STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Juvenile Offender Correctional Center

TrueCore Behavioral Solutions, LLC
(Contract Provider)
5050 SE 168th Street
Okeechobee, Florida 34972

Review Date(s): April 21-24, 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)
Nicos Antonakos, Office of Program Accountability, Regional Monitor (Standard 2)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 4)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 3)
Sharon Wong, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Okeechobee Juvenile Offender Correctional Center MQI Program Code: 1047
Provider Name: TrueCore Behavioral Solutions, LLC Contract Number: 10289
Location: Okeechobee County / Circuit 19 Number of Beds: 48
Review Date(s): April 21-24, 2020 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

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

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

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Program Overview

The Okeechobee Juvenile Offender Correctional Center is a forty-eight-bed hardware-secure program, for thirteen to twenty-one-year-old male 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). In addition, the program fosters each youth by providing Skillstreaming the Adolescent, The Passport Program, The Bullying Workbook for Teens, Problem Solving Training, Social Perception Training, Empathy and Competence Training, Living In Balance, Resilience Builder Program for Children and Adolescents, 100 Activities for Mental Health and Substance Abuse Recovery, Thinking Feeling Behaving, Pathway to Self-Discovery and Change, Anger Management for Substance Abuse and Mental Health Clients, and Strategies for Anger Management. The program's restorative justice programming includes Impact of Crime, and gender-specific programming is offered through Male Healthy Relationships and Violence Prevention which is comprised of The Teen Relationship Workbook and Young Men's Work. The program also provides recreational therapy and an animal husbandry program involving the care and keeping of multiple chicken breeds.

Program administration is comprised of a facility administrator, director of case management, director of clinical services/designated mental health clinician authority (DMHCA), and an academic principal. Case management services are provided by five case managers, an intake specialist, a case administrator, and a transitional services manager. In addition to the DMHCA, mental health staff at the program include a licensed clinical social worker who serves as the lead therapist, two master's-level therapists, a file analyst, a contracted certified behavior analyst, and two recreational therapists which are shared with the co-located program Okeechobee Juvenile Sex Offender (OJSO). Medical services are offered seven days a week and are provided by the registered nurse (RN) serving as the health services administrator, three additional RNs, a medical support technician, a contracted medical physician, a contracted optometrist, a contracted dentist, and a contracted psychiatrist. Educational services are provided by TrueCore employed staff with oversight from the Okeechobee County School District.

The layout of the program includes two mirror-image wings of the building, each comprised of three separate living modules. The east wing comprises the Okeechobee Juvenile Offender Correctional Center, while the west wing houses the co-located Okeechobee Juvenile Sexual Offender Treatment Program. Each living module has a case management office and adjoining classroom. The program has a main master control, a sub-master control station for each co-located program, therapist offices, a computer lab, an education administration office, program administration offices, a maintenance office and storage area, one large recreation field, six small recreation courts, a kitchen, a medical clinic, two medication pass rooms, and an automotive sally port. The program has fifty-two video security cameras monitored by master control staff, all of which were operational at the time of the annual compliance review and are capable of maintain thirty-days of recorded video footage. At the time of the annual compliance review, the program, which shares staff with OJSO), had thirty-three vacant positions, which included thirty youth care workers, one non-licensed master's-level therapist, one medical support technician, and one education transition specialist.

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 to be in compliance with the Department's Background Screening (BSU) through the Agency for Health Care Administration's (AHCA) Clearinghouse. The program had eighteen newly hired staff since the last annual compliance review. There were no new applicable contracted staff or volunteers. A review of documentation supported all eighteen newly hired staff received background screenings completed by the 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 a low, medium, or 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. Ten of the eighteen newly hired staff were applicable for a pre-employment assessment. A review of the ten applicable direct-care staff records documentation showed each staff completed an 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 4, 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 rescreenings are required to be submitted to the

Department's Background Screening Unit (BSU) through the Agency for Health Care Administration's (AHCA) 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 six 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 through the 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 seven 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 and 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 annual compliance review was conducted off-site; therefore, observations of CCC and Florida Abuse Hotline postings was conducted through photographs. The photographs validated the CCC and Florida Abuse Hotline telephone numbers were posted in the youth living areas and throughout the program.

The program had four abuse allegations reported to the CCC since the last annual compliance review. Two allegations were reported by youth over the age of eighteen, and two were reported anonymously. Each allegation was investigated and were found to be unsubstantiated, which

required no action from the program. None of the four allegations were against a staff member. The program's practice is once a youth requests to call the Florida Abuse Hotline and/or CCC, the youth care worker will use the radio to call the shift supervisor, and the shift supervisor will take the youth to go place the call. 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 is projected to be completed in May 2020.

Seven interviewed youth stated they feel safe while in the program, and they have never been stopped from reporting abuse to the Florida Abuse Hotline. Five of the seven youth stated staff are respectful when talking with youth and to other youth. One youth stated no, and offered no additional comments, and one youth declined to answer. Seven interviewed staff were able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or CCC. Seven 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 use profanity when specking with youth. An interview with the facility administrator (FA) stated the employee code of conduct operates on a progressive discipline format. Physical abuse, threats, or profanity towards youth fall under a critical offense and can result in termination. Youth at the program have unimpeded access to the Florida Abuse Hotline. Anytime a youth alleges abuse of any type against a staff member, the staff is removed from contact with the youth. If there is an incident needing to be reported to the CCC, the shift manager will notify the administrative duty officer (ADO) who will then notify the FA or assistant facility administrator (AFA), to gather preliminary information, and make the report.

1.04 Management Response to Allegations (Critical)	**Non-Applicable**
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 had no incidents of physical, psychological, or emotional abuse in the program during the annual compliance review period; therefore, this indicator is rated as non-applicable.

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 being notified of the incident. The program had twenty-one incidents reported to the CCC 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 logged in the program's master control logbook. A review of the program's internal incident reports found there were no additional incidents which were required to be reported to the CCC. The program had a decrease in the number of reportable incidents to the CCC compared to the last annual compliance review. An interview with the facility administrator (FA) revealed all youth at the program have unimpeded access to the Florida Abuse Hotline. Anytime a youth alleges abuse of any type on a staff member, the staff is removed from contact with youth. If there is an incident which needs to be reported to the CCC,

the shift manager will notify the administrative duty officer (ADO) who will then notify the FA or assistant facility administrator (AFA), to gather preliminary information, and make the report.

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 and should include statements from every staff member involved and be completed by the end of the staff members 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 twenty PAR incidents in the past six months, which was eight more than the last annual review. The FA stated the increase is due to "the use of physical force is not something which is determined by the program. Level 2 PAR is utilized as a Department-approved response to a youth's escalating behavior. In PAR, staff are required to use the least amount of force required to gain control. Level 2 PAR is determined completely by the youth's behavior, unless the staff is acting outside of Department Rule. There were no reported instances of excessive force since the last annual compliance review. Seventeen uses of Level 2 PAR could be attributed to four youth and stemmed from staff intervening to break up fights between youth."

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 was completed by the end of the staff member's workday, with each staff involved completing a statement. All five reports documented 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 2.81, which is above the statewide residential PAR rate of 2.41. An interview with the FA determined PAR reports are written by the staff involved in the PAR incident. The report is reviewed within twenty-four hours by the assistant facility administrator (AFA) or FA. If video is available, it will also be reviewed by the AFA and/or shift manager. PARs are discussed during the program's morning management meetings (MMM) and logged in the MMM data base. A monthly PAR report is completed and submitted to the Department each month.

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

The program has a 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 January 8, 2020. A review of seven pre-service staff training records indicated all reviewed staff were certified within 180-days of their hire date, as required. Each of the seven staff was 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. All review of the Department's Learning Management System (SkillPro) reflected each staff completed the required 120 hours of pre-service training. 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 January 8, 2020. Reviewed documentation validated the program has an annual in-service calendar which is updated as changes occur. Three supervisor and four direct care staff training records, for a total of seven 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. Applicable supervisory staff completed eight hours of supervisor training in the areas of management, leadership, personal accountability, employee relations, communication skills, and fiscal. All trainings were 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 seven 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. Youth fill out a "Let's Talk" form prior to filling out a 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 "Let's Talk" and grievance forms for at least twelve months. The program had fourteen grievances in the past year. A review of five grievances determined the forms were filled out completely with the required signatures and responses. None of the reviewed grievances required an appeal.

Seven interviewed youth all stated they can request assistance with completing a grievance form. Seven interviewed staff were all able to explain the program's youth grievance process. The facility administrator (FA) stated grievance are available to the youth at all times on the dormitories. Once the youth has completed a grievance, it is placed in the grievance box by the youth. Each morning, the grievances are collected and turned into the FA and/or assistant facility administrator (AFA) for review. Once reviewed, the grievance will be marked formal or informal. The formal grievances will then be issued a number and tracked. Grievances are reviewed with the youth and a decision is made within seventy-two hours. If the decision supports the grievance action corrected the problem, the grievance is closed. When the grievance action is not supported, it is forwarded to the FA for review. In the event a youth does not agree with the outcome, the youth can appeal the findings. The FA will then have seventy-two hours to meet with the youth. The program policy for any grievance of sexual abuse is to immediately forward the grievance to the FA for resolution.

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 Impact of Crime (IOC) and Thinking for a Change (T4C) as the program's required delinquency curricula. The program has three staff trained to facilitate T4C and three to facilitate IOC. All facilitators hold a bachelor's-level degree and have over two years of experience working with youth. An interview with the facility administrator (FA) reported the program provides T4C and IOC. 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 delivered, as required. The T4C group started on November 4, 2019 and ended March 25, 2020 with eleven youth. An additional group was in progress at the time of the annual compliance review, which started on April 13, 2020 with eleven youth. The IOC group started on September 9, 2019 and ended January 8, 2020 with ten youth. There was a group which started on January 27, 2020 and was in progress at the time annual compliance review with eight youth. A review of seven youth records found three youth participated in T4C and four youth participated in IOC, and each youth had goals included on the performance plan to address their individualized delinquency needs.

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 the Skillstreaming, Living in Balance, and the Teen Relationship Workbook 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 once a week for one-hour a day by a therapist. A review of group sign-in sheets for the past six months verified youth received life skills training, as scheduled. Seven interviewed youth were all able to explain which groups they participated in and were able to explain the skills they learned while in the program. Youth reported some acquired skills included coping skills, breathing techniques, and how to be quiet.

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 training records showed there were three staff trained to facilitate IOC groups. A review of the program's activity schedule indicated IOC groups are facilitated twice a week for one hour each group. A review of seven youth records indicated three youth completed IOC and four were scheduled to participate in an upcoming IOC group. A group started on September 9, 2019 and ended January 8, 2020 with ten youth. There was a group which started on January 27, 2020 and was currently in progress at the time of the annual compliance review with eight youth. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a restorative justice awareness group was not possible.

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 Male Healthy Relationships, Violence Prevention, Teen Relationships, and Young Men's Work (YMW) as the gender-specific curricula to be provided. All youth in the program are provided Male Healthy Relationships and Violence Prevention which is an evidence-based gender-specific curriculum and includes male-specific exercises, lessons regarding issues of violence, bullying, substance abuse, and teen fatherhood. A review of the program's activity schedule and sign-in sheets since the last annual compliance review confirmed gender-specific programing were provided to the youth, as required. The facility administrator (FA) stated gender-specific groups provided at the program include YMW and Teen Relationships.

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 into 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 master control, 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. Reviewed documentation showed the program reviews internal alerts during shift briefings.

A review of the seven youth records for medical, mental health, and case management alerts showed alerts were entered into JJIS, as required. When comparing JJIS alerts to the program's internal alert list, there were three youth which had an alert for sports restrictions which were in JJIS, but were not included on the program's internal alert list. 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 seven staff stated they are notified of youth alerts by the supervisors and during shift briefings. An interview with the facility administrator (FA) stated all important medical issues and alerts are reviewed during shift briefing. The FA explained alerts are placed into JJIS by each department manager. The internal alert system is updated daily and reviewed during the program's morning meetings. Copies of alerts are passed out to all the living units, shift manager, kitchen, mental health, and education staff.

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 seven youth healthcare, mental health and substance abuse, and case management records were marked "Confidential" and each record 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 designed 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 input regarding the program. 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 included sign-in sheets and meeting minutes, documenting the topics which were discussed for the past six months. The meetings were conducted with the program's facility administrator (FA) and assistant facility administrator (AFA). In an effort to obtain youth input, the program administration also conducts quarterly surveys with randomly selected youth. The results of the surveys are forwarded to the corporate office and formally reviewed and discussed whereby possible changes are made, accordingly. Seven youth were interviewed regarding their ability to provide input at the program. Four youth stated the program has a process for allowing youth to provide input about what happens at the program. Two youth stated they were unsure, and one youth stated "no." An interview with the FA indicated youth can add input to resolve issues and improve conditions within the program by submitting "Let's Talk" forms and through the advisory board. Each month, the FA and AFA meet with the youth advisory board to discuss issues, concerns, and improvements which can be made in 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 of the 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 supported the program's community advisory board met 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 facility administrator (FA) confirmed the community advisory board meets quarterly to help the program come up with creative ways to help the youth reintegrate back into the community, and to assist the community in understanding what the program is doing to get the youth back into the community. The FA added, there are several members from the community who patriciate, and meetings usually occur between 11:00 a.m. through 2:00 p.m.

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 for staff employed by the program. 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. 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. Seven staff were interviewed regarding program planning. Two of the seven staff stated meetings are held daily, and five staff stated meetings are held monthly. Five of the seven staff stated meeting topics range from the program policies, behavior management system (BMS), ten-minute checks, radios, supervision, ratio, Prison Rape Elimination Act (PREA), facility cleanliness, and staff incentives. Two staff gave no response regarding meeting topics. Three of the seven staff stated they are briefed on annual reports and on youth and parent/guardian surveys. Four of the seven staff gave no response. Four of the seven staff stated the communication in the program is very good and three of the seven stated communication is fair. Four of the seven staff stated they are able to provide feedback and input into the program operations. Three of the seven staff provided no response. An interview with the facility administrator (FA) stated the turnover at the program has a lot to do with the location of the facility and the distance staff have to drive to work. The FA does not feel there are any problems with staff morale and reported the program continues to recognize staff performing well in the all-staff meetings and continue to use prize-based incentives and recognize one staff each month as the employee of the month. The program provides youth and parent/guardian surveys, which are reviewed by the FA and assistant facility administrate (AFA) to identify areas for needed improvement. The program also utilizes data collected through their internal reports and trends from their morning meeting to identify areas of improvement. The Department's Comprehensive Accountability Report (CAR) report is used annually to review length of stay and recidivism with management and program staff. The FA continued to explain, the monthly department meetings are held with each department and a facility wide all-staff meeting is held monthly to inform staff on updates and changes.

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 October each year, which is a new process as of November 2019. Since the last annual compliance review, the program had four staff applicable for a performance evaluation. Documentation showed all four staff performance evaluations

were completed on time. All four 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 staff are evaluated after ninety days of employment, and annually thereafter. Additionally, staff are evaluated in several different areas and graded based on performance. Seven interviewed staff all stated they receive a formal evaluation yearly.

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 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 maintains a bachelor's-level degree in recreation and sport management with an emphasis in recreational therapy. 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 four and one-half years of prior experience at the time of hire. Documentation indicated the program maintained a monthly calendar of indoor and outdoor recreation activities which consisted of football, basketball, card games, and board games. Youth are provided at least one hour of activity daily during the weekdays and weekends. 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 facility. A review of the program's logbooks found the program consistently documented recreation time. A review of seven youth records documented recreational therapy activities were provided and were 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, this annual compliance review was conducted off-site; therefore, observations of youth recreational activities was not possible. Seven interviewed youth stated they receive at least one hour of physical and leisure activities. Six of the seven youth stated they are provided with varying degrees of mental and physical exertion throughout the day. One of the seven youth gave no examples of activities provided. Seven staff were interviewed, and each staff stated youth receive one hour of recreation and leisure activities daily, which consist of board games, cards, table tennis, basketball, football, chess, video games, and television.

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 maintains a written policy and procedures requiring parental and court notifications to occur within twenty-four hours of the youth's admission and written notification within forty-eight hours of admission. Seven youth case management records were reviewed and documented the program notified the youth's parent/guardian by telephone within forty-eight hours of the youth's admission to the program. Each reviewed record contained documentation reflecting a letter was sent to the committing court and the juvenile probation officer (JPO) within five working days of the youth's admission to the program, as required.

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 maintains a written policy and procedures to address youth orientation. Seven youth case management records were reviewed, and each record contained documentation reflecting the program provided an orientation of program rules, expectations, and services available to each youth within twenty-four hours of admission. A review of the program's orientation checklist indicated the orientation includes information regarding the program services available, daily schedule, youth expectations, behavioral management system, access to medical and mental health services, access to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), if the youth is over eighteen years of age. The youth's orientation also includes the program's zero-tolerance policy regarding sexual misconduct, including how to report incidents or suspicion of sexual misconduct, special accommodations available to ensure all written information about sexual misconduct policies including how to report sexual misconduct is conveyed to youth with limited reading skills or who are visually impaired, deaf, or otherwise disabled. The right to be free from sexual misconduct, rights to be free from retaliation for reporting such misconduct, and the agency's sexual misconduct response policies and procedures are also discussed. Each reviewed record contained a list of contraband and prohibited items, the performance planning process, dress code, hygiene practices, procedures on visitation, sending and receiving mail, telephone use, expectation for release from the program community access, grievance procedures, emergency procedures, facility tour, and assignment to a living unit. Each reviewed record documented the youth's signature acknowledging receipt of orientation. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of a youth admission was not possible. Seven interviewed youth confirmed they received an orientation to the program within twenty-four hours of their admission.

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 maintains a policy and procedures which address obtaining written consent of youth who are eighteen years of age or older. A review of seven youth case management records found two youth were applicable for written consent of youth over the age of eighteen before providing or discussing with the parent/guardian and/or any other individual any information related to the youth's physical or mental health screening, assessment, or treatment. Both applicable reviewed youth records documented information related to the youth's physical or mental health screening or substance abuse assessment and treatment was not provided to the youth's parent/guardian prior to written consent from the youth. Documentation showed each youth record contained consent forms signed by the youth allowing the program to share, or prevent sharing, information with the parent/guardian.

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 maintains a written policy and procedures to address the classification process. The program utilizes a classification system to promote safety, security, and to deliver effective treatment. The initial classification assessment is used for assigning each newly admitted youth to an appropriate living unit, sleeping room, youth group, and staff advisor. Seven youth case management records were reviewed to ensure the program completed each classification inclusive of all factors in accordance with the Florida Administrative Code. Each reviewed youth record indicated the program utilized an admission classification form, which identifies the youth's physical classification, age, maturity level, special needs, history of violence, gang affiliation (if applicable), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), criminal behavior, and sexual aggression or vulnerability. Each reviewed case management record identified risk factors which included suicide, medical, escape and security. A review of the program's internal alert system and log generated from the Department's Juvenile Justice Information System (JJIS) indicated there were no issues affecting the youth's classification. All seven youth case management records documented the utilization of the admission classification.

Each reviewed record indicated all applicable medical, mental health, substance abuse, security risk factors, and/or special needs identified during or subsequent to the classification process were immediately entered into the program's internal alert system and into JJIS. Youth reassessments were completed prior to considering an increase in the youth's privileges or freedom of movement, participate in work projects, or other activities involving tools or

instrument which may be used as potential weapons or means of escape. Participation in off-campus activities were not applicable. An interview with the facility administrator (FA) revealed factors such as mental health status, physical health status cognitive performance, age, and prior victimization are considered when assigning a youth to a living unit and/or sleeping room. The policy addresses when reassessment is warranted based upon changes in the youth's supervision status, new/updated alerts, relevant information available to the treatment team, and/or behavioral concerns. During the classification meeting, the practice is taken into consideration when deciding where to place the youth in the program. Interviewed staff indicated youth who are considered vulnerable are placed towards the front of the dormitory hallway. The program continually updates their internal alert system, which is easily accessible to all program staff and keeps them alerted of youth who are identified as a risk, including escape risk, suicide or other mental health risk, medical risk, sexual predator risk, and other assaultive or violent behavior risks. The program has an alert board which is located in master control and all alerts are discussed during the shift briefing meeting with all on-coming staff.

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

The program maintains a written policy and procedures outlining gang identification and notification to law enforcement regarding youth who are identified with suspected criminal gang activity or association. During the admission screening process, each youth is screened for possible gang involvement. Seven youth case management records were reviewed and five were applicable for gang association. The program maintains a gang binder which contains all pertinent information regarding applicable youth gang involvement. Reviewed documentation confirmed the program e-mails local law enforcement to notify them of those youth with suspected criminal gang activity. Reviewed documentation verified each applicable youth's gang alerts was added into the program's internal alert system and entered into the Department's Juvenile Justice Information System (JJIS). Reviewed documentation verified each applicable youth's gang status was shared with the education provider, juvenile probation officer (JPO), and the youth's post-residential 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 maintained a written policy and procedures outlining gang prevention and intervention. Seven youth case management records were reviewed and five records were applicable for gang association. Each of the five reviewed applicable records documented the youth participated in gang prevention and intervention strategies which consist of the seven-lesson Gang Resistance and Drug Education (GRADE) curriculum adopted by the Coral Springs Police Department which address goal settings, respect, making good choices, conflict resolution, internet safety, gang intervention, and drug awareness.. Reviewed documentation indicated each youth's performance plan included goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. None of the reviewed records indicated the youth made a request to dis-affiliate from their gang.

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. Seven youth case management records were reviewed for an initial Residential Assessment for Youth (RAY) Assessment, as well as Reassessments. Each youth record contained an initial RAY completed within thirty days of the youth's admission into the program. The program maintained all RAY assessment in the Department's Juvenile Justice Information System (JJIS). Five of the seven reviewed youth case management records were applicable for a RAY Reassessment. Each of the five applicable records reflected a RAY Reassessment was completed within the required ninety days. In each applicable record, the program maintained all RAY Reassessment documentation in the youth's case management record.

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

The program maintains a written policy and procedures regarding the completion of Youth Needs Assessment Summary (YNAS). Each of the seven reviewed youth case management records contained a YNAS completed within thirty days of the youth's admission to the program. Each reviewed YNAS was maintained in the youth's case management record, as well as within the Department's Juvenile Justice Information System (JJIS).

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

The program maintains a written policy and procedures regarding performance plan development. Seven reviewed youth case management records found each record contained an individual performance plan developed within thirty days of the youth's admission to the program. All seven reviewed records reflected the treatment leader, youth, administrative

representative, living unit representative, treatment staff, and educational staff participated in the development of the performance plans. There was one applicable youth receiving services from the Department of Children and Families (DCF) and none of the youth were applicable for receiving services from the Agency for Persons with Disabilities (APD). There was no documentation to support the DCF case worker participated in the development of the youth's performance plan.

Seven reviewed performance plans were signed by the youth and intervention and treatment team leader and members. Reviewed practice supported all seven reviewed records had a parent/guardian signature sheet attached to the youth's original performance plan and was filed in the case management record. All seven reviewed performance plans included goals based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process. Each reviewed performance plan contained all the required elements, such as the youth's individualized goals, top three criminogenic needs, delinquency interventions, court sanctions, target completion dates, and goals for transition. Each of the seven reviewed performance plans outlined staff and youth responsibilities to accomplish the goals. All seven reviewed case management records contained documentation indicating a copy of the performance plan was sent to the committing court, assigned juvenile probation officer (JPO), parent/guardian, and the applicable DCF case worker within ten working days of plan completion. Seven interviewed youth confirmed participating in the development of their performance plans, aware of their current performance plan goals, and receiving a copy of their performance plan.

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

The program has a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY). Seven youth case management records were reviewed for performance plan revisions. Each record reflected revisions were completed based on the RAY Reassessment results, as well as newly acquired information. Six of the seven youth records contained performance plan revisions based upon demonstrated progress toward completing a goal. One of the seven reviewed records demonstrated lack of progress toward completing any of the goals; however, staff interviews indicated the youth was finally coming around and participating in the program. Each youth record required revisions to the performance plan and there was clear documentation indicating the treatment team members made changes, as applicable. Although each reviewed performance plan documented transition goals, there were no applicable youth in transition during the last sixty days of the youth's stay. A review of three closed youth records demonstrated the treatment team made final revisions to the performance plans during the last sixty days of youth stay.

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 ensuring performance summaries and transmittals are completed every ninety calendar days. Seven youth case management records were reviewed. Each record was applicable for the completion of a performance plan summary. Each reviewed performance plan summary was completed within ninety calendar days, as required. Reviewed summaries reflected each included the youth's status on each performance plan goal, overall treatment progress, academic status, credits earned in the program, behavior, level of motivation and readiness to change, interactions with staff, peers, overall behavior adjustment to the program, and significant positive and negative events. Each record documented the youth was allowed to read and add comments prior to signing the performance summary, the youth was provided with a copy of the summary, and the original summary was filed in the youth case management record. Each reviewed performance summary was signed and dated by the treatment team leader, case manager, facility administrator or designee, and the youth.

Each of the seven youth case management records was reviewed for performance transmittals. Documentation revealed each performance summary was sent within ten working days of completion to the committing court, the youth's juvenile probation officer (JPO), and the youth's and parent/guardian. One reviewed record was applicable for Department of Children and Families (DCF) involvement, and a copy of the summary was sent to the DCF case a manger within ten working days, as required.

Three closed records were reviewed for discharge summary requirements. Each reviewed record contained documentation indicating the original summary was sent with a Pre-Release Notification (PRN) to the assigned JPO. Each discharge summary and PRN was sent at least forty-five days prior to each youth's anticipated release date, and a signed copy was maintained in each youth's record. None of the three closed records documented the court objected to the PRN. All three closed records documented the program provided written notification to the youth's parent/guardian, advising of the youth's anticipated release upon the approval of the PRN. Each record contained a completed Residential Assessment for Youth (RAY) Exit Assessment. None of the reviewed case management records were applicable for the Sexually Violent Predator Program (SVPP) and none required a release letter of notification to the victim. Each of the three closed youth case management records documented the program provided the JPO with the performance summary, transition plan, and all applicable psychological/psychiatric reports completed while the youth was in the program. The program's practice is to send the youth's performance summary and transition plan to the assigned JPO by e-mail prior to release, and to send the entire youth record by mail upon release. Reviewed documentation validated this practice. Seven interviewed youth indicated they received a copy of the performance summary sent to the court.

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

The program has a policy and procedures which encourages and facilitates parent/guardian involvement in the case management process. The case manager contacts the youth's parent/guardian by telephone upon the youth's admission to the program. An admission packet is mailed within forty-eight hours of admission to the parent/guardian. The admission packet includes an informational letter, a parent/guardian youth input form, and a parent handbook. Reviewed documentation indicated the parents/guardians were invited and encouraged to participate in the assessment process, the development of the youth's performance plan, progress reviews, formal treatment team meetings, and transition planning. The parents/guardians were given the opportunity to participate by telephone or provide verbal/written input if unable to attend the meetings in person.

The annual compliance review was conducted off-site due to COVID-19; therefore, the review team participated in a formal treatment team meeting by telephone. The parent/guardian was given advance notice of the formal treatment team date and time; however, they were unable to attend. The case manager stated a follow-up call will be made to the parent/guardian to provide updates of the youth's progress at the program. The program's facility administrator stated each youth's parent/guardian is contacted upon intake and is consistently updated on the youth's progress during the stay at the program. In addition, parents/guardians are invited to attend all special events including family days. Five of the seven interviewed youth reported their parent/guardian was involved in their case management process and treatment team meetings. Two youth were eighteen years old or older and declined parental participation.

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

The program has a policy and procedures addressing treatment team and its members. At a minimum, treatment team includes the youth, case manager, administrative representative, living unit representative, educational staff, juvenile probation officer (JPO), parent/guardian, transition services manager (TSM), and others responsible for providing or overseeing the provision of intervention and treatment services. Seven youth case management records were reviewed, and each contained documentation the youth's JPO, parent/guardian, and any other pertinent parties were notified in advance and encourage to participate in the formal treatment team meetings. All seven youth records verified participants included the youth, case manager, program administration, living unit representative, education representative, medical and mental health staff, and additional pertinent staff responsible for providing or overseeing the provision of intervention and treatment services. Five of the seven youth records included documentation of parent/guardian participation during the treatment team meetings. Two youth were eighteen years old or older and declined parental participation.

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 policy and procedures indicating when a youth has been identified with a mental health, substance abuse, or physical health need, the care treatment plan shall be coordinated into the youth's performance plan. When a youth has a current behavior support plan or case plan through the Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD), the program coordinates the youth's performance plan with the youth's DCF/APD care plan for related issues. A review of seven youth case management records revealed each youth's performance plan contained goals or information from the youth's mental health and substance abuse treatment plans, wellness plans, and medical plans. In addition, each youth had separate academic plans which were incorporated into the individual performance plan. One youth, under the supervision of DCF, had a separate DCF plan which was incorporated into the youth's performance plan. There were no youth with an APD plan; however, one youth associated with the Guardian Ad Litem program had independent living skills added to the performance plan.

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

The program has a policy and procedures addressing formal and informal treatment team meetings. Seven case management records were reviewed, and each documented formal and informal treatment team review meetings were conducted at least once every thirty days. The program utilized a performance plan review form which included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions. Reviewed documentation confirmed treatment team meeting attendees consisted of the youth, youth care worker, case management staff who act as the treatment team leader, clinical staff, medical staff and education provided written input. , and a program administration representative. Each youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress and the Residential Assessment for Youth (RAY) Reassessment results. All staff provided verbal or written input in the treatment process and the youth were able to demonstrate new skills acquired at the program.

The annual compliance review was conducted off-site due to COVID-19; therefore, the review team participated in a formal treatment team by telephone. During the formal treatment team meeting, all required staff were present. The team reviewed the youth's progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions and treatment progress. In addition, the youth was provided an opportunity to demonstrate skills acquired in the program. Seven youth case management records were reviewed, and each contained documentation supporting the youth had formal and informal treatment team meetings at least once every thirty days. All required attendees participated and signed the performance plan review form. Six of the seven interviewed youth reported they were provided an opportunity to demonstrate the skills they have learned while at the program in

treatment team meetings. Five of the seven youth reported staff reviewed youth performance which included progress on performance plan goals, positive and negative behaviors 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 records indicated employability skills goals is were added to each youth's education plan. All three reviewed records included a sample employment application, a résumé summarizing education, work experience, and/or career training. All three reviewed records also contained appropriate documents essential to obtain employment, and documentation to validate the youth and parent/guardian, when applicable, were aware of the youth's vocational plan. Documentation verified youth were provided the location and business hours of their local Career Source Center. Each of the youth records included documentation the program provided Career and Professional Education (CAPE) courses leading to pre-apprentice certifications and industry certification. The program provides Type 3 vocational competency development programming which offers employability skills training and includes vocational classes in introduction to hospitality, culinary arts, and on-site Home Builders Institute (HBI) Pre-Apprenticeship Certificate Training (PACT). The career education programing provided includes communication, interpersonal, and decision-making skills. Youth can earn certifications in vocational classes including SafeStaff ® food handler training through the National Restaurant Association, and hospitality. In an interview, the program's facility administrator stated the school is operated by TrueCore Behavioral Solutions, LLC with oversight from the Okeechobee County School District. The program offers several vocational opportunities which include food manager, and HBI/PACT Core Building Construction Technology. In an interview, the lead educator stated the youth receive career education services through HBI and certifications through the American Hotel and Lodging Association.

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 provides year-round educational services to the youth. The program's teachers are TrueCore Behavioral Solutions, LLC employees. The Okeechobee County School District subcontracts with Tantie Juvenile Residential Facility School to provide education credentials, monitor, and train the TrueCore Behavior Solutions, LLC education staff. The program provides Type 3 vocational competency development programming inclusive of vocational classes in hospitality, culinary arts, and on-site Home Builders Institute Pre-Apprenticeship Certificate Training (PACT). Each class provides hands-on experience in their respective areas. Youth receive standard instruction in mathematics, reading, language arts, science, and social studies, at a level appropriate with their grade and in a manner indicated by their Individual Education Plan (IEP). Youth are also provided the opportunity to take the General Equivalency Diploma (GED), and if youth meet the requirements, can graduate with a standard high school diploma during their stay in the program.

During the annual compliance review, youth received 300 minutes of daily instruction, as scheduled. Reviewed activity schedules and logbook documentation supported there is minimal

interference of educational instruction. Seven youth were interviewed. Three youth stated there was minimal disruptions during school instruction. Four youth stated there were disruptions during class such as excessive talking. 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 has a policy and procedures outlining transition, release, and discharge. Three closed youth records were reviewed, and each indicated the youth had an individual education transition plan developed based on their post-release goals, beginning at admission. The education transition plan addressed services and interventions based upon each youth's assessed educational needs, post-release education plans, as well as services to be provided during the program stay and to be implemented upon release. Key personnel involved in the youth transition activities included the youth, parent/guardian, program education staff, department personnel, and personnel from the youth's home school district. All three reviewed closed youth records contained an education transition plan developed with the youth, program education staff, and aftercare staff which included specific plans for continued education and/or employment. Each reviewed closed case management record indicated the required transition activities, target dates, and individual responsibilities were discussed. In addition, the three closed youth records included a sample completed employment application, a résumé, a valid Florida identification card, documentation indicating the location and business hours of a local Career Source Center, and any additional documents essential to obtaining employment upon release from the program. The reviewed records included evidence the parent/guardian were aware of youth's 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 policy and procedures in place regarding transition planning, releases, transfers, 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 or designee, and other team members participated on each transition conference. One closed youth record included evidence the case manager participated in the transition conference but did not sign the transition conference form. Documentation indicated all treatment team members were invited and encouraged to participate in the transition conference in person, by telephone, or provide verbal/written input. 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. All three reviewed youth records documented the exit conference was conducted and documented on the exit conference form. During the transition conference, participants reviewed the transition activities outlined on each youth's performance plan during the transition conference. There were no applicable revisions to the performance plans reviewed. Documentation supported target completion dates and persons responsible for goal completion were identified at each completed conference. There was documentation in two of the three closed records which supported the program received an invitation to the CRT meetings. One youth was a direct release from the program and had obtained a General Equivalency Diploma (GED) at the program; therefore, a CRT meeting was not applicable. Documentation in two applicable youth closed records was reviewed and verified the program, youth, parent/guardian, and assigned juvenile probation officer (JPO) participated in the CRT meeting.

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. Transition and release planning is an ongoing planning process which begins at the time of the youth's admission to the program. The transition process is continuously re-evaluated throughout the youth's stay and fully considers the youth's risks, protective factors, as well as identification of ongoing follow-up needs to be addressed upon the youth's release from the program. The multidisciplinary treatment team compiles assembled documents to assist the youth after release. Exit portfolios include the youth's identification card, Social Security card, birth certificate, all educational documentation, school transcripts, résumé, sample employment applications, and educational/vocational certificates earned in the program, along with a calendar of upcoming appointments. A review of three closed youth case management records found the exit portfolios were discussed and signed by each youth during the transition conferences. All three closed youth records found each had a completed exit portfolio with all required elements, as outlined in the program's policy. In addition, each youth had a Plan for Success which contained identified goals, contact person, location, and appointment dates. 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).

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 conferences. The program conducts a conference at least fourteen days prior to the youth's targeted release date, whereby the youth, residential program staff, the youth's juvenile probation officer (JPO),

parent/guardian, and other pertinent parties review the status of the youth's transitional activities and finalize plans for the youth's release and re-entry into their home community. A review of three closed youth case management records documented a completed Exit Conference form outlining youth identifying information to include travel arrangements, residence address, post-residential supervision plans, the status of the transition plan, and a summary of youth progress and identification of ongoing strengths, abilities, needs, preferences, and goals to be completed upon return to the community. The multidisciplinary treatment team documented court-ordered sanctions completed and yet to be completed, education plans, mental health and/or substance abuse follow-up plans, and any applicable healthcare needs. Additional information including societal and community-based needs were addressed. All three youth had a plan for continuation of education and/or employment and instructions for their post-release supervision. The date of admission and the date of termination documentation in the record correlated with the information in the Department's Juvenile Justice Information System (JJIS). Each reviewed record also contained documentation to the parent/guardian and JPO which confirmed the youth's release date and transportation arrangements for the youth's return to the community

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time licensed 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 8:30 a.m. to 5:00 p.m. and is on-call and available for consultation twenty-four hours a day, seven days a week. The DMHCA is responsible for ensuring all aspects of mental health and substance abuse services in the program. The DMHCA oversees the delivery from intake through discharge, ensuring youth receive an overview of services, appropriate assessments, and education of rights and consents upon admission. 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) and supplemental specialty services for dual diagnosed youth ensuring each youth's unique clinical needs are addressed. An interview with the DMHCA indicated they provide annual training and updates for all staff in the program regarding MHOS, psychiatric crisis needs, and suicide prevention. The DMHCA ensures members of the clinical team receive outside training opportunities to ensure they are prepared to facilitate the clinical curricula as intended, and to allow them to grow as clinicians and utilize new skills and techniques to improve the emotional, physical, and spiritual wellness of the youth served. The DMHCA facilitates individual, group, and family therapy and assists with completing intake clinical assessments. The DMHCA also indicated they facilitate crisis counseling and stabilization, Baker Act and/or Marchman Act proceedings, provide staff training, and facilitates mental health and substance abuse drills and suicide drills throughout the year to all program staff. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and also participates in weekly meetings with the psychiatrist 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. An interview with the DMHCA indicated they coordinate daily with case management, medical, and operations departments to ensure a clinical lens is used by all staff, and gender-specific, trauma-informed practices are utilized in every aspect of the program.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	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 facility administrator is responsible for ensuring mental health and substance abuse services are provided by appropriate and qualified individuals. The program's contract was amended July 15, 2019 to add an additional licensed therapist and to reduce the non-licensed master's-level therapists from eight to six. In addition to the licensed mental health counselor (LMHC) who serves as the director of clinical services and the program's designated mental health clinician authority (DMHCA), the program has one licensed clinical social worker (LCSW) serving as the lead therapist. The LCSW has a clear and active license in the State of Florida with an expiration date of March 31, 2021. The program also utilizes two pro re nata (PRN) licensed clinicians on an as-needed basis. One is a LMHC with a clear and active license in the State of Florida with an expiration date of March 31, 2021. The other is a LCSW with a clear and active license in the State of Florida with an expiration date of March 31, 2021.

The program hired a new psychiatrist in May 2019 and reviewed credentials supported they maintain a clear and active license in the State of Florida with an expiration date of January 31, 2021. Reviewed credentials supported the psychiatrist is a medical doctor with an educational background in child and adolescent psychiatry and is a member of the American Board of Psychiatry and Neurology. The psychiatrist is scheduled to be on-site weekly for approximately four hours and reviewed attendance logs supported this practice. The reviewed personnel records of each licensed staff indicated each worked within the scope of their licensure, experience, and training. In addition, each licensed staff member maintained a signed position description and in the case of the psychiatrist, a signed independent contractor agreement. The agreement was signed on March 18, 2019 commencing on May 6, 2019. Both the DMHCA and the psychiatrist are on-call twenty-fours a day, seven days a week for emergencies and consultation.

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's contract for Okeechobee Juvenile Offender Correctional Center (OJOCC) and Okeechobee Juvenile Sexual Offender Treatment Program (OJSOP) was amended July 15, 2019 to add an additional licensed therapist to serve as the lead sex offender therapist and to reduce the non-licensed master's-level therapists from eight to six. At the time of the annual compliance review, there was one non-licensed therapist vacancy for OJOCC. The position became vacant on March 21, 2020 when the therapist became licensed and moved into the lead therapist position for OJSOP. An interview with the regional compliance manager indicated a new non-licensed therapist is scheduled to begin working April 27, 2020.

Two non-licensed master's-level therapists were assigned to the OJOCC program and three were assigned to OJSOP. The licensed lead therapist was assigned a caseload to cover for the

vacancy. Both non-licensed master's-level therapists carry a caseload, with one assigned twelve youth and the other assigned eleven youth. The lead therapist is assigned eleven youth. One non-licensed therapist holds a master's-level degree in psychology and is a registered mental health counselor intern in the State of Florida with an expiration date of March 31, 2020. The other non-licensed therapist holds a master's-level degree in social work. All non-licensed therapists work under the direct supervision of the designated mental health clinician authority (DMHCA).

Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by a board-certified behavior analyst (CBA). The program utilizes a part-time CBA providing services to twelve youth in the program and is on-site on Monday's and Wednesdays each week. The CBA's certification expires on December 31, 2020 and they work on Monday's with the program and on Wednesday's with the school. Services provided include conducting functional behavioral assessments and developing behavioral plans. The youth are referred through program staff and the teachers. The CBA maintains monthly data sheets on each youth to document the progress of each youth and provides weekly incentives and monthly incentives. Examples of weekly incentives include snacks and the monthly incentive includes a big meal.

A review of the clinical supervision logs from October 2019 through April 2020 found the non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA. The reviewed documentation found the program utilized a clinical supervision log which included all required elements, as outlined in Department Rule. 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 proactively and any issues are constructively and diligently resolved. The DMHCA indicated members of the clinical team receive outside training opportunities which not only ensure they are prepared to facilitate their contractual curriculum as intended, but also allow them to grow as clinicians and utilize new skills and techniques to improve the emotional, physical, and spiritual wellness of the youth served.

Training records for the two non-licensed OJOCC assigned staff 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 on March 1, 2018 and the other completed the training on December 17, 2018. 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 clinical staff 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 seven youth mental health and substance abuse records validated each youth received a MAYSI-2 screening and an Assessment of Suicide Risk (ASR) administered by the assigned therapist or a licensed mental health counselor (LMHC) on the date of admission to the program. The MAYSI-2 is a validated instrument and includes the youth's mental health/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. Reviewed training records supported each staff who administered the MAYSI-2 was trained to do so and the training was documented in the Department's Learning Management System (SkillPro).

Reviewed documentation supported each youth's available information inclusive of the commitment packet, reports, and records of mental health, substance abuse, and suicide issues were reviewed by the mental health clinicians during the admission process and documented on the program's Records Review Form. An interview with the facility administrator (FA) and the designated mental health clinician authority (DMHCA) validated the practice. A review of seven mental health and substance abuse youth records found the program completed the commitment packet documentation review, a MAYSI-2, an ASR, and the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) for each youth upon admission. Five of the seven reviewed youth MAYSI-2 assessments indicated the need for a further evaluation. The program's FA or designee was notified, and referrals were made for further evaluations. One of the seven completed youth MAYSI-2 assessments indicated a suicide ideation category required an ASR and it was completed by the LMHC. Program practice is to complete an ASR during the admission screening process regardless of the MAYSI-2 findings. An interview with the FA indicated the Victimization and Sexually Aggressive Behavior (VSAB), the MAYSI-2, and the ASR are used during the intake screening process 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 seven youth mental health and substance abuse records found youth were assessed utilizing the Adolescent Psychopathology Scale – Short Form (APS-SF), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Substance Abuse Subtle Screening Inventory – Fourth Edition (SASSI-4 for applicable adults), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and the Trauma Symptom Checklist for Children (TSCC). The results of the assessments are utilized for the completion of the Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. Reviewed documentation supported six of the seven Bio-Psychosocial Evaluations were completed within thirty calendar days of the youth's admission and the program's practice is to complete a new evaluation annually. One was completed ten days late. All seven reviewed evaluations were completed by non-licensed, master's-level therapists. The licensed mental health counselor or licensed clinical social worker 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. An interview with the designated mental health clinician authority (DMHCA) indicated they assist in completing intake assessments and admission consents. The DMHCA also indicated the classification team identifies the needs for referrals for comprehensive evaluation, mental health and substance abuse alert status, as well as the need for placement on precautionary observation when indicated.

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 seven youth mental health and substance abuse records found each youth was assigned to a multidisciplinary treatment team upon admission into the program. Each reviewed 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 seven 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 and two youth were eighteen years of age or older and signed consent to receive services. Each youth record also had a signed Youth Consent for Substance Abuse Treatment and a signed Youth Consent for Release of Substance Abuse Treatment Records 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 therapy, daily group therapy, and monthly family therapy. Reviewed documentation supported five mental health therapists were trained to deliver Aggression Replacement Therapy (ART) and five case management staff were trained to deliver Impact of Crime (IOC) and three to deliver Thinking for a Change (T4C). Five youth were also determined to be in need of psychiatric medication management. Each youth received services, as outlined.

A review of treatment team documentation validated the meetings were held, as required, and the treatment team members were in attendance. The education and medical staff provided written updates prior to each treatment team meeting. The annual compliance review team participated by telephone in the scheduled treatment team meetings scheduled during the annual compliance review week. All seven reviewed youth records determined each youth required substance abuse treatment and found goals outlined on the individualized mental health and substance abuse treatment plan. In addition, each youth received substance abuse education. 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 had less than ten youth. The DMHCA has a certified therapy dog, Xena, providing animal-assisted therapy to youth in the program. According to the DMHCA, animal-assisted therapy has been proven helpful in increasing self-esteem, reducing anxiety, depression, reducing blood pressure, improving self-control, and enhancing social skills. In addition, the animal-assisted therapy helps with increasing trust, empathy, and is beneficial for individuals who are resistant to treatment or have difficulty assessing emotions and/or expressing themselves in therapy. The DMHCA indicated Xena was rescued after being found malnourished and tied to a lawnmower in the backyard of an abandoned house. After spending eight months at a shelter, she was adopted and shortly thereafter began therapy training. The day after completing her training, she was diagnosed cancer and had surgery to remove a tumor. Youth in the program can relate to her story, specifically to themes of abandonment, rejection, distrust, and eventually overcoming and achieving a new sense of purpose in life. Xena provides services in the program such as participating in formal animal-assisted therapies in individual therapy sessions, family therapy, and group therapy, along with informal supports including greeting youth during treatment team meetings and providing youth an opportunity to engage in healthy, appropriate touch and affection.

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. In addition, the DMHCA oversees monthly treatment team planning and review, monthly psychiatric meetings and medication review, and annual assessments and updates. According to the DMHCA, they provide individual, group, and family therapy, assist in facilitating mental health groups when needed. The DMHCA indicated they complete and review Assessments of Suicide Risk and Crisis Assessments for youth experiencing crisis issues. The DMHCA is responsible for ensuring communication with the clinical staff occurs daily and on a continual basis. Immediately following the daily management meeting, the DMHCA confers with the clinical staff to relay any pertinent information coming from the morning meeting. Group clinical supervision occurs every Wednesday at 12:00 p.m. and all members of the clinical department are present and issues in the areas of caseload review, clinical services delivery documentation trends, primary services, training, and fidelity are discussed. E-mail is utilized daily, as well as written and visual notifications of information

pertaining to scheduling, group/client assignments, review of Precautionary Observation, and issues/updates on documentation. Seven interviewed youth indicated each youth was participating in groups and receiving specialized therapies. The youth indicated they were attending groups such as ART, T4C, and IOC. Seven interviewed staff validated the clinical staff facilitate mental health and substance abuse groups.

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. Seven 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.

Five of the seven reviewed youth records were applicable for being admitted on prescribed psychotropic medications. All five applicable youth reviewed treatment plans documented each youth was referred for medication management and included details of the psychotropic medication dosage, and monitoring frequency. Reviewed documentation supported all seven individualized treatment plans were completed within thirty days of admission and documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form which contained all elements outlined in Florida Administrative Code. Each reviewed plan documented the designated mental health clinician authority (DMHCA) reviewed and signed the plan within ten days of completion, as required. Each reviewed plan contained the required signatures of all treatment team members who participated in the development of the plan. Five applicable youth were currently on 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 seven reviewed youth records required monthly treatment team reviews, and each was completed, as required. A review of the contract and amendments found the program is required to provide Aggression Replacement Therapy, Skillstreaming the Adolescent, The Passport Program, The Bullying Workbook for Teens, Male Healthy Relationships, Problem

Solving Training, Social Perception Training, Empathy and Social Competence Training, Living in Balance, Resilience Builder Program for Children and Adolescents, 100 Activities for Mental Health/Substance Abuse Recovery, Group Treatment for Substance Abuse, Thinking, Feeling, Behaving mental health treatment, Pathway to Self-Discovery and Change substance abuse treatment, and Impact of Crime.

Reviewed group schedules, attendance sheets, Weekly Progress Notes, and an interview with the DMCHA 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 program is a maximum-risk program serving males between the ages of thirteen and twenty-one. The program is co-located with the Okeechobee Juvenile Offender Sexual Offender Program (OJSOP). 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). The program services include a cognitive-behavioral treatment approach to include individual, group, and family counseling. The program has two licensed clinicians who are scheduled to work Monday through Friday, 8:30 a.m. to 5:00 p.m. The licensed mental health counselor serves as the director of clinical services and designated mental health clinician authority (DMHCA). The licensed clinical social worker serves as the lead therapist. Each youth is assessed upon admission for mental health and substance abuse needs utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). 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.

Mental health groups include group process therapy, anger management groups, conflict resolution, clinical education group forums, and other psycho-educational training groups are provided seven days a week. Supportive counseling is provided on an as-needed basis. Other services include initial screening process, clinical intake interviews, clinical assessments and evaluation, record review, Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation, psychiatric services, functional behavioral assessments, treatment plan development, daily therapeutic activities, and behavior modification. A review of seven youth mental health and substance abuse records confirmed each youth received individualized mental health services and substance abuse services. Each session addressed mental health, as well as substance abuse needs of the youth if applicable. The program has three master's-level non-licensed therapist assigned; however, at the time of the annual compliance review one position was vacant and the LCSW was carrying the caseload. Reviewed documentation supported all three clinician's caseloads were less than sixteen youth.

The program's contract requires a licensed psychologist under Chapter 490, F.S. must be available, as needed. The program's previous psychologist resigned in May 2019. The program utilizes the psychologist already contracted with two other TrueCore programs; however, this psychologist has not signed the contract at the time of the annual compliance review. An interview with the DMHCA indicated individualized treatment begins at the time of admission. Each youth is assigned to a multidisciplinary intervention and treatment team and primary therapist who develop, review, and update the youth treatment while in the program.

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 an independent psychiatrist agreement with a State of Florida board certified licensed psychiatrist commencing on May 6, 2019. The agreement was signed and dated by the psychiatrist and TrueCore's president and chief executive officer (CEO) on March 18, 2019 and March 21, 2019, respectively. There was an amendment indicating the psychiatrist agreed to the term of the May 6, 2019 agreement and was signed on November 22, 2019 by the CEO and the psychiatrist on September 9, 2019. The psychiatrist's license expires on January 31, 2021. The psychiatrist education is in child and adolescent psychiatry and is a member of the American Board of Psychiatry and Neurology, Inc. A review of the psychiatrist's license with the Florida Department of Health found there were no disciplinary actions taken by a specialty board or licensing board in the last ten years.

The psychiatrist provides medication evaluations and on-going monitoring of psychiatric medications. Routine services include psychiatric screenings, assessments, and evaluations of youth upon admission and through referral by program staff. All youth prescribed psychotropic medications are evaluated at least monthly. The program's contract with the Department outlines the psychiatrist is required to be on-site four hours bi-weekly. A review of the attendance logs from October 2019 through April 2020 validated the psychiatrist has been providing on-site services weekly and was on-site for at least four hours bi-weekly. Each reviewed attendance log documented the psychiatrist signed-in and out accompanied with their signature. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. The program does not utilize a psychiatric advanced practice registered nurse. Reviewed documentation supported the psychiatrist reviewed and approved all facility operating procedures related to psychiatric services and psychotropic medication management on July 30, 2019.

An interview with the designated mental health clinician authority (DMHCA) indicated meetings with the psychiatrist occur weekly on the day psychiatrist is on-site, typically on Mondays. The DMHCA briefs with the psychiatrist prior to the youth being seen for their follow-up psychiatric appointments and is present for any discussions between youth and the psychiatrist. Any medication issues brought up during formal treatment team meetings are revisited in greater depth with the clinical director, youth's primary therapist, and youth to determine an appropriate course of action. When the psychiatrist is not physically on-site, communication occurs by completion of Mental Health Referral form, which documents behaviors and events

necessitating psychiatric referral/evaluation. In the event of a more urgent matter, the psychiatrist is contacted by telephone.

A review of seven youth mental health and substance abuse records found five youth entered the program on prescribed psychotropic medications. However, program practice is for every youth to receive an initial diagnostic psychiatric interview within fourteen calendar days of admission. All initial psychiatric evaluations were completed on the Department's Clinical Psychotropic Progress Note (CPPN). The five applicable reviewed youth records indicated each youth received the prescribed psychotropic medications and each documented monthly face-to-face medication monitoring reviews and the corresponding CPPNs were completed, signed, and dated by the psychiatrist. The program's practice is to conduct a psychiatric evaluation for each youth and seven reviewed youth mental health and substance abuse records validated this practice. Five reviewed youth records documented psychiatric services in each individual treatment plan including addendums related to psychotropic medications.

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 written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. The MHSA plan was updated and approved by the facility administrator on January 18, 2018 and corporate office on July 10, 2017. The facility administrator and psychiatrist documented their annual review on July 24, 2019 and the designated mental health clinician authority (DMHCA) documented their review on July 30, 2019.

The program's written plan detailed suicide prevention procedures and 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. In an interview, the facility administrator validated the program conducted monthly mock drills for staff which include emergency response to suicide or self-inflicted injury. In addition, suicide prevention training is conducted for all pre-service staff and then annually for all in-service staff. The facility administrator was interviewed and stated emergency drills are completed at least monthly, inclusive of mental health and suicide drills.

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 constant supervision of the youth throughout the intake process. A review of seven youth mental health and substance abuse records validated each youth was screened for suicide risk utilizing the Department's Assessment of Suicide Risk (ASR). All seven ASRs were completed by either the licensed mental health counselor or the licensed clinical social worker. 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. None of the seven youth ASRs were identified with an elevated risk of suicide.

An interview with the designated mental health clinician authority (DMHCA) indicated the program had three youth placed on precautionary observation in the last twelve months. All three applicable youth were placed on precautionary observation (PO) due to self-reporting and 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 completed by the DMHCA for two youth and the licensed clinical social worker (LCSW) for one youth. Discontinuation of Close Supervision was documented in accordance with the program's suicide prevention plan. The program had no youth placed in secure observation within the last twelve months. Seven interviewed staff indicated when a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health staff, place the youth on constant sight and sound, radio the commander, search the youth and room for sharp objects, and document the youth supervision. Seven interviewed staff were aware of the program's suicide response kits located in master control. Six were aware of one located in sub-control and the medical clinic. Two indicated one kit was located in the supervisor's office.

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. Three applicable youth mental health records were reviewed for youth with elevated suicide risks and placed on Precaution Observation (PO). 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. There were no applicable youth who had been placed in secure observation within the last twelve months.

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 training is provided as part of the annual in-service staff training. Drills in response to suicide attempt and/or serious self-injurious behaviors are conducted once a quarter on each shift. A review of seven staff training records and nine mental health staff training records 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. Reviewed mental health drills reflected clinical drills simulating a youth suicide attempt were conducted on each shift. Reviewed documentation supported direct care staff participated in drills during the last twelve months. Documentation presented for review supported thirty-six of forty-three direct-care staff, including the maintenance staff, participated in a semi-annual suicide drill during the first six months. Documentation for the second six months supported twenty-eight of forty-three staff participated in a semi-annual suicide drill and ninety-nine percent of all staff participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR) annually. There was one recently hired staff out of the 100 staff members who has not had the opportunity to participate in a CPR drill. Each reviewed drill documented the description of the incident, a synopsis of the

response, any applicable deficiencies identified, and any applicable corrective action required. Reviewed documentation supported drills which demonstrated life saving techniques such as CPR and use of the automatic external defibrillator (AED) were conducted at least once a quarter. Participating staff signed the Clinical Drill Participation Log indicating their understanding and compliance with the procedures.

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 July 25, 2017 and corporate office on July 10, 2017. The facility administrator documented a review on July 24, 2019 and the designated mental health clinician authority (DMHCA) documented a review on July 30, 2019. 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 facility 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. Seven youth mental health and substance abuse records were reviewed and 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 completed by the DMHCA, who is a licensed mental health counselor, on May 8, 2019 on the date the youth was determined to be in crisis. The youth was assessed and was placed on Constant Supervision. A Mental Status Examination was conducted on May 9, 2019 and the youth was placed on Standard Supervision. A review of the Department's Juvenile Justice Information System 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 re-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 25, 2017 and the corporate office on July 10, 2017. The facility administrator documented a review on July 24, 2019 and the designated mental health clinician authority (DMHCA) on July 30, 2019. 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. 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 Lawnwood Regional Medical Center in Fort Pierce, Florida for Marchman Act services.

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 procedure during this annual compliance 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 establishing a health authority with the responsibility 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) executed on March 6, 2020, with an automatic annual renewal. The DHA holds an active, unrestricted license under Chapter 458, Florida Statute, and is an osteopathic physician with specialty training in internal medicine with a license expiration date of February 28, 2022. Previously, the program had an independent contractor agreement with a licensed an osteopathic physician to serve as the designated health authority (DHA) which was executed on September 10, 2019. The DHA held an active, unrestricted license under Chapter 458, Florida State Statute as an osteopathic physician with a license expiration date of March 31, 2020. The prior DHA's last on-site visit to the program was completed on March 3, 2020.

The program does not utilize an advance practice registered nurse (APRN) or physician's assistant. The DHA is scheduled to be on-site weekly for a minimum of two hours. Reviewed physician weekly clinic logs for the previous six months validated the DHA was on-site weekly and there was never more than eight days passing between visits. 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, assessment and treatment of sick call referrals, episodic and chronic health conditions, provision of medication evaluation, prescription of medications and on-going monitoring of medications.

Supporting documentation validated the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans as needed. The program has an agreement with a medical doctor holding an active, unrestricted license as the back-up physician. Additionally, the provider agency utilizes a full-time corporate staff for secondary back-up coverage who is a licensed medical doctor with a clear and active license expiring on January 31, 2021. An interview with the DHA indicated their role includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and review of healthcare policies and procedures and nursing protocols. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist whose current license expires on January 31, 2021 and whose certificate of insurance expires March 21, 2021. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist's license expires February 28, 2022 and maintains certificate of liability insurance with an expiration date of January 21, 2020. 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 written 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 supported the previous DHA signed all healthcare policies and procedures on October 1, 2019 and the current DHA signed all healthcare policies and procedures on March 5, 2020. The facility administrator documented a review on October 3, 2019, and the psychiatrist documented a review on June 17, 2019. The program maintains three full-time registered nurses (RN), and one health services administrator (HSA), although one RN was on maternity leave at the time of the annual compliance review.

The program maintains a training requirement whereby newly employed healthcare personnel are to receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code, provided by HSA. Reviewed training curricula and plan supported a new RN would receive the required pre-service and orientation training to include on-the-job training. The program maintains a written nursing protocol manual developed and approved by the previous DHA on October 15, 2019 and the current DHA on March 5, 2020. Reviewed training records for healthcare staff supported training on the treatment protocols and healthcare policies and procedures in January and February 2020. Treatment protocols were reviewed by the previous DHA on October 1, 2019 and the current DHA on March 5, 2020. The treatment protocols 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 to ensure parents/guardians are afforded the right to give or withhold consent specific to 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 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 specified 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 ages eighteen 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, including to whom the information may be released or shared.

A review of seven youth healthcare records found two youth were eighteen years of age or older and both signed a Release of Information form. Four applicable reviewed youth healthcare records each contained a copy of the signed AET with the word "Copy" clearly stamped on each. There were no original AETs reviewed. One youth was in the custody of the Department of Children and Families (DCF); with parental rights terminated and the record contained a court order authorizing the administration of specified healthcare treatments. Each reviewed AET and/or Release of Information form was maintained in each youth's healthcare record in the

appropriate section. An interview with the health services administrator (HSA) indicated the HSA reviews 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. Upon intake or when the youth reaches eighteen years of age, two releases of information are to be completed for the youth to indicate in writing what information, if any, should be released and an emergency contact.

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 requiring the parent/guardian to be informed of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. Procedures also require notification to the parent/guardian to obtain consent for new psychotropic medications, discontinuances, or psychotropic medication adjustments. Seven reviewed youth healthcare records revealed two were for youth ages eighteen years or older. Five applicable reviewed healthcare records validated the parents/guardians were notified when a significant change to existing medication occurred, when there was a change in condition, and/or a change in medication for youth identified with a chronic condition.

There were five applicable youth records for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) form and documentation supported parental notification was sent in each instance. None of the reviewed youth healthcare records were applicable for off-site emergency care. Program practice is the parents/guardians are notified, in writing, within twenty-four hours. Verbal consent is obtained as soon as possible after an order is written. Consent is obtained for any OTC medication which has not been previously approved. For new prescriptions, any significant medication dosage change, or for discontinuing a medication, a parental notification is also completed, and consent obtained.

The program attempts to verbally contact the parent/guardian prior to a youth departing the program for emergency medical care. The parent/guardian is also contacted upon the youth's return with the results of the emergency room (ER) visit and written notification is also completed after the return from the ER. An interview with the health services administrator (HSA) indicated parental notifications are written and sent within twenty-four hours of a youth's off-site appointment, new intake, being seen on-site by the designated health authority, and/or any other pertinent medical event. The program's practice is for all youth to receive a comprehensive psychiatric evaluation within fourteen days of admission. The program's practice is to also complete page three of the Department's Clinical Psychiatric Progress Note (CPPN) regardless of prescribed medications.

Seven reviewed records contained documentation of a completed psychiatric evaluation and page three of the CPPN sent to the parent/guardian. Four of the seven reviewed youth healthcare records were applicable for the prescription of a psychotropic medication and the required parent/guardian consents were obtained. Each reviewed healthcare record documented a verbal consent by telephone was conducted by the psychiatrist and witnessed by the nurse. A checkbox on one CPPN in one record was not completed to indicate verbal consent had been obtained; however, the CPPN did document the nurse witnessed the verbal consent, and the nursing progress note documented the parent/guardian's verbal consent was

obtained. The parent/guardian received a written follow-up of a copy of the Department's 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 healthcare record. There were no applicable youth requiring any immunizations nor any parent/guardian not consenting to vaccinations due to religious reasons; however, policy and procedures outline the AET form provides an opportunity for parental consent to be obtained for missing vaccinations. Program practice is for the healthcare staff to obtain each youth's immunization record from the Florida Shots website within the first week of admission and the designated health authority's review of the record documented.

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

The program maintains a written policy and procedures requiring each youth to receive a routine healthcare screening and evaluation upon admission and to ensure a healthcare admission rescreening is completed each time a youth's physical custody changes and the youth are subsequently returned or readmitted to the program. A review of seven youth healthcare records validated 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). An interview with the health services administrator indicated a nursing assessment is conducted immediately following the initial search, typically within ten to fifteen minutes of the youth's arrival at the program. It is the program's practice for the RN to notify the designated health authority (DHA) by telephone or verbally, if on-site, of all admissions with the youth's history and identified chronic condition and document the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is maintained in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. One of the seven reviewed healthcare records was applicable for a change in custody. The program had one additional applicable youth healthcare record for change in custody which was also reviewed. Both applicable youths received a re-screening upon admission utilizing the FEPHS.

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 requiring all youth to be oriented to the healthcare system upon admission or the next available opportunity. Health education and orientation is to be provided by the healthcare staff, in writing, and during an individual session with the youth to ensure youth with hearing, visual or cognitive disabilities understand the information provided. When applicable, the orientation/admission health education will be provided in Spanish, or in any other language a youth uses as a primary language. A review of seven youth healthcare records validated each youth received a healthcare orientation on the date of admission which was documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents. The youth and registered nurse (RN) signed the health education packet to acknowledge the training was conducted and the youth reviewed and understood the presented information. In addition to the admission health orientation, youth

received health education throughout their stay which is also documented in the healthcare record. Each reviewed healthcare record 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 or verbally, if on-site, of all admissions and when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Healthcare 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 seven youth healthcare records validated the DHA was notified by telephone and the Notification of Admission form was maintained in the practitioner's section of the healthcare record. The nurse additionally documents the DHA notification on the Nursing Chronological/Notification Progress Note 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 to requiring healthcare staff to complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of seven youth healthcare records found a new HRH form was completed for each youth within seven days of the youth's admission. Reviewed practice validated the HRH form was completed on each youth's date of admission. The healthcare staff provided their electronic signature on the HRH form. The DHA documented a review of the HRH form on the completed CPA. An interview with the health services administrator validated the practice and indicated the HRH form is also completed whenever any new significant medical event or change occurs and then annually, if needed.

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

The program maintains a written policy and procedures to ensure each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity and evaluation for latent or active tuberculosis. A review of seven youth healthcare records validated 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." All seven reviewed CPAs did not have sections twenty-five and twenty-six (rectum examination) completed and six of the seven assessments documented the deferral of those sections as age inappropriate on the CPA. One record completed by the DHA completed sections twenty-five and twenty-six as "N/A" without any additional comment noted on the CPA rather than "Deferred by Clinician," as required by the program's facility operating procedures. Reviewed documented practice validated the Department's Problem List was updated for each youth throughout the youth's stay, when applicable. A review of seven youth healthcare

validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. Additionally, as part of the healthcare admission screening, healthcare staff utilized 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 date of admission for each youth. The results of the TST were also documented on the Department's Infectious and Communicable Disease (ICD) form in each reviewed record. An interview with the health services administrator indicated healthcare staff 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. There were no youth with current symptoms suggestive of active TB. Program procedures stipulate if the screening indicates any youth has symptoms suggestive of active TB, the youth is not to be 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 to ensure all youth admitted to the program are clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) is to then decide based on the screening tool and medical evaluation whether to order testing for sexually transmitted diseases/infections. It is the program's practice to refer all youth to the DHA for further evaluation of sexually transmitted infections. A review of seven youth healthcare records found five youth were identified as sexually active and all seven youth were clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation. 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.

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. An interview with the health services administrator supported the practice. The program maintains a written policy and procedures to ensure all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of seven youth healthcare records validated each youth was offered the opportunity to receive counseling and testing for HIV. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. Six youth consented to testing. The program's DHA provides HIV pre-counseling, testing, and post-counseling. Reviewed youth healthcare records validated when youth received pre-counseling, testing, and post-counseling, the youth's Health Education Record form was updated. Test results were maintained in a sealed envelope marked "confidential" and the youth's name and test date documented on the outside of the envelope. An interview with the health services administrator indicated the confidential results are given to the youth upon discharge. Healthcare 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-HIV counseling date, post-HIV counseling and results date, and provider name. Seven interviewed youth indicated they can request HIV testing.

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

The program maintains a written policy and procedures to ensure all youth are 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, are to be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to the 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 a non-emergent nature, but which require 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 to the program. The youth are to complete a sick call request form and place it in a wall mounted locked box located in the "horseshoe" adjacent to the entrance of each dormitory which preserves the youth's privacy and confidentiality. An interview with the health services administrator indicated the sick call box is monitored at least every two hours throughout the day by nursing staff. The program conducts sick call at least twice daily, seven days a week, and is conducted by a registered nurse. Sick call is conducted from 6:30 a.m. to 6:55 a.m. and 2:05 p.m. to 4:00 p.m., Monday through Friday. On Saturdays and Sundays, sick call is conducted from 8:00 a.m. to 8:30 a.m., 9:30 a.m. to 11:45 a.m., and 2:00 p.m. to 4:00 p.m.

A review of seven youth healthcare records validated six youth completed a Sick Call Request form at least once during their stay, with a total of thirty-five sick call requests among the six applicable records. One youth submitted two separate sick call requests, one youth submitted three requests, three youth each submitted five sick call complaints, while one youth submitted fifteen requests. The registered nurse (RN) documented the treatment and instructions provided to each youth during the sick call event on the Sick Call referral log. Seven reviewed records indicate one youth presented three or more times within a fourteen-day period for a similar sick call complaint and the youth was automatically referred to the DHA for evaluation and/or treatment, as required by the program's facility operating procedures. The sick call referral log included a sick call visit on November 29, 2019 for which actually occurred on November 27, 2019 as indicated by the handwritten and typed sick call requests. The program's sick call index instructions indicate the sick call complaint is to be listed on the index as it occurs. Reviewed healthcare records indicated each sick call incident was documented on the youth's Sick Call Index and the program's Sick Call Referral Log. However, three of the applicable six Sick Call Indexes included a total of five late entries which were entered twenty-six, thirty-five, sixty-four, eighty-nine, and 115 days late, respectively. When a licensed healthcare staff is not on-site, all Sick Call Request forms are to be turned into the shift manager for review. The shift manager is required to review the sick call complaint promptly but no longer than two hours after the request was submitted. The shift manager will determine if the sick call requires immediate attention. The designated health authority (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 or the severity of which cannot determined shall be treated as an emergency and requires immediate referral

to a licensed healthcare professional. All youth are seen within twenty-four hours of submitting a sick call request. Seven interviewed staff all indicated the nursing staff conduct sick call. Seven interviewed youth found six indicated they can be seen within one day of submitting a request, and one youth indicated they are seen within three days of submitting a Sick Call Request form. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observations of sick call were not possible.

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 to ensure there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed, in response to unexpected illnesses, accidents or conditions requiring immediate attention or an immediate professional assessment to determine their severity. A review of seven youth healthcare records found six youth requiring episodic and/or first aid care during their stay in the program. All treatment services were provided by healthcare staff and the nursing progress notes clearly documented treatment services rendered utilizing problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Healthcare 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/illness, treatment rendered, staff initials, registered nurse (RN) initials, and whether the youth was referred to the RN or designated health authority (DHA). Youth who are sent off-site for emergency care are tracked in the nursing progress notes as well as documented on the Episodic Log. An interview with the health services administrator (HSA) validated this practice.

The program maintains a written policy and procedures requiring proper management and administration of the program-based automated external defibrillator (AED) to persons eight years of age and older who experience sudden cardiac arrest. The program maintains four AEDs located in the medical clinic, master control, the east living unit, and the west living unit. All staff, volunteers, and interns are authorized to provide assistance to victims of sudden cardiac arrest, if they have been trained in the use of the AED, as documented in the respective training records. The program maintains eight first aid kits located in the medical clinic, kitchen, east living unit, the west living unit, master control, and one each in the transport bags for van number one, and van number two which are stored in master control when vans are not in use. The program also maintains four suicide response kits located in the medical clinic, master control, east sub-control, and west sub-control, each containing a knife-for-life, wire cutters, and needle nose pliers. The first aid kits are checked weekly by healthcare staff to ensure each is adequately supplied and the AEDs are checked monthly by healthcare staff are checked monthly to ensure each is in working order and pads/batteries are within their functional life. The AED procedures are available within the program's policy manual, as well as through audio instructions from each unit when activated. An interview with the health services administrator (HSA) revealed AED batteries expire in March and August 2023 and were last changed in March and August 2019. AED pads are new and unopened with expiration dates in August 2020, December 2020, and June 2021. AED pads are replaced after each use. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. Healthcare staff maintained current certifications in CPR and AED.

The program's facility operating procedures require announced and/or unannounced emergency medical drills with various simulated events to be conducted monthly on each shift. Reviewed drills supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the prior twelve months supported drills were conducted each month on the "A" shift. However, there was no documentation to support emergency medical drills were conducted on the "B" shift in May or August 2019, nor on the "C" shift in June or September 2019. Conducted drills did include at least quarterly CPR/AED demonstration. A review of twelve months of emergency medical drills, as well as the Department's Learning Management System (SkillPro) training reports for 2019 and the first four months of 2020 revealed one of 100 current staff at the program did not have demonstrated CPR in the past twelve months in either a drill or CPR recertification. Reviewed training records supported all healthcare and supervisory direct care staff have been trained in the administration of the epinephrine auto injector.

The program provided three examples of when healthcare staff were not on-site, and a non-licensed staff provided episodic care. Two youth complained of a headache and one complained of shortness of breath two youth were provided with two Ibuprofen tablets and the other was provided his prescribed inhaler in accordance with the medication administration records. The incidents were documented on the Report of On-Site Healthcare by Non-Healthcare Staff form, which the RN reviewed the next day, signed the form, and conducted a follow-up assessment of the youth. Five of the seven interviewed staff responded they were permitted to call 9-1-1 if a youth were to have a medical emergency. One staff indicated the shift supervisor would be notified immediately as there is no telephone available on the living units. One staff failed to respond to this interview question. Seven interviewed youth indicated they can see a dentist in the event they have tooth pain and/or doctor if needed.

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

The program maintains a written policy and procedures requiring timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site are to 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 seven youth healthcare records indicated three youth required off-site and/or emergency care. Each youth off-site care event was documented in the youth's individual healthcare record. Two of the three youth were eighteen years of age or older. One reviewed youth healthcare records indicated the youth were under eighteen years of age and the parent/guardian was notified, as required. 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 the DHA's initials and date. Two youth required follow-up care, and one record documented the attempt to receive services as prescribed; however, the appointment was cancelled by the off-site practitioner due to the COVID-19 pandemic. The other youth had not yet reached the date for follow-up. An interview with the health services administrator indicated the healthcare staff track follow-up testing, referrals, and appointments on the nursing calendar and the health services tracker.

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.	

Periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The program maintains a written policy and procedures to ensure youth identified with a chronic illness receive regularly scheduled evaluations and necessary follow-up treatment. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of seven youth healthcare records indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. Five of the seven youth were classified with a medical grade of two through five. The seven records did not include any youth currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth roster 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 supported each youth received periodic evaluations as required.

An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every thirty to sixty days dependent upon the number and severity of chronic illnesses. The DHA further indicated youth identified with a chronic condition are placed on the scheduler to ensure the DHA follows-up with each applicable youth. One youth with two identified chronic conditions was not included on the chronic conditions roster; however, there was no indication of lapses in care or missed periodic evaluations. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The DHA diagnosis the chronic condition with a treatment plan. The DHA conducts a periodic examination of the youth no more than every sixty days, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. 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 requiring medical staff to verify any medications arriving with a newly admitted youth and to continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff are to conduct a preliminary assessment and interview to determine the medication is verified and indicated. Healthcare staff complete the Facility Entry Physical Health Screening (FEPHS) form to determine medical needs. The signed Authority for Evaluation and Treatment (AET) form serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. An interview with the health services administrator (HSA) indicated only registered nurses complete the healthcare admission and any applicable medications are verified with the medical records and the youth's parent/guardian.

A review of seven youth healthcare records indicated five youth were admitted into the program with prescribed medication. Reviewed nursing admission notes documented the youth's current medication. The designated health authority (DHA) Notification of Admission form detailed the current prescribed medication and verbal or telephonic notification made. Program practice is to notify the DHA for all youth admissions. The DHA or psychiatrist continued the prescribed medication for each applicable 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 supported all medications had a current, valid order, and were given pursuant to a current practitioner's order. Each of five applicable reviewed youth healthcare records indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. Each time the practitioner's order clearly documented the medication and dosage. Oral prescription medications were administered, according to instructions. All staff administering medications are to have knowledge or be informed of the common side effects and precautions of prescribed medications. Seven reviewed youth healthcare records found each youth had a MAR outlining over-the-counter medications approved through the AET form. The medication was administered in accordance with the approved protocols and physician's order.

A review of the five applicable healthcare records for youth with current prescribed medication documented three instances of healthcare visits by registered nurses while the youth was in controlled observation for behavioral disturbances; however, there were no instances of medication administrations missed. Five of the seven youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 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. Five applicable youth were taking prescribed medications upon admission and the initial MAR matched the medication listed.

Observations found the medications were procured through a pharmacy. 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 registered nurses. All seven reviewed MARs supported the youth received the medication(s), as prescribed. The MARs clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Trained non-licensed staff are permitted to assist youth in OTC medications when healthcare staff are offsite.

Seven interviewed staff and seven interview youth all indicated healthcare staff provide medication to youth. Four interviewed staff and one interviewed youth indicated the shift supervisor can provide youth with medication. Two interviewed staff clarified the shift supervisor can only provide medication during overnight hours when healthcare staff are not on-site, and they may only provide approved over-the-counter medication and inhalers. There were no indications of lapses and/or errors in the medication administration. Healthcare staff documented side effect monitoring on the MAR daily each time medication was administered. Three youth were applicable for a refusal of medication and each was clearly documented on the MAR and healthcare staff completed the Department's Refusal of Treatment form and had the youth sign the 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, observations of medication administration and medication counts were not possible. The program maintains a written policy and procedures requiring all controlled substances to be inventoried, stored, and documented as required by the Board of

Pharmacy and Department requirements. Program procedures outline all controlled substances are to be maintained in a securely locked box within the securely locked medication cart located in the medical clinic. An interview with the health services administrator (HSA) validated the practice.

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

The program maintains a written policy and procedures requiring all medications to be identified and secured in a locked area designated for storage of medications. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this annual compliance review was conducted off-site; therefore, observations of medication storage were not possible. The program's practice was reported to store the mediations in a locked box located in the locked medication cart, which is stored in the medical clinic. The program's reported practice is to securely stored sharps and syringes separate from medications. The program maintains a written policy and procedures requiring all chemical products, medicines, medical and dental instruments assigned to the medical department to be securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws.

Reviewed documentation and interview with the health services administrator (HSA) confirm all over-the-counter (OTC) medications are inventoried at least weekly. The program's reported practice is for OTC medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a 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. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator and registered nursing staff. T

he program maintains written procedures for the disposal of narcotics and other controlled substances. An interview with the HSA revealed it is the program's practice is for licensed healthcare staff to destroy class II medications on-site with the consultant pharmacist. Other medications are returned to the pharmacy for destruction. A review of documented program's inventory counts from the previous six months validated no discrepancies were identified with the counts. In compliance with the CDC guidelines regarding COVID-19, this annual compliance review was conducted off-site; therefore, observation of medication administration, medication inventory counts were not possible.

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 to ensure there is an approved plan for exposure control and infection control to ensure 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 October 3, 2019, and designated health authority (DHA) on October 1, 2019. 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 outline 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 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 an exemption certificate for Biomedical Waste-Medical Doctor from the State of Florida, Department of Health with an issue date of October 1, 2019. The program maintains monthly receipts of medical waste pick-up. 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 facility administrator 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. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the FA indicated the program's exposure Control Plan/Infection Control Plan is located in the FA's office, medical clinic, and in master control and the plan is reviewed with newly hired staff as well as with all staff at a minimum of once a year.

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

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

Standard 5: Safety and Security

5.01 Youth Supervision	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 accordance with the Center 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 reviewed at a later date.

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 to address the implementation and training of the program's behavioral management system (BMS) approved by the facility administrator (FA) on July 25, 2017and the annual policy review was conducted on July 24, 2019. The program has a written BMS which fosters compliance with the program rules and teach youth alternative pro-social methods of dealing with problems by utilizing rewards and a system of progressive discipline. According to the regional compliance manager, there has been no change to the BMS since the last annual compliance review. A review of seven staff training records indicated each staff was trained in the BMS during pre-service and in-service training.

A review of training documentation indicated the teachers were provided BMS training. The program's contract indicated subcontractors and volunteers are to be trained in the BMS. According to the regional compliance manager, the program had no volunteers during the annual compliance review period. A review of the youth handbook verified the BMS included a description of the rules and the consequences for violation of the rules. According to the program's regional compliance manager and unit manager, the BMS is posted in each living area of the youth dorms. A review of seven youth records indicated the orientation process included informing the youth of the BMS including youth expectations, responsibilities, and consequences. An interview with the FA indicated the program uses a token economy system to reward the youth for positive behavior and behavior is also addressed through treatment team meetings and level progression. Rewards are monitored by the director of case manager (DCM).

Each morning, the DCM reviews the negative and positive behavior reports written by staff. The case managers also review the contact cards for each youth. Seven youth were interviewed and each youth knew the difference between each level and how to move from one level to the next. Seven staff were interviewed and stated the BMS consists of a point and level system and is posted throughout the facility. Each of the seven interviewed staff stated food, games, and

hygiene items are some of the rewards provided as a part of the BMS. Seven staff were interviewed, and five stated items can be taken away from a youth as a consequence related to the BMS. One youth stated yes and indicated canteen, points, and drop of level privileges.

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 maintains a written policy and procedures to ensure 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 BMS and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff. Staff are provided feedback regarding the implementation of the BMS.

A review of the BMS indicated it is not used solely to increase a youth's length of stay, deny basic rights or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program utilizes a process for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity to explain their behavior during treatment team meetings. The program does not utilize room restriction for major infractions. A random review of staff position descriptions indicated implementation of the BMS is addressed as a part of the daily functions. An interview with the facility administrator (FA) indicated consequences are monitored through treatment team meetings and the BMS. Seven youth were interviewed and were able to explain the process for receiving consequences and stated staff are consistent in the use of punishments and rewards. All of the youth were able to explain the rewards used in the program and reported youth are not allowed to punish other youth. Each of the youth stated they have never been sent to their room for punishment reasons. Seven staff were interviewed and stated verbal feedback on the BMS is given in daily briefing treatment and by supervisors.

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 accordance with the Center 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 reviewed at a later date.

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 to track the daily census at the program. Staff promote safety and security by maintaining active supervision of youth to include interacting positively with youth, constructive activities, closely observing behavior of youth and consistently applying the program's positive performance system. Youth are always accounted for by a physical count and random head counts when requested by master control. A review of the facility logbooks for the previous six months found the logbooks contained documentation of youth counts conducted at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, emergency counts, and reconciliation of the count.

Interviews with staff indicated when the count is not reconciled, master control is contacted, and all movement stops until the count is corrected. The staff must know how many youth are under their supervision without having to count the youth. Seven staff were interviewed and knew when youth counts were conducted, including emergency counts and what happens when there is a discrepancy regarding the count.

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 written policy and procedures for logbook documentation. Master control maintains a bound logbook with numbered pages. The logbook documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), Florida Abuse Hotline, and supervisors are able to leave special instructions pertaining to supervision of youth. Each entry was made in ink with no erasures or white-out. A review of the logbooks for the past six month indicated entire mistakes were struck through with a single line and initialed. The program conducts staff briefings prior to the beginning of each shift. Incoming staff is briefed on the previous shift and sign the shift report to acknowledge information has been shared. The programs also utilize a housing unit report to relay the daily content for incoming staff. Review of random shift reports for the previous six months verified this practice.

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 for missing or lost keys, replacing damage keys, key assignment, inventory of keys, tracking, and storage of keys. The program has a daily key log for tracking keys. Observations by face time of facility keys were observed a on a key board located in a locked closet in mater control. Keys are bound on a tamper-resistant ring which includes a brass colored tag with the tracking number. According to the program's policy, all facility keys are maintained within master control. In order to provide strict accountability of facility keys, master control is responsible for inventory, issuance, inspection, return and documentation of active, file, and emergency keys. After staff have been searched, they proceed to master control to turn in their personal keys, receive facility keys, and sign the key control log verifying keys were issued. Staff must also sign the key control log upon returning keys to master control, verifying keys have been returned. Restricted keys are issued to teachers, case managers, therapists, and nursing staff by master control and reconciled daily. Review of the master control key log verified this practice. Damaged keys are turned over to the physical plant manager to have the key replaced. The program also has a list of staff who are assigned permanent keys. When permanent keys are issued, staff sign an acknowledgment form indicating the key identification number and the number of keys issued. A key check of all facility keys is conducted monthly to ensure all keys are accounted. A review of the key checklist verified this practice. An interview with the facility administrator (FA) indicated there have not been any missing or lost keys since the last annual compliance review. Informal interview with the unit manager and regional compliance manager along with the program policy

indicated if lost keys have not been found within two hours, the incident is reported to the Central Communications Center (CCC). Seven staff were interviewed regarding the process for missing, damaged, and restricted keys. All staff stated staff keys are given to master control upon entry, six staff stated personal keys are stored securely, all staff stated keys are tracked daily and are assigned to staff. Regarding missing, lost, or damaged keys, all seven interviewed staff stated if keys are missing or lost, master control is notified, and the facility is searched, and six staff stated youth do not have access to the program keys.

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

The program maintains a written policy and procedures which address illegal contraband and prohibited items. The policy identifies a list of unauthorized and illegal contraband and how it is to be disposed when found in the possession of a youth. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. A random review of youth records verified the youth are informed of contraband policy by signing the contraband list form after reviewing the youth handbook at the time of orientation. Visitors are also notified of unauthorized and prohibited contraband during visitation. Review of the program's policy, to include the youth handbook and visitor contraband list, verified a list of the required unauthorized items not permitted include personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program conducts weekly unannounced random searches of youths sleeping rooms. A review of the reports for the previous six months indicated checks were conducted and any contraband found was documented. An interview with the facility administrator (FA) reported any contraband collected is turned over to the department during the initial review. If not requested, the contraband is disposed of. All illegal contraband will be turned over to the local sheriff department.

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 accordance with the Center 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 reviewed at a later date.

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 to ensure vehicles used to transport youth are properly maintained. The program has two vans utilized to transport youth. The vans are identified as van-five and van-eight. Van-eight received an annual safety inspection on January 28, 2020 and van-five on February 28, 2020. Vehicles are equipped with an up-to-date fire extinguisher, first aid kit, seatbelt cutter, window punch, and operable seatbelts for each passenger. First aid kits are stored in master control until the vehicle is ready for use. Due to COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of a transport or random checks of the vehicles were unable to be conducted.

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

The program maintains a written policy and procedures to ensure appropriate minimum staff-to-youth ratio for the safety and security of youth, staff, and the community when youth are transported outside of the facility. Reviewed program policy ensured compliance of all requirements outlined by the Department relating to transportation of youth and driver eligibility. Rear passenger doors are unable to be open from the inside. The program maintains a list of staff who have eligible driver's licenses, which is updated monthly and provide a ratio of one staff to five youth during transport. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Staff are not allowed to transport youth in their personal vehicles. Seven staff were interviewed, and stated staff are not allowed to transport youth in their personal vehicle. Seven staff indicated cellular telephones and two-way radios are provided during youth transports.

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

The program has a written policy and procedures to ensure safety and security of the facility grounds and perimeter. The policy addresses who is responsible for conducting the audits,

procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. Weekly safety and security audits are conducted by the facility administrator (FA) and documented on the safety and security audit inspection form. Any deficiencies are addressed on the form and discussed during the program's morning meetings. A review of the safety and security inspection forms for the previous six months verified audits were conducted consistently and documented in the facility logbook. Checks are conducted on each shift and after youth outside recreation. A review of the facility logbooks for the previous six months verified checks were conducted, as required. An interview with the FA revealed TrueCore has developed a risk management and quality improvement system, which involves collaboration and corporate oversite to ensure fidelity, address arising needs and program progress, as well as promote continuous quality improvement. The internal program control structure will be continually assessed, evaluated, and appropriately updated to meet the individual needs of the youth, program, mandated guidelines, and requirements of the customer.

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 to ensure youth do not use tools or equipment as weapons or security breaches. The policy addresses storing and inventory of tools, as well as class type. The program's maintenance tools are kept in the carpenter's shop located outside of the secure area of the facility. A daily tool inventory is kept for each tool. Tools are organized in a locked area with a list of each tool. All tools are classified, and each tool is stored on a shadow board, labeled and inventoried daily. When a tool is needed, it is signed out by the maintenance staff to include the day, and time the tool was signed out and returned. A review of the inventory list and daily sign in and out documentation for the carpenter shop verified there were no missing tools. Seven staff training records were reviewed and indicated staff were trained in the safe use of class tools. Seven youth were interviewed and stated they are allowed to use scrub rush, five said mops and brooms.

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

The program maintains a written policy and procedure to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth and staff. Youth are only allowed to use class B tools. A tool protocol for the use of class B tools is provided to the youth explaining the rules. A random review of the protocol indicated it is reviewed and signed by the youth. The program policy requires a minimum ratio of one staff for every five youth during activities involving tools, except in the case of disciplinary work projects involving tools, which require a minimum ratio of one staff for every three youth. Youth are not allowed to handle tools unless a risk assessment has been completed and determined the youth is not at risk. A review of youth case management records verified assessment are completed monthly. Due to COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of youth using tools was unable to be conducted. Seven staff were interviewed and Six indicated youth are only allowed to use scrub brushes, mops, and brooms. Seven youth were interviewed and stated they use scrub brushes. Five stated they uses mops and brooms.

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 maintains a written policy and procedure to address outside contractors prior to beginning any work in the facility. When a contractor arrives on campus, they sign in and out on the facility sign-in log. The physical plant manager maintains contractor tool control procedures and inventory sheet. The sheet provides the contractor with the rules of the program and requires an inventory of all tools needed to complete the work. A review of the program contractor tool control procedures and inventory sheets indicated tools were inventoried and the contractors reviewed and signed the document. An interview with the facility administrator (FA), coupled with reviewed documentation, indicated contractors enter the program by way of the sally port or through the main entrance if repairs are conducted within the facility. Five random invoice and inventory sheets were reviewed, along with the logbook and facility sign-in and out logs indicated contractors are documented in the logbook. An informal interview with the regional compliance manager and unit manager indicated when contractors are on-site, youth are not allowed in the vicinity of the work area. While the work is performed, a maintenance staff is assigned to the contractor to ensure the work is completed and all tools are accounted. The FA is responsible for approving items such as personal cellular telephones and/or equipment/electronic devices capable of taking pictures and/or audio/video recordings are prohibited in the secure area.

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's Continuity of Operations Plan (COOP), which was approved by the Department, addresses fire, safety, and evacuation emergency drill which are to be conducted monthly, at random times, and under varied conditions. Drills are documented on the program's facility drill form and which indicates the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A random sample of the program's facility drill forms for the previous six months were reviewed and verified drills were performed on each of the three shifts. The forms also included debriefing documentation and feedback on how the drills was performed. Reviewed documentation confirmed the program completed unannounced fire drills and COOP drills on each shift in accordance with their COOP. Seven youth were interviewed and stated they were told what to do in case of a fire and drills are conducted monthly. Seven staff were interviewed and asked what type of drills they participated in the last twelve months. Four stated a major disturbance, bomb threat, and five stated hostage situation, seven staff stated fire drills, six stated escape, and four stated flooding. An interview with the facility administrator (FA) stated COOP drills are completed monthly on each shift. They consist of fire, chemical spills, severe weather, disturbances, riots, bomb threats, and hostage drills.

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

The program has a written Continuity of Operations Plan (COOP) which include a coordinated disaster plan. plan provides for a continuity of mission essential functions across a wide range of potential emergency situations. The plan was reviewed and updated on March 11, 2020 and approved by the Department on March 16, 2020. The COOP is maintained in administration, master control, east sub-control, and west sub-control and is readily available to all staff. The program has identified the various location within the program where staff, youth, and visitors can easily access the plan. Review of the plan indicated alternative housing if the program needs to be vacated due to an emergency or disaster. An interview with the facility administrator (FA) indicated a copy of the COOP is located in sub-control, master control, and in administration. Reviewed youth records confirmed the program maintained a hard copy file identifying information for each youth in case of emergency if the program needs to evacuate and relocate.

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 for the storage and inventory of flammable, poisonous and toxic materials. Toxics items and materials are stored in a secure area not inaccessible to youth. The program maintains a list of staff who are authorized to use chemicals. All caustic materials are stored according to type and use. A complete inventory of all such items was conducted. A Safety Data Sheet (SDS) binder is maintained with a picture of each material and a number corresponding to the SDS for each chemical. When comparing the chemicals stored in the secure and locked cabinet with the SDS records, there were no inconsistencies noted. An ongoing chemical inventory list is maintained, and the chemicals are checked daily. A review of the inventory list verified the chemicals were stored and checked daily. The program also has a chemical daily usage log used to track all toxic when in use by authorized staff. The form identifies the chemical number, description, amount used, amount remaining, date chemical is used and initial of staff. Due to COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of the program's storage area was unable to be conducted. However, the program provided pictures which indicated it is clearly marked hazardous chemicals and securely locked. Items were neatly stored on metal shelving and numbered according to the SDS. Flammable items are stored in a metal cabinet clearly marked as flammable items.

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 to ensure youth do not handle poisonous, flammable, and toxic items and materials. Authorized staff maintains control over all flammable, poisonous, toxic items with limited access. The physical plant manager keeps strict control of flammable, poisonous, and toxic items and materials stored in the program. Youth are not allowed to possess flammable, poisonous, toxic, and caustic items. A designated locked closet is used to maintain chemicals used to clean the facility. Safety Data Sheets (SDS) are maintained for each chemical. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waste. A review of the program's Preventive Maintenance Checklist confirmed the maintenance schedules and repairs were conducted as outlined in the Department's Rule. Each of the seven interviewed youth stated they do not use chemicals or cleaning products.

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

The program maintains a written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials**.** The physical plant manager, facility administrator (FA), dietary manger, youth care worker II (YCWII), and shift managers are authorized and trained to handle hazardous items and toxic materials. All unused hazardous materials are kept in the locked storage cabinet and are disposed of according to the Safety Data Sheet (SDS). An interview with the physical plant manager indicated materials are used until gone or disposed of according to the Occupational Safety and Health Administration (OSHA) standard. Used kitchen grease and waste is stored in a large container outside the kitchen area. All hazardous materials are maintained in maintenance area and disposal through Okeechobee County Amnesty Day at least once a year. All chemical spills are reported to master control and shift supervisor immediately. An evacuation of the affected area is conducted and a determination by the FA whether to contact outside assistance to contain the spill. Staff and youth are not allowed to return to the affected

area until it has been deemed safe by a qualified professional**.** An interview with the FA indicated there have been no chemical spills in the past six months**.**

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 for youth to have visitation and communication while in the program. The program affords youth opportunities maintain a strengthening a positive family member in order re-establish family and community ties. Youth are informed of visitation upon admission during the orientation process. The program encourages visitation from the parents/guardians by forwarding a welcome letter, upon the youth's admission, which includes information regarding the days and time of visitation, who is allowed to visit, and the corresponding rules of visitation. Family involvement and visitation, as well as telephone and mail correspondence, are outlined in the youth handbook. A list of authorized visitors and correspondence is maintained in the youth's case management records

and updated, as needed. Visitation is held in the bay area of administration on Saturdays and Sundays from 9:00 a.m. to 11:30 a.m., and 1:00 p.m. to 3:30 p.m. Youth are also provided weekly telephone calls initiated by the case manager, writing material and send letters to approved family members. Youth can have unimpeded access with the courts, attorneys, juvenile probation officer, and/ or the Department of Children and Families case worker. A review of visitation log, telephone log confirmed the program provided opportunities to communication family and community ties. Seven youth were interviewed, and each stated they have been given the opportunity to communicate with family members by mail, telephone, or visitation.

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

The program maintains a written policy and procedures in place to conduct youth searches and room inspections prior to placing a youth on controlled observations. Searches are conducted and documented on the controlled observation report. There was a total of eleven youth placed in control observation within the past six months. All eleven controlled observation reports indicated the controlled observation room and youth were searched prior to placing youth in controlled observation and the youth were searched by the same gender staff member.

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

The program maintains a written policy and procedures for placing a youth in controlled observation when non-physical intervention would not be effective. Controlled Observations may be used in response to a dangerous crisis when staff cans not control a youth aggressive and violent behavior with less restrictive measure or when less restrictive measure are inappropriate. There were 108 youth placed on controlled observation in the past six months. Each use of controlled observation is authorized by the facility administrator (FA), assistant facility administrator (AFA) or a supervisor to determine if it would jeopardize safety and security. Staff will discuss with the youth the reason for controlled observation and the expected behavior for removal. Eleven random reviewed controlled observation reports indicated the date and time the youth was placed in confinement and youth was placed due to having uncontrollable behavior due to less restrictive methods were ineffective. A health status checklist was completed on the same date the youth was placed in controlled observation. A review of eleven youth granted extension or a total time for placement over two hours but did not exceed twenty-four hours was approved. In each case, the FA or designee granted an extension and documented on the controlled observation report. None of the eleven controlled observations reviewed were held over twenty-four hours.

5.25 Controlled Observation Safety Checks Release Procedures	Satisfactory Compliance
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 maintains a written policy and procedures to ensure safety checks on all youth placed in controlled observation and releasing youth from controlled observation. The facility administrator (FA) or designee shall approve any youth's release from controlled observation when the youth is no longer an imminent threat to himself or others. There were 108 youth placed on controlled observation in the past six months. Upon review of eleven controlled observations reports, it was determined staff complete the first page of the report and submitted to the supervisor, and all safety checks were conducted at a minimum of fifteen-minute intervals. A review of eleven reports indicated staff observed the youth's behavior and documented safety checks every ten minutes. Each entry indicated the time, code explaining youth's behavior while in controlled observation, and the staff's initials. Review and approval are required within fourteen days of the youth's release from controlled observation by the facility administrator or designee to ensure placement was appropriate. A review of eleven controlled observation reports indicated the appropriate administrative staff member authorized the youth's release from controlled observation and an in-house alert was not required when the youth were release. All reports were reviewed and approved by the assistant facility administration within the fourteen-day time frame from the youth's release from controlled observation.

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. Each safety plan must address, at a minimum, warning signs, youth baseline behavior, history, evaluations, crisis recognition, interventions strategies, debriefing and jointly developed coping strategies, to include people and healthy environments as defined by the youth. The youth safety plans are located in a designated binder in the shift reporting room. Youth are also encouraged to keep a copy of their safety plan with them at all times. A review of seven youth safety plans indicated five of seven safety plans were not completed within fourteen days upon admission, and/or not updated, as required. A review of the two completed safety plans showed each contained all the required topic areas and were updated, as required. The program self-identified the safety planning issues and completed a retraining for all staff in the entire program on March 31, 2020 and currently reviews training for the safety plan during each shift briefing. The program has not had any admissions since March 27, 2020; therefore, has not had the opportunity to demonstrate the change. A program co-located Okeechobee Juvenile Sex Offender (OJSO) had two admissions in April 2020. The program provided documentation to show the corrected program practice. The program shares staff between both programs. All seven interviewed staff stated they were involved in the development of their safety plan. Seven staff were interviewed, and all stated they are aware of the location of the youth's safety plan. Four of the seven interviewed staff did not provide an answer to if they understand the safety plan review process.