indicated youth are never allowed to punish other youth. Five staff were interviewed regarding staff receiving feedback on the use of the BMS. All five staff indicated they receive feedback from supervisors regarding the BMS system.

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

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be rated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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

The program maintains a written policy and procedures for tracking counts and maintaining a census. A review of the program's logbooks from November 2019 to April 24, 2020, revealed a daily count of youth in the program. The program has one program shift logbook, which the shift manager oversees and maintains. The staff document head counts at the beginning and end of each shift and outdoor activities. All formal counts in the logbook include the time of the count, location, and number of youth accounted. Emergency counts were observed in the logbooks and accounted for the basis of the count, time, location, and number of youth accounted. A review of the logbook indicated the documentation of daily counts, head counts, youth movements, admissions, releases, and youth temporarily away from the program. The staff write in red ink for any Prison Rape Elimination Act (PREA) situations. Due to COVID-19 pandemic this review was conducted off-site; therefore, observation of youth headcounts was unable to be conducted. There is a tracking board in the administration office one and two with the daily census for the program which keeps the daily totals, admissions, the youth's photograph with their name, date of birth, Department identification number (DJJID), releases, and youth temporarily off-site. An interview with five staff reflected staff are aware of the program's policy and procedures on adequate supervision of youth, and the procedures for reconciling discrepancies in youth counts as well as conducting counts during an emergency.

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

The program maintains a program shift logbook containing a chronological record of events, incidents, and activities. The program shift logbooks were reviewed from November 2019 to April 24, 2020, and revealed the logbooks were bound with no loose or missing pages and all pages were numbered, with the exception of the logbook for December 2019 and January 2020. The December 2019 and January 2020 logbooks were falling apart, and pages were not an order. All logbook entries were brief and legible, written in ink, and included the date and time of the event. The entries consistently included the full name and the signature of the staff making the entry. All entries were consistently color-coded and highlighted. Any errors were struck through with a single line and initialed by the person making the correction. The program conducts shift briefings prior to each shift with significant issues identified on the previous shift. The shift briefing information is documented in the program shift logbook and shift report. All staff signed the shift report at the beginning of briefing. A shift manager is assigned to maintain the program shift logbook and make entries regarding chronological events for their shift. Shift entries were inclusive of population counts throughout each shift, perimeter and other security checks, youth movement in and out of the program, and upon youth departure. The program logbook was reviewed for reporting incidents to the Florida Abuse Hotline and/or Department's Central Communications Center (CCC) and all five CCC report numbers were documented in the logbook.

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 maintains a written policy and procedures regarding key control. The program's key policy includes procedures for assignment of the keys, usage, restrictions, inventory, tracking, and storage. The policy also includes procedures for reconciling missing, damaged and/or lost keys. Documentation of permanent issue keys included the chit identification of keys on the key ring, key identification number, and the names and title of the person issued the permanent keys. All program keys are maintained in the shift manager's office and are housed within a central key box. The key box remains locked when not in use and youth do not have access to the program keys. In order to provide strict accountability of program keys, the program's facility administrator (FA) is responsible for the inventory, inspection, return, and documentation of active, restricted, and emergency keys once a month. Staff turn in their personal keys, sign the attendance sheet/key log, in order to obtain the program keys. Staff must return the assigned keys upon completion of their shift in order to obtain their personal keys. Restricted keys are maintained in a separate key box located in the administration office.

Only medical staff and the assistant FA have access to the restricted key box. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of keys distribution and collection, and key rings comparison to the key inventory could not be observed. A review of the program's daily key logs from November 2019 to April 30, 2020, revealed the program's sign-in and out for keys was consistently tracking keys and assigning keys. A review of the Department's Central Communications Center (CCC) showed the program has not had any incidents of missing or lost keys in the last six months. An interview with five staff confirmed all staff are aware of the program key control protocols regarding lost/missing, damaged keys, and restricted keys.

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

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be rated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be rated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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

The program maintains a written policy and procedures regarding transportation, vehicles equipment, and maintenance. The program has two vehicles to transport the youth. Both vehicles received an annual safety inspection, and required maintenance, with documentation of services completed on each of the vehicles. Documentation showed first aid kits are maintained inside the administration office until the vehicles are in use, and then transport staff bring the designated first aid kits with them on all transports. Based on documentation the two vehicles used to transport youth are documented to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. Due to COVID-19 pandemic this review was conducted off-site; therefore, observation of transportation, and check of the program and staff vehicles were unable to be conducted. Three of the five interviewed staff reported the program provides them with a cellular telephone during transports in case of an emergency or if there are any issues with the vehicle while in use and two staff reported staff are allowed to bring their personal cellular telephone because the program's transport cellular telephone does not work. In an interview with the compliance manger it was confirmed she was unaware of how long the cellular telephones were not working.

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

The program maintains a written policy and procedures regarding transporting youth and the use of communication devices. The program has two operable vans utilized to transport youth and one of the vans was at the repair shop during the annual compliance review week. Review of the vehicle inspection sheet dated for the past six months indicated the program met the Department's requirement for each vehicle used to transport youth, passed an annual safety vehicle inspection. The program's policy states staff are not allowed to transport youth in their personal vehicles, nor are youth allowed to operate program or staff vehicles. Due to COVID-19 pandemic this review was conducted off-site; therefore, observation of transportation, and check of the program and staff vehicles were unable to be conducted. The program maintains driver lists for four of the six months which includes the staff member's name and title. According to the program policy and procedures, the program's human resource department shall check each staff driver's license and update the list monthly; however, there was no approved driver's list for December 2019 and January 2020.There was no monthly checks of staff valid driver's license for December 2019 and January 2020. Documentation showed the driver's list for February and March 2020 were not approved by the program's facility administrator and did not follow the program's policy. An interview with five staff confirmed staff are not allowed to transport youth in their personal vehicles.

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 written policy and procedures regarding weekly safety and security audits. The program's policy meets all the requirements of Florida Administrative Code 63E-7.107 (5). The program's facility administrator (FA), assistant facility administrator (AFA), and physical plant worker are responsible for conducting the weekly security audits, documenting the outcome, and recommendations on the inspection logs. The weekly security audits and safety inspections address camera surveillance, digital video recorder (DVR), radios and communication devices, perimeter, and fencing to ensure all areas are secure. A review of the program's security audit and safety inspection logs showed the program is conducting weekly safety and security audits for the last six months. An interview with the program's FA indicated there is a facility walk through each week with the physical plant worker to identify and track completion of deficiencies identified. Documentation showed the program addresses any deficiencies found and documents the course of action needed to correct the deficiency.

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

The program maintains a written policy and procedures regarding tool management, preventative, and corrective maintenance which provides instructions and procedures regarding storage and tracking of tools. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department had one building which housed tools and other supplies needed for maintenance. An informal interview with the program's facility administrator (FA) stated all tools stored in the building are Class A tools. The tools are secured and locked inside the building. The physical plant staff are the only workers assigned keys to unlock the building. Inventory of the tools are completed daily and weekly. Documentation of the maintenance building supported the practice of daily and weekly inventories. The physical plant worker maintains a perpetual inventory of all tools which is attached to the wall near the door on a clipboard inside the building. The staff sign-out and sign-in the tools as they use them. The program has a list of Class B tools to be maintained in a locked room on each dorm area away from the youth. Inventory of the Class B tools are maintained by the program's shift manager. The program's kitchen knives are locked in a box inside a locked cabinet in the kitchen and are inventoried daily by the kitchen staff. The staff sign-out and sign-in the tools as they use them. Youth are trained to use mops and brooms. A review of five staff in-service and five staff pre-service training records found staff are trained on Class A and Class B tools. Five youth were interviewed regarding what tools they use in the program and all five youth responded mops and brooms. Five interviewed staff reported youth in the program are allowed to use mops and brooms, and scrub brush.

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 written policy and procedures regarding supervising youth handling tools. Youth are only allowed to use Class B tools under direct supervision of staff. The staff-to-youth ratio during work detail activities is one-to-five. Documentation showed youth are

searched to ensure no contraband has been removed upon completion of the work activity. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of staff-to-youth ratios when youth are using tools and youth searched after each work period could not be observed. A review of five youth case management records found risk assessments were completed monthly. Documentation indicated certain youth are qualified to use Class A tools; however, the program's practice does not allow youth to use Class A tools unless if they are a part of the vocational program. Five staff were interviewed regarding youth access to tools. The staff reported youth in the program are allowed to use mops and brooms, and scrub brush. Five interviewed youth reported youth can use mops, brooms, and scrub brushes.

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

The program has a written policy and procedures in place regarding outside contractors and requirements the contractor must adhere to while working on-site at the program. The program's practice is all contractors will sign a yearly contractor's guideline to include the visitor contraband list and the Prison Rape Elimination Act (PREA). Thereafter, the contractor will only sign-in and sign-out the contractors log each time when a repairman enters the program grounds to perform a work project. A review of the program's outside contractor binder documented the provider signed and dated the required forms once a year in all five occasions. The program's policy states all contractors, while on-site, must be in direct supervision of the physical plant worker or authorized staff. A random review of five of the outside contractor's sign-in and sign-out logs confirmed the program's practice. Documentation supported the contractor's tools were checked upon their arrival and departure from the program. There were no reports of missing contractor tools during the annual compliance review period. According to the program's facility administrator, whenever an outside contractor arrives on-site to perform a work project, a physical plant worker is always with them to ensure direct supervision and monitor the contractor's movement. The program's policy outlines who is responsible for providing approval/permissions if a contractor's personal cellular telephone and/or equipment/electronic devices are required.

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

The program maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on April 7, 2020. The COOP requires the program to conduct safety, disaster, fire, and evacuation drills on a random basis, for each shift, monthly, and under varying conditions when the majority of the youth are available. Furthermore, the COOP requires the program to conduct unannounced fire drills once a month for each shift. An interview with the program's facility administrator (FA) and regional compliance manager stated fire drills are always conducted monthly and unannounced on each shift. Reviewed documentation of drills confirmed the program completed drills in accordance with their COOP. The program conducted twelve COOP drills relating to safety, evacuation, escape, disturbance, disaster, and chemical spill within the last twelve months. Four interviewed youth reported the program conducted fire drills all the time and one youth reported not sure on how often fire drills are conducted. All five

youth reported they have been instructed what to do in case of a fire. Five interviewed staff indicated they have participated in fire, escape, flood, weather-related drill, major disturbance, mental health, and bomb threat drills. An interview with the FA stated fire drills are completed one time a month on each shift and all other drills are conducted one time a month on each shift quarterly.

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

The program maintains a written policy and procedures regarding the Continuity of Operations Plan (COOP). The COOP included all required elements of Florida Administrative Code 63E-7. The COOP was submitted and approved by the Department on April 7, 2020. An interview with the facility administrator (FA) stated the COOP is available to all the program staff and located in the FA office and administration building at the program. A review of five staff in-service and five staff pre-service training records found staff were trained on the COOP. All completed training was documented in the Department's Learning Management System (SkillPro).

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

The program maintains a written policy and procedures in place regarding the control of hazardous materials. These items are stored at the main campus in a metal cabinet inside building number thirty-two identified as flammables and are inaccessible to the youth. The physical plant assistant maintains a perpetual inventory of all chemicals at a different location and not on the same property with the program. The program only kept cleaning products at the program. These items are stored in a lock room in the first administration office identified as flammables, poisonous, toxic items, and are inaccessible to the youth in the program. The Safety Data Sheets (SDS) book is located with the chemical items, which includes a photograph of the item along with the perpetual inventory for each item. In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of the program's storage area could not be observed in person was observed through photographs. A review of five chemicals and the inventory sheet matched the actual chemicals stored. The program's facility administrator (FA) maintains a list of materials, a list of staff authorized to access chemicals posted on the inside of the door, along with a permanent log to show the sign-out and sign-in of chemicals. The program records the daily use of chemicals on a daily chemical usage log to include the initial of the authorized staff using each chemical. Only authorized staff are permitted to sign-out and sign-in chemicals and hold a key to the chemical room.

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

The program maintains a written policy and procedures prohibiting the handling of flammable, poisonous, and toxic items and materials by youth. The program's physical plant workers maintain strict control at the main campus over the flammable, poisonous, toxic items and materials in sheds not accessible to the youth. The facility administrator (FA) stated the program does not keep any flammable, poisonous, and toxic items at the program, with the exception of cleaning products. All the flammable items are kept at another program in building thirty-two. In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of youth during daily cleaning activities could not be observed was not possible. Five youth were interviewed about what type of chemicals they have handled since being at the program. Three of the five-youth reported they do not use any chemicals and/or cleaning products and two reported using paint during vocational and Home Builders Institute (HBI) classes.

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

The program maintains a written policy and procedures regarding the disposal of flammable, poisonous, toxic items, and materials. The physical plant worker is authorized to dispose flammable, toxic, poisonous, and caustic items. An interview with the facility administrator (FA) stated the program does not keep any flammable, poisonous, and toxic items at the program, with the exception of cleaning products. All the flammable items are kept at another program on the main campus in building thirty-two. The physical plant worker reported all supplies at the main campus are used until exhausted: however, when there is a need the program will utilize Okeechobee County's free Amnesty Day to dispose any unused flammable, poisonous, and toxic items. Documentation showed the program maintained a disposal log at the main campus to document chemical disposal as needed. The program maintains all chemical materials in building number twenty-one inside a locked room at the main campus. The program's policy is to dispose of items in accordance with the Occupational Safety and Health Administration (OSHA) standards. The program continues to maintain a contract with KRK Enterprises Inc. to dispose of kitchen grease accumulated from cooking on a quarterly basis. An interview with the

FA verified the program's practice for the disposal of flammable, poisonous, toxic items and materials.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable

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

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

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

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

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

The program does not participate in any water-related activities; therefore, this indicator rates as non-applicable.

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures to ensure youth are provided opportunities to participate in visitation and family reunification activities. Upon admission to the program, a letter and a copy of the parent/guardian handbook was mailed to each parent/guardian, which contains information about visitation, telephone calls, and letter writing. The program maintains a visitor list in a single binder. Each youth has an approved list for visitors, as well as telephone and written contacts. The program holds quarterly family days and visitation is conducted on Saturday and Sunday from 11:00 a.m. to 2:00 p.m.

Due to the COVID-19 pandemic as of April 9, 2020, visitation is schedule through facetime until further notice. Youth letters are mailed daily, and youth are not limited in the number of letters they can receive or mail. A review of chronological documentation and telephone logs confirmed youth contacted their family members or parent/guardian one time a week. A review of visitation sign-in and sign-out logs documented youth visitation with family members or parent/guardian on a quarterly basis prior to April 9, 2020. In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observation of the program posted visitation schedule could not be observed was not possible. Five youth interviews confirmed youth have been given the opportunity to communicate with their family members by mail, during visitation, or by telephone.

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

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

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

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

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

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

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

The program maintains a standard policy and procedures to ensure the program is conducting an on-going safety planning process for each youth. A review of five youth case management records was conducted in reference to a safety planning process for each youth. Reviewed documentation showed the program has developed a program's Safety Plan form which identifies stimuli including positive and negative effects on the youth. The program's Safety Plan form included an initial and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth admission to the program. The safety plans are jointly prepared by the youth, case manager, and clinical staff. The plans are reviewed and signed by all staff involved and the youth. Thereafter, the youth's safety plan will be updated every thirty-days to include signatures and date of the youth and staff. The

program's safety plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences. Each youth's safety plan was updated every thirty days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. All five youth's safety plans incorporated recommendations of previous and current clinical assessments as required. The youth's safety plans were maintained in a centralized binder inside supervisor office, in the dorm area, and easily accessible to all staff. Five youth were interviewed, and each reported they were involved in the development process of their safety plan. Five staff were interviewed, and each staff was aware of the location of the youth's safety plan and understand the review process.