STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Juvenile Sex Offender Treatment Program

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

Review Date(s): February 4-7, 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:

Yvrose Sylvain, Office of Program Accountability, Lead Reviewer (Standard1)
Nicos Antonakos, Office of Program Accountability, Regional Monitor (Interviews & Standard 1)
Stacey Dunkel, DJJ Probation, Circuit 17, Juvenile Probation Officer Supervisor (Standard 2)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Joann Law, DJJ Probation, Circuit 11, Juvenile Probation Officer Supervisor (Standard 2)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 3)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard 4)

Program Name: Okeechobee Juvenile Sex Offender Treatment | MQI Program Code: 1428
Provider Name: TrueCore Behavioral Solutions, LLC | Contract Number: 10289
Location: Okeechobee County / Circuit 19 | Number of Beds: 48
Review Date(s): February 4-7, 2020 | Lead Reviewer Code: 125

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.19 Staff Performance	
5.26 Safety Planning Process for Youth	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Non-Applicable
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	Limited
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 *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	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 *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	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	Limited

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

Program Overview

The Okeechobee Juvenile Sex Offender Treatment Program is a forty-eight-bed, hardware secure program, for thirteen to twenty-one-year-old males, located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides juvenile sex offender therapy, mental health overlay services (MHOS), and substance abuse treatment overlay services (SAOS). The program fosters youth by providing group MHOS and SAOS treatment (as appropriate) utilizing curricula for 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 uses sex offender specific curricula to include Pathways - A Guided Workbook for Youth Beginning Treatment, Building a Better Life, Healthy Sexuality Group Roadmaps to Recovery, and Footprints. The program's restorative justice programming includes Impact of Crime, and gender-specific programming is offered through Male Healthy Relationships and Violence Prevention; consisting of Teen Relationship and Young Men's Work. The program also provides individual counseling, family therapy, recreational therapy, and an animal husbandry program. The program's administration is comprised of a facility administrator, director of case management, director of clinical services, and a principal. Case management services are provided by five case managers, an intake specialist, a case administrator, and a transitional services manager. Mental health staff at the program include a licensed lead therapist, eight master's-level therapists, a file analyst, a contracted certified behavior analyst, and one recreational therapist. Medical services are offered seven days a week and are provided by the health services administrator, a medical support technician, four registered nurses, a contracted medical doctor, 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 Board. The layout of the program includes two wings with three dormitories each. The three west side dormitories and one east side dormitory house youth for the Okeechobee Juvenile Sex Offender Treatment Program. Each dormitory contains a case management office and a classroom. The program has a main master control, two sub-master control stations, 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 a sally port. The program has 103 recording video cameras monitored by master control and capable of recording thirty-days of video footage. At the time of the annual compliance review, the program had twenty-four vacancies to include the licensed therapist position, one shift supervisor position, twelve youth care worker-I (YCW) positions, seven YCW-II positions, one master control technician position, one teacher position, and one transition specialist position. These vacancies were for both Okeechobee Juvenile Sex Offender Treatment Program and Okeechobee Juvenile Offender Correctional Center.

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 maintains a written policy and procedures requiring compliance with the Department's background screening requirements. The program had twenty-six staff members who were applicable for an initial background screening during this annual compliance review period. A review of initial background screenings for the twenty-six newly hired staff found the program received background screenings from the Department's Background Screening Unit (BSU)/Clearinghouse prior to each staff having access to youth and confidential records. Documentation revealed the program added all staff to the program's roster in the Clearinghouse. The program utilizes an ergometric pre-employment assessment tool for all direct care applicants. Documentation indicated applicants must have a minimum score of sixty-five percent to pass the human relations video portion of the assessment and a minimum score of sixty percent on the reading portion of the assessment. A review of eighteen applicable direct care staff records revealed each staff passed both portions of the pre-employment assessment tool. 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 Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the BSU on December 4, 2019, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was completed and submitted to the BSU on December 4, 2019, meeting the annual requirement. There were no contracted staff who required an initial background screening since the last annual compliance review. The program reported no current volunteers providing services at the program.

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

The program maintains a written policy and procedures requiring compliance with the Department's five-year background re-screening requirements. The program's human resource manager tracks the five-year anniversary of hire dates and processes the five-year re-

screenings for all staff. A review of the program's staff roster and contracted staff lists indicated there were five staff applicable for a five-year rescreening during this annual compliance review period. Each staff's re-screening was completed and submitted to the Department's Background Screening Unit/Clearinghouse prior to their anniversary date. There were no contracted staff who required five-year re-screenings 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 outlining an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. The youth orientation handbook is provided to each youth upon admission. The youth's handbook includes the youth's rights, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC). Additionally, all program staff are required to sign an acknowledgment receipt of the employee handbook and code of conduct which outlines the grievance policies. A review of five personnel records found each contained documentation of acknowledgement of receipt, and review of the program's code of conduct. Observations during the annual compliance review found postings of the Florida Abuse Hotline and the Department's CCC throughout the program. The program had one incident reported to CCC in reference to allegations of abuse against staff since the last annual compliance review. A review of the one abuse allegation showed it was reported to the Department's CCC since the youth was nineteen years of age. The finding result of the abuse allegation was unsubstantiated which required no action from the program. The program had zero substantiated incidents of abuse since the last annual compliance review. Five interviewed youth reported never being stopped from reporting abuse to the Florida Abuse Hotline or CCC. All five youth reported staff are respectful when speaking with them. Five youth reported never hearing staff use curse words when speaking to youth. All five interviewed youth reported feeling safe in the program. None of the five interviewed staff reported ever seeing a co-worker deny a youth an abuse call. Four of the five interviewed staff reported they had never observed

a co-worker using profanity when speaking to youth and one reported occasionally some profanity was used. An interview with the facility administrator (FA) reported youth have unhindered access to report allegations of abuse to the Florida Abuse Hotline and if the youth eighteen years of age or older, to the CCC.

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

A review of the program's policy outlined procedures regarding abuse reporting in compliance with the Department's criteria for reporting abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff involved from contact with youth, when necessary. The program had one allegation of abuse involving a staff member within the last six months. Reviewed documentation found management took immediate action regarding the staff-involved incident by initiating an internal investigation. Documentation indicated the abuse allegation was unsubstantiated which required no further action from the program.

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 written policy and procedures regarding response to incidents in accordance with Florida Administrative Code. The program had fourteen reportable incidents during the annual compliance review period. A review of five incidents found the incidents were reported to the Department's Central Communications Center (CCC) within two hours of the incident or when staff becoming aware of the incident. All five incidents were documented in the program's facility logbook. A review of the program's internal incident reports and Let's Talk forms, found there were no incidents which should have been reported to the Department's CCC but were not. The program has experienced a decrease in the number of reportable incidents to the Department's CCC compared to the last annual compliance review period. An interview with the program's facility administrator confirmed the program has a policy in reference to the Department's CCC and ensures all matters which require reporting is verbally reported within two hours of when the program became aware of the incident.

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 the utilization of physical intervention techniques in accordance with Florida Administrative Code. The program had fifteen Protective Action Response (PAR) incidents in the past six months. There was

documentation to support a monthly summary of PAR reports was submitted to the Department. A review of five PAR reports found all involved staff completed appropriate statements prior to the end of their shift. The PAR reports were reviewed and processed within seventy-two hours by all required parties. The PAR reports documented a post-PAR interview was conducted with the youth by the facility administrator (FA) within thirty minutes after the incident. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. The program has experienced an increase in the number of PAR reports compared to the last annual compliance review period. The program's administrators reported the PAR rate increase was due to inappropriate placement of youth with serious mental health issues at the program within the last six months. 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 reported staff were instructed to complete a PAR report at the end of their shift if a PAR occurred and signatures and any corrective action taken after the PAR must be documented.

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 maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training plan was approved by the Department's Office of Staff Development and Training on January 8, 2020. Pre-service training is provided through a combination of instructor-led and web-based courses. Five staff training records were reviewed for pre-service certification training. All five reviewed training records documented each staff completed the certification process within 180 days of hire. The staff completed the required trainings related to Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All completed training was documented in the Department's Learning Management System (SkillPro) and was 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 maintains a written policy and procedures regarding in-service training for all staff. Five staff training records were reviewed for in-service training. All five reviewed staff training records documented each staff exceeded the twenty-four hours of annual in-service training requirements. All five staff had current certifications in Protective Action Response (PAR). Each staff had certification in first aid, automated external defibrillator (AED), cardiopulmonary resuscitation (CPR), and six hours of suicide prevention training. The two applicable staff exceeded the eight hours of management/supervisory training. The program has a training calendar which is updated, as necessary. All trainings were delivered by qualified trainers and were documented in the Department's Learning Management System (SkillPro). The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 8, 2020.

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 has a written policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. According to the program's policy, procedures are in place to confirm each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's grievance procedures include informal, formal, and appeal phases with time frames of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are also provided with the opportunity to file an alternative informal request by utilizing a Let's Talk form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and Let's Talk forms were available to youth, as observed during the program tour. Reviewed documentation found there were five grievances and more than one hundred Let's Talk forms submitted by youth since the last annual compliance review. A review of the five grievances revealed all the youth's grievances were resolved at the formal phase. Each grievance was addressed within the seventy-two-hour timeframe. Five pre-service staff training records and five in-service training records were reviewed. All ten training records documented each staff received the required training on the program's grievance process and procedures. During the annual compliance review, five youth and five staff were interviewed. Four of the five youth were able to explain the grievance process to include submission of a completed grievance form into the secured grievance box. One youth did not know what steps to take for the grievance process and reported never filing a grievance before. All five interviewed youth reported being able to request assistance in completing a grievance form, if needed. All five interviewed staff were able to explain the grievance process. An interview with the facility administrator (FA) reported grievance forms are available to the youth on each dorm. The program's FA stated the grievance boxes are checked daily prior to the program morning management meeting. The grievances are then reviewed during the morning meetings with the management team and addressed by the program staff within seventy-two hours.

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 policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract of required services identified Thinking for a Change (T4C) as a promising practice intervention curriculum. The program currently has three staff trained to facilitate T4C. All three facilitators had a bachelor's-level degree and over three years of experience working with youth. An interview with the facility administrator determined the program provides T4C as a promising practice intervention. The program completes a

Residential Assessment for Youth (RAY) on each youth to determine criminogenic needs of the youth and based on the outcome, the decision is made on which group the youth is placed. A review of the program's activity schedule confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. The T4C groups are held twice a week, for one hour each. A review of five youth records confirmed three youth were currently in T4C groups, two youth had completed the T4C group, and each youth had goals in their performance plan to address the 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 maintains a written policy and procedures to address life skills training for youth. The program provides life skills training through Teen Relationships groups and Skillstreaming the Adolescent. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. A review of the program's activity schedule confirmed a one-hour life skills training group is provided to the youth once a week by the therapist. All staff conducting groups received formal training and on-the-job training by a certified trainer to deliver the curriculum. Reviewed documentation found all five youth were actively participating in Skillstreaming the Adolescent groups. A review of five youth case management records and group sign-in sheets indicated services were delivered, as required. Five interviewed youth were able to explain the new skills or behavior they were taught in life skills group such as coping skills, how to handle situations in a positive way, and breathing techniques to calm down. All five interviewed youth also reported they were able to demonstrate the skills by doing role-play activities in groups. An informal interview with the clinical director stated youth can practice skills in group role-play activities and interactions with staff and youth while at the program.

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. A review of the program's contract indicated Impact of Crime (IOC) curriculum is a required service to be provided to all youth in the program. The program had three staff trained to facilitate IOC group at the time of the annual compliance review. The program's current activity schedule showed there were four IOC groups in progress, facilitated two times a week for one hour each group. Documentation showed group schedules were followed. There was no gap of service delivery for the four groups. A review of five youth records confirmed the youth were participating in an IOC group.

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.	

A review of the program's contract of required services identified Male Healthy Relationships and Violence Prevention, which includes Young Men's Work (YMW) and Teen relationships, as the gender-specific curriculum provided to the youth. All youth in the program are provided Male Healthy Relationships and Violence Prevention which is a gender-specific curriculum and includes exercises specifically for males regarding issues of violence, bullying, substance abuse, and issues related to teen fatherhood. A review of five youth case management records confirmed youth were currently in or had completed this gender-specific group. A review of the program's activity schedule and sign-in sheets confirmed gender-specific programing is provided to the youth. A review of sign-in sheets validated the program youth are participating in groups. The facility administrator (FA) reported gender needs are addressed through Young Men's Work and Teen Relationships group, and youth engagement in activities such as football, basketball, and kickball. All five interviewed youth reported they participated in substance abuse, Pathways, and Skillstreaming the Adolescent groups.

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 policy and procedures addressing youth alerts. The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert which may not have been previously entered prior to the youth's admission. The program has an alert board in master control which identifies each youth's special alerts, escape risk, and/or gang affiliation. The alert board also identifies youth placed on any type of mental health alert. Reviewed documentation indicated the program's internal alert report is reviewed daily during shift briefings by the program's shift supervisory staff. An extra copy of the program's internal alert report is located on each living module daily. Five youth records were reviewed for case management, medical, and mental health and substance abuse, and all applicable alerts were accurately entered into JJIS. The program's medical staff can remove or downgrade a medical alert and only licensed mental health staff are able to remove or downgrade a mental health alert. All internal and JJIS alerts in reference to case management were downgraded or discontinued by the Director of Case Management. Five staff were interviewed to include two supervisors. Each reported they are informed of youth alerts during shift meetings, review the program's alert board for youth alerts in master control, and alerts sheets are available on each living module. An interview with the two applicable supervisory staff found during morning management meetings, medical staff provides an updated alert list. An interview with the facility

administrator (FA) determined all internal alerts are entered into JJIS by their specific departments and medical alerts are updated and provided to the shift supervisor daily. The program's FA stated youth's alerts are reviewed daily during morning management meetings, and copies are provided to shift managers and 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 to ensure the management of all records are consistent across operations and programs, consistent with company philosophy, goals, and objectives, and consistent with legal and contractual requirements. A review of five youth healthcare, mental health and substance abuse, and case management records showed each was marked "Confidential" and each record documented the youth's name, Department identification number (DJJID), the youth's date of birth, county of youth's residence, date of admission, and committing offense. Observations during the annual compliance review showed all individual healthcare records (IHRC), mental health and substance abuse records, and case management records were secured in a locked room, 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's recreation and leisure activities and behavior management system policies address written provisions for youth input through a student advisory board. The program has a student advisory board where elected youth represent their respective dormitories. Youth are allowed to discuss issues and ideas on behalf of other youth in the program during a meeting with the facility administrator (FA) and assistant facility administrator (AFA) in an effort to come to a resolution. A review of the student advisory board meeting binder reflected an agenda, sign-in sheets, and meeting minutes summarizing the subject areas which were discussed. The meetings provide youth opportunities to identify issues impacting their residential community and recommendations to improve conditions enhancing the quality of life for both the youth and staff in the program. Further, program administration 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. Five youth were interviewed, and each reported the program does provide a process allowing youth to provide input regarding what happens at the program. In addition, each youth reported filling out a Let's Talk form to express their concerns and needs. An interview with the FA indicated the youth completes and signs the Let's Talk form as a first attempt where youth will voice issues and concerns in the program. The youth meet once a month to discuss youth issues in their particular living cottage and present these findings to administration.

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 six programs located in Okeechobee County. The advisory board meets quarterly and were combined due to a limited amount of people living in this rural community; however, sign-in sheets and agendas reflected each program was addressed separately during the meetings. Reviewed documentation supported the program's community advisory board meets at least quarterly; however, participant attendance is low. The reviewed meeting minutes, sign-in sheets, and agendas documented meetings occurred in September and December 2019. The next community advisory board meeting is scheduled for March 2, 2020. The advisory board members currently consist of a member from law enforcement, interested community partners, a community business member, school board member, a member from the judiciary, and a faith-based community member. The current list for advisory board members did not include a victim advocate/victim services member or a parent/guardian whose child was previously involved in the juvenile justice system, and the program was unable to provide any documentation to support recruitment efforts. A review of community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and community service activities. The board rotates meeting locations between Okeechobee Juvenile Offender Correctional Center, Okeechobee Youth Development Center, and Okeechobee Girls Academy each quarter and serves as the board for Okeechobee Youth Treatment Center and Okeechobee Intensive Halfway House, as well. A telephone call was made during the annual compliance review to the local faith-based community who serves as a board member and indicated they send a member to participate in the scheduled meetings and also confirmed the program's regular invitations to events and meetings.

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. 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 conducts daily morning management meetings, shift briefings, and monthly meetings for all staff to discuss relevant issues affecting the program's operation and to keep staff informed of corporate objectives. 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 has incentives for staff such as tuition, registration certification, employee appreciation, staff celebration, and continuing education (CEU) reimbursement. Five interviewed staff reported staff meetings are held monthly and shift briefings are held daily. Three staff reported the communication amongst the staff at the program is very good and two staff reported fair. According to the interviewed staff, the topics discussed during the monthly meetings at the program includes staff positions during sight and sound supervision, human resources, class A and B tools, youth supervision, dress codes, staff

attendance, and any upcoming events. An interview with the facility administrator (FA) revealed an internal review is used to help reduce staff turnover in the program.

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

The program conducts ninety-day performance evaluations for newly hired staff and annual evaluations for all staff thereafter. Five personnel records were reviewed, of which three contained an annual performance evaluation and two contained a ninety-day performance evaluation. The performance evaluations were specific to the applicable staff's job description. All five reviewed performance evaluations found each staff's evaluation was based on the performance standards for their position. Documentation showed all five staff performance evaluations were late from two days to four months. Three of the five staff performance evaluations were reviewed by the program's administrator during the week of the annual compliance review. 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. Two interviewed staff reported receiving an annual evaluation, two reported receiving a six month evaluation, and one reported receiving a ninety-day evaluation. An interview with the facility administrator (FA) revealed staff are given a ninety-day performance evaluation and an annual performance evaluation. The program's FA reported each staff receive an annual evaluation to determine how the staff performed throughout the year.

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

The program has a written policy and procedures regarding recreation and leisure activities. According to the contract, the program is required to have a recreational therapist position. The educational requirements listed state the candidate should preferably have a bachelor's-level degree of science in recreation and sports management with a track in recreational therapy. Reviewed documentation reflected the recreational therapist is a bachelor's-level with education in sports management in recreation and meets the educational requirements. The program provides a variety of recreation and leisure activities for the youth in the program. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. The recreational and leisure activities are provided during the weekdays and on weekends. Youth are provided at least one hour daily of large muscle activity promoting or creating teamwork, healthy competition, and mental stimulation. The program provides activities such as football, basketball, card games, and board games. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth targeted to promote team building and leadership skills. The weekday activity schedule includes recreation each afternoon for one hour. When the heat index is above the approved temperature or when there is inclement weather, the youth are afforded one hour of recreation time inside the facility. A review of five youth records documented recreational therapy activities are provided and are incorporated into goals on each youth's individualized treatment plan. Randomly selected dates and times were reviewed in the program's master control logbooks and confirmed the youth have allotted time each day for recreation. Observations made during the annual compliance review of recreational activities found youth are participating in teamwork, healthy competition,

and physical fitness. Five interviewed youth reported they are provided at least one hour of large muscle activity daily and the program provides activities promoting or creating teamwork, healthy competition, mental stimulation, and physical fitness. Five staff were interviewed and indicated the type of recreation and leisure activities are provided to youth are basketball, football, frisbee, chess, video games, and ping pong table.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures regarding initial contact to a youth's parent/guardian and addressing court notification upon each youth's admission. Five youth case management records were reviewed. All five reviewed records documented the program notified the youth's parent/guardian by telephone within twenty-four hours of admission. Each of the five reviewed records included documentation indicating the program notified the parent/guardian and the court in writing within forty-eight hours of the youth's admission.

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

The program has a policy and procedures regarding youth orientation. A review of five youth case management records contained documentation indicating orientation was conducted with each youth within twenty-four hours of admission into the program. The orientation included services available, daily schedule, expectations and responsibilities of the youth, written information on the program's behavior management system, information on how to access medical and mental health services, access to the Florida Abuse Hotline or the Department's Central Communications Center if the youth is over eighteen years of age, and items considered contraband. The youth orientation also included information on the performance plan process, dress code and hygiene requirements, procedures regarding visitation, mail, and use of the telephone, anticipated length of stay, community access, grievance procedures, emergency drills, physical design of the facility, and assignment to a living dorm. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet including a copy of the youth handbook. The program did not have an admission during the annual compliance review week; therefore, a youth admission was not observed. A review of the program's logbooks and shift reports indicated youth orientations are documented either in the master control logbooks or the shift reports. Five interviewed youth stated they received an orientation to the program within twenty-four hours of 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 has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Five youth case management records were reviewed, and one was applicable for written consent of youth over the age of eighteen years of age

before providing or discussing information with the parent/guardian. An additional two youth case management records were reviewed. All three applicable youth records contained consent forms signed by the youth allowing the program to share with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.

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's policy and procedures outline the classification process and includes a classification system which promotes safety and security, as well as effective delivery of treatment services, based on determination of each youth's individual needs and risk factors. The policy also addresses when reassessments are warranted and based upon changes in the youth's supervision status, new and updated alerts, relevant information available to the treatment team, and/or behavioral concerns. Five youth case management records were reviewed. Each youth record had an initial classification completed on the same day of admission to the program. The initial classification forms included the physical characteristics of the youth, age, maturity level, identified special needs, history of violence, gang affiliation, criminal behavior, and/or sexual aggression or vulnerability to victimization. The classification form also included suicide, medical, and security risks. An interview with the facility administrator (FA) was conducted to explain how factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning a youth to the living dorm. The FA reported a classification meeting takes place on the date of each youth's arrival to determine the most appropriate room assignment. The FA stated the case manager conducts a risk assessment during the intake process for each youth and every month thereafter to ensure there are no presenting problems. The classification factors taken into consideration includes a review of alerts entered into the Department's Juvenile Justice Information System (JJIS). All five youth records indicated alerts were entered in the JJIS alert system after issues were identified during or after the classification process. The program has a policy and procedures in which the internal alert system is continually updated for youth who are a security or safety risk which includes escape risks, suicide or other mental health, medical, sexual predator, and other violent behavior risks. The program's internal alert system is easily accessible to the program staff.

All five youth records reviewed had a reassessment completed. Four of the five youths' reassessments indicated an increase of the youth's privileges or freedom of movement. The youth were allowed to move to the honor room and received a later bedtime. One youth's reassessments did not indicate an increase of privileges. All five youth case management records included documentation for the reclassification of youth prior to engaging in certain activities. A review of the program's policy and procedures, Individual Performance Plan (IPP), master control logbooks, treatment team notes, and/or performance summaries validated the

youth were reclassified before engaging in increased privileges. The program is a secure high-risk and maximum-risk program and youth are only allowed to participate in off-campus activities with court approval.

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

The program has a policy and procedures addressing gang identification which includes notification to law enforcement. Each youth is assessed at intake for suspected gang involvement. Five youth case management records were reviewed and three were applicable for youth gang involvement or association. Documentation supported the program notified the law enforcement gang liaison by e-mail of the suspected gang members residing at the program for each youth. The program informed the educational provider and post-residential provider of the suspected gang youth. A review of the Department's Juvenile Justice Information System (JJIS) system indicated each youth's juvenile probation officer (JPO) was also notified by the program of the youth's suspected gang member classification and the alert was entered into the Department's JJIS.

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 maintains a gang binder which contains information on youth who have been documented as gang members or associated with a gang. Five youth case management records were reviewed, and three were applicable for youth gang involvement or association. The three applicable youth records documented each youth was identified as an affiliated gang member. Each youth's Individual Performance Plan included gang prevention and intervention strategies. The program utilizes Arise Life Skills and Impact of Crime (IOC) curriculums. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities. The program's practice is if youth are identified as gang members during the classification meeting, the youth are assigned gang intervention goals and attend gang groups.

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 requiring each youth's individualized needs to be identified and prioritized through a comprehensive needs assessment process completed by a multidisciplinary intervention and treatment team staff. Each youth's intervention and treatment team shall identify the youth's criminogenic risk and protective factors, and prioritize the youth's criminogenic needs. The Residential Assessment for Youth (RAY) assessment shall be completed within thirty days of the youth's admission to the program. Five youth case management records were reviewed, and found the program assessed each youth utilizing the RAY to identify criminogenic risk and protective factors and to prioritize the youth's criminogenic needs. Each reviewed RAY was completed in the Department's Juvenile Justice Information System (JJIS) within thirty days of each youth's admission date into the program. Reviewed documentation supported the program completed a RAY re-assessment within ninety-days after the completion of the initial RAY assessment in four of the five reviewed records. One youth record reflected the youth was attending the program for less than ninety-days. Reviewed records documented updates or re-assessments were completed when deemed necessary by the multidisciplinary treatment team to effectively manage each youth's progress. All applicable re-assessment documentation for each of the four youth was maintained in each 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 has a policy and procedures addressing the Youth Needs Assessment Summary (YNAS) process which is completed within thirty days of the youth's admission. Five youth case management records were reviewed, and each documented a YNAS was completed within thirty days of the youth's admission to the program. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in each youth's case management record.

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

The program maintains a policy and procedures addressing the multidisciplinary treatment team, which includes the youth shall meet and develop the Individual Performance Plan (IPP) with individualized delinquency intervention goals to be achieved before the youth is released from the program. Each youth's IPP is based on the initial findings of the assessment of the youth and shall be completed within thirty days of the youth's admission. The developed IPP facilitates the youth's successful reintegration into the community upon release from the program and to also facilitate the youth's rehabilitation. Five youth case management records were reviewed. All five youth records documented the IPPs were developed within thirty days of the youth's admission and after the initial assessment. Each reviewed IPP was developed and signed by the treatment leader, youth, treatment staff, and education staff. The administrative representative participated and signed all five IPPs and living unit representatives documented their participation and signature on the reviewed performance plans. One youth was in the custody of the Department of Children and Families (DCF), and there was documentation to support the DCF case manager participated on the development of the youth's performance plan. Each reviewed performance plan clearly documented the top three criminogenic needs and individualized goals based upon the prioritized needs reflecting the risk and protective factors identified in the Youth Needs Assessment Summary (YNAS) and RAY assessment. Reviewed documentation demonstrated the performance plans were completed with specific delinquency interventions with measurable outcomes which will decrease criminogenic risk factors and promote strengths, skills, and support reducing the likelihood of the youth reoffending. The start date, projected completion date, status, frequency, youth's responsibilities to accomplish the intervention, and the program's responsibilities to enable the youth to complete the goal. In all five records, court-ordered sanctions which can be reasonably initiated and/or completed while the youth is in the program were included on the youths IPPs. Each performance plan identified the youth's responsibilities and timelines to accomplish the goals and the responsibilities of staff to enable the youth to complete the goals. Reviewed documentation supported within ten working days of the performance plan being completed, a transmittal letter and a copy of the plan was sent to the committing court, juvenile probation officer, DCF case manager, and each youth's parent/guardian. There were three signature pages returned to the program and filed with the original performance plans. Five interviewed youth found each was able to verbalize their current goals they are working towards completing. Each validated they were provided 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 maintains a policy and procedures ensuring each youth's performance plan will be revised, as needed, for completion. A review of five youth case management records documented each performance plan had revisions either based on the Residential Assessment for Youth (RAY) re-assessment results or newly acquired information which warranted a change. Reviewed practice indicated the multidisciplinary treatment team met formally approximately every thirty days to discuss each youth's performance plan and documented the youth's demonstrated progress toward completing each goal. In the event a youth demonstrated lack of progress toward completing a goal, this would be discussed by the team during a special treatment team meeting and modifications would be made to the youth's performance plan. None of the five reviewed records were applicable for a youth in transition; therefore, three closed youth records were reviewed. Each of the three closed records documented during the last sixty days of the youth's stay in the program, revisions were made to each individualized performance plan to ensure the youth's successful completion of the identified goals for release.

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 maintains a policy and procedures ensuring a formal performance review requiring a meeting of the multidisciplinary treatment team to be held at least every thirty days. The treatment team assesses each youth's progress on their performance plan goals and overall behavior in the program and documents a summary which is maintained in the program's Lauris case note system. The treatment team will also develop a performance summary within ninety calendar days following the completion and signing of the performance plan. Each summary includes the youth's status on each performance plan goal, youth's overall treatment progress based on their treatment plan, and the youth's academic status including performance and behaviors in school. In addition, the youth's behavior including the level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment, and the youth's adjustment to the program. Five reviewed youth case management records indicated each youth had a performance summary completed within the required ninety-day time frame. Reviewed performance transmittals supported each youth was provided the opportunity to review and add comments prior to signing the completed performance summary. All five interviewed youth reported each was provided a copy of their performance plan. Four of five interviewed youth indicated they received a copy of the performance summary sent to the court and one youth reported did not received a copy. Reviewed practice supported each completed performance summary was signed by the treatment team leader, staff member(s) participating in the preparation of the summary, facility administrator or designee, and the youth. Transmittal documentation supported each performance summary was sent to the applicable committing

court, assigned juvenile probation officer (JPO), parent/guardian, and the Department of Children and Families (DCF) case worker for one applicable youth, within ten working days of completion. Reviewed documentation supported the original completed performance summary was filed in each youth case management record. A review of three closed youth case management records supported the original release summary along with justification for release and Pre-Release Notification (PRN) was sent to the assigned JPO. All three summaries and PRNs were sent at least forty-five days prior to the planned release date. Transmittal documentation validated when the youth was released from the program, the assigned JPO received the final performance summary. One youth was applicable for the Sexually Violent Predator Program (SVPP) and victim notification. The program provided the JPO with the SVPP eligibility notification checklist, performance plan and summary, physical health summary, and psychological/psychiatric reports for the one applicable youth. Documentation also showed the program mailed the Victim Notification of Release form to the victim at least ten days prior to the youth's release.

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 addresses the encouragement of parent/guardian involvement in case management assessment, performance planning and development, progress reviews, and transition planning. Documentation indicated each parent/guardian is contacted by telephone by the case manager upon each youth's admission into the program and a welcome letter is mailed within forty-eight hours of each admission. Documentation also supported each youth is allowed weekly phone calls. The program conducts a family day once a quarter inviting the parents/guardians to come on-site and meet face-to-face with the youth's assigned treatment team members and to enjoy food and scheduled activities. Reviewed documentation confirmed involvement of the youth's parent/guardian in the case management process and confirmed efforts were made to include the parent/guardian in the assessment process, treatment team meetings, in the development of the performance plan, and transition planning. There was documentation in five reviewed youth records which supported letters were forward to the youth's parent/guardian advising them of the date and time of treatment team meetings and encouraging their participation either in writing, in person, or by telephone. An interview with the facility administrator (FA) confirmed parents/guardians are invited by program staff to participate by telephone, and/or provide input in writing. The FA further revealed the program encourages parent/guardians to join the treatment team process. There were no scheduled formal treatment teams during the annual compliance review week; therefore, a formal treatment teams meeting was not observed. Five interviewed youth reported their parent/guardians were involved in their case management such as performance plans and formal treatment team meetings.

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. The program assigns each youth to a treatment team upon admission into the program. 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. The program assigns each youth to a treatment team upon admission into the program. The treatment teams are comprised of the youth, case manager, a representative from education, a mental health therapist, the youth's parent/guardian, assigned juvenile probation officer (JPO), medical staff, a representative from the living unit, and a representative from the program's administration. Five youth case management records were reviewed to verify composition of the treatment team. A review of twenty-nine total treatment team meetings combined for all five youth indicated all required attendees participated and signed the performance plan review form for each youth. The assistant facility administrator and the director of case management each signed as the administration representative one time, and pursuant to the program's policy which was updated June 24, 2019, the unit manager signed as the program's administrative representative for all other meetings. One youth's performance plan review dated February 27, 2020 was missing all signatures; however, documentation validated the youth was out of the program's custody and detained in the Okeechobee County Jail. The education staff used the feedback form to provide youth's grades/behavior information prior to the treatment team meetings. Reviewed documentation validated each assigned youth's JPO and parent/guardian were invited to participate in the treatment team.

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 with the youth's performance plan through the multi-disciplinary intervention and treatment team process to ensure compatibility of goals, services, and service delivery. The youth's performance plan shall reference or incorporate the youth's treatment or care 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 shall coordinate the youth's performance plan with the youth's DCF/APD care plan for related issues. A review of five 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. Each youth had separate academic plans which were incorporated into the individual performance plan. Reviewed documentation supported each performance plan was discussed during formal treatment team meetings and the progress or lack of progress was documented on the overall adjustment and behavior section of the performance plan review form. One youth was under the supervision of DCF, had a separate DCF plan, and the plan was incorporated into the youth's performance plan. There were no applicable youth with an APD plan needing to be addressed and/or incorporated into 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. Five case management records were reviewed and each documented formal treatment team reviews were conducted at least once every thirty days and informal treatment team reviews were conducted at least once within 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, case management staff who act as the treatment team leader, clinical staff, education, and a program administration representative. Each youth's juvenile probation officer (JPO), parent(s)/guardian(s), 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. The Residential Assessment for Youth (RAY) reassessment results were not documented as reviewed in two of the five youth records during formal treatment team meetings. In three of the five youth records RAY reassessment results were not documented as reviewed in informal treatment team meetings. All staff gave relevant input on the youth and agreed on how to proceed to formal treatment team. Treatment team was held the week prior to the annual compliance review; therefore, a treatment team meeting was unable to be observed. Five youth case management records were reviewed, and each contained documentation supporting the youth had a treatment team meeting at least once every thirty days. All required attendees participated and signed the performance plan review form. According to the youth interviews, four of five youth reported they are provided an opportunity to demonstrate the skills they have learned while at the program in treatment team meetings. One youth reported, "sometimes I feel like I get shut down during treatment team. I am not allowed to say what I wanted to say, so I just stopped trying." This was discussed with the facility administrator and will be addressed with the treatment team.

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. 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 Pre-Apprenticeship Certificate Training (PACT). Each class type provides hands-on experience in their respective area. Youth have the opportunity to earn certifications in vocational classes including SafeStaff ® food handler training through the National Restaurant Association, and hospitality. A review of three closed youth records indicated employability skills training is addressed on each youth's education plan. Each reviewed record also validated youth are provided the opportunity to complete a sample application, a résumé summarizing education, work experience, and/or career training. Each record 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. Youth are provided a calendar with the appointment date(s) and address of their local Career Source Center. Each of the youth records documented the program provided Career and Professional Education (CAPE) courses leading to pre-apprentice certifications and industry certification. An interview with the program's facility administrator found vocational opportunities at the program include culinary arts, food manager certifications, technology, and building construction.

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

The program operates year-round educational services. The program's teachers are TrueCore Behavioral Solutions, LLC employees with oversight through Tantie Juvenile Residential Facility School through the Okeechobee County School Board. 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. An interview with the program's principal indicated educational services are provided 250 days a year. Six periods a day, for a total of 300 minutes of instruction, are conducted five days each week. 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 given 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.

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. The education department provides each youth with an opportunity to complete job applications, résumés, and practical experience with interviewing techniques. Each reviewed closed case management record indicated the required transition activities, target dates, and individual responsibilities were discussed.

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. A review of five youth case management records revealed no youth were in the transitional phase of the program; therefore, three closed youth case management records were reviewed. Documentation indicated all treatment team members were invited and encouraged to participate in the transition conference. Documentation supported each youth's transition conference was held at least sixty days prior to the youth's targeted release date and the youth, treatment team leader, facility administrator or designee, and other team members participated on each 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 all three closed records to support the program received an invitation to the CRT meetings. The Department's Juvenile Justice Information System (JJIS) was reviewed to determine the knowledge of the meeting and participation by the program, youth, parent/guardian, and assigned juvenile probation officer (JPO). Reviewed documentation of the three closed records indicated the program, youth, and the parent/guardian participated in each 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 are 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 their 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.

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

The program maintains a written policy and procedures pertaining to exit conference. 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, parent/guardian, and other pertinent parties review the status of the youth's transitional activities and finalize plans for the youth's release and reentry 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 juvenile probation officer (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 State of Florida licensed mental health counselor (LMHC) who serves as the 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 also serves as one of the licensed clinicians qualified to provide sexual offender therapy services as outlined in 64B4-7.007 Florida Administrative Code (F.A.C.). The DMHCA is responsible for ensuring youth receive group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required primary Standardized Program Evaluation Protocol (SPEP) services, and supplemental specialty services addressing each youth's unique clinical needs. At the time of the annual compliance review, the DMHCA carried a caseload of two youth and also facilitated individual therapy, group therapy, and family therapy. An interview with the DMHCA also indicated they facilitate crisis counseling and stabilization, Baker Act and/or Marchman Act proceedings, provide staff training, and facilitates mock mental health and substance abuse drills and mock 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 being used by all staff, and gender-specific, trauma-informed practices are being 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 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, the lead sex offender therapist position was vacant. The position became vacant on November 4, 2019 when the full-time therapist became pro re nata (PRN). The program's designated mental health clinician authority (DMHCA) has been providing sex offender therapy services in accordance with 64B4-7.007 Florida Administrative Code (F.A.C.). Okeechobee Juvenile Offender Correctional Center (OJOCC) maximum-risk program has a licensed clinical social worker (LCSW) assigned as the lead therapist and the program has been utilizing the LCSW to provide clinical groups and education. The LCSW has a clear and active license in the State of Florida with an expiration date of March 31, 2021. The DMHCA has a training plan to document the qualified training requirements to practice juvenile sex offender therapy, as outlined in F.A.C. 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 also has a part-time CBA providing services to twelve youth in the sex offender program and twelve youth in the Mental Health Overlay Services (MHOS) 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. 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. The psychiatrist is scheduling 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 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. Each of the six non-licensed therapists provide sex offender treatment to youth. All six non-licensed master's-level therapists hold degrees in mental health counseling, psychology, and social work, respectively. All six staff work under the direct supervision of the designated mental health clinician authority (DMHCA). The program maintains an independent contract agreement with a master's-level board certified behavior analyst (CBA). The CBA is scheduled to be on-site for approximately five hours each week for the entire Okeechobee campus, splitting time between each program. An interview with the CBA indicated they are on-site on Monday and Wednesday each week. Monday's are utilized to evaluate and assess youth referred from the program and Wednesday's are utilized to evaluate

and asses youth referred from the school. The CBA carries a caseload of twelve youth for the sexual offender program and twelve youth for the Mental Health Overlay Services program. Each youth receives a Functional Behavioral Assessment Plan and receives weekly incentives to include extra snacks and once a monthly a big meal. A review of the clinical supervision logs from August 2019 through February 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 their own clinical supervision log which included all required elements, as outlined in Chapter 397, Florida Statutes. 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 members of the clinical team to ensure program issues are addressed proactively and any issues are constructively and diligently resolved. The DMHCA indicated they ensure 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. The DMHCA indicated they are the qualified supervisor for two master's-level non-licensed clinicians and provides each of them with an additional hour of individual supervision as they prepare for licensure. Training records for the six non-licensed 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.

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

The program maintains a policy and procedures regarding mental health and substance abuse screening. The program identifies the mental health and substance abuse needs of youth through a comprehensive screening process to ensure referrals are made when youth have mental health and/or substance abuse needs or suicide risk. The program has a written comprehensive plan for mental health and substance abuse services which includes a standard admission mental health and substance abuse screening, and the administration of the Massachusetts Youth Screening Inventory – Second Version (MAYSI-2). A review of five youth mental health and substance abuse records validated each youth received a MAYSI-2 screening and an Assessment of Suicide Risk (ASR) administered by the assigned therapist or the designated mental health clinician authority (DMHCA) 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 administering the MAYSI-2 were 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. An interview with the facility administrator validated the practice. A review of

five randomly selected active mental health and substance abuse youth records found the program completed a review of the commitment packet documentation, a MAYSI-2, an ASR, and the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) for each youth upon admission. Five reviewed youth MAYSI-2 assessments indicated three required a further assessment and one was overridden by the staff. The program's facility administrator or designee was notified, and referrals were made for further evaluations. None of the five completed youth MAYSI-2 assessments indicated a suicide ideation category required an ASR; however, program practice is to complete the ASR during the admission screening process. An interview with the facility administrator 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 five youth mental health and substance abuse records found each youth was assessed utilizing the Adolescent Psychopathology Scale – Short Form (APS-SF), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), American Society of Addiction Medicine (ASAM), Bumby Cognitive Distortion Scales: The Molest Scale, Juvenile Sex Offender Assessment Protocol – II (J-SOAP-II), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Substance Abuse Subtle Screening Inventory – Fourth Edition (SASSI-4 for applicable adults), 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 four of five Bio-Psychosocial Evaluation were completed within thirty calendar days of the youth's admission and the program practice is to complete a new evaluation annually. One was completed forty-two days late. All five reviewed evaluations were completed by non-licensed, master's-level therapists. the designated mental health clinician authority (DMHCA) 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 DMHCA indicated they assist in completing intake assessments and admission consents.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance

Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.

The program maintains a written policy and procedures ensuring all mental health and substance abuse treatment services are available to each youth who is determined to meet clinical criteria to receive services. Mental health and substance abuse treatment is steered by an individualized treatment plan addressing all of the youth's needs in accordance with Florida Administrative Code. A review of five youth mental health and substance abuse records 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, education, medical, and parent/guardian, when applicable. Reviewed documentation validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form and one youth was eighteen years of age 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. The program's practice is to document progress daily on the Mental Health and Substance Abuse Daily Services Program Record and Progress Notes. Each youth was determined to be in need of weekly individual therapy, daily group therapy, and monthly family therapy. Three youth were also determined to be in need of psychiatric medication management. Each youth received the services as outlined. A review of treatment team documentation validated the meetings were held, as required, and the treatment team members were in attendance. The education and medical staff provided written updates prior to each treatment team meeting. There were no treatment team meetings scheduled during the annual compliance review week; therefore, the annual compliance review team did not observe. One of five reviewed youth records determined the youth required substance abuse treatment and found goals outlined on the individualized mental health and substance abuse treatment plan. The four youth without a substance abuse diagnosis each had a goal of substance abuse education. The program maintains a current Chapter 397 license through the Department of Children and Families with an expiration date of April 7, 2020. At the time of the annual compliance re-review, the program had one full-time LCSW position vacant as of November 4, 2019. The LCSW moved into a pro re nata (PRN) position. A review of the four non-licensed therapist's caseload assignments found one had ten assigned, one had six assigned, and two had five each assigned. The designated mental health clinician authority (DMHCA) had a caseload of two. 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 groups were in compliance with this requirement. 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 clinical director they are responsible for coordinating and implementing 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, education of rights and consents upon admission, receive daily, evidenced-based group therapy from qualified, supervised clinicians, and receive specialty services to address each youth's unique clinical needs. The DMHCA oversees the monitoring and tracking of clinical service delivery and documentation, including daily group therapy, monthly individual therapy, monthly 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. Five interviewed youth indicated each youth was participating in groups and receiving specialized therapies. The youth indicated they were attending groups such as Skillstreaming, Anger Management, Sexual Education, Living in Balance, and Young Men's Work. Five 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. Five reviewed mental health and substance abuse records supported the multidisciplinary treatment team developed an initial treatment plan on each youth's date of admission to the program. Each initial plan was signed by treatment team members participating in the development of the plan. The initial treatment plans were documented on a form containing all required elements, as outlined in Florida Administrative Code 63N-1, and on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed plan contained mental health and substance abuse planning for the youth. Three of the five reviewed youth records were applicable for being admitted on prescribed psychotropic medications. All three 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 five youth's individualized treatment plans were completed within thirty days of admission and documented on the Department's Individualized Mental Health/Substance Abuse Treatment Plan form which contained all elements outlined in Florida Administrative Code 63N-1. All five reviewed plans documented the designated mental health clinician authority (DMHCA) reviewed and signed each plan within ten days of completion, as required. Each reviewed plan contained the required signatures of all treatment team members who participated in the development of the plan with the exception of one missing the living unit representative. Three 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. Four of five reviewed youth records required monthly treatment team reviews, and each was completed, as required. One youth was admitted at the end of December 2019 and did not require a treatment team review as of the annual compliance review. A review of the contract and amendments found the program is required to provide Skillstreaming the Adolescent, Living in Balance, Pathways to Self-Discovery and change, The Passport Program, Impact of Crime, Male healthy Relationships – Teen Relationships and Young Men's Work, Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Pathways a Guided Workbook for Youth Beginning Treatment, Building a Better Life, Health Sexuality Group, Roadmaps to Recovery, and Footprints – Steps to a Healthy Life. Reviewed group schedule, sign-in logs, and an interview with the DMCHA supported all 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 being 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.".	

A review of the program's contract and clinical program description indicated the program provides specialized treatment services to youth ages thirteen to twenty-one years of age and classified as high-risk or maximum-risk to public safety and in need of juvenile sex offender treatment services. The program's contract requires the program to have a licensed juvenile sex offender therapist available to provide services and is required to be on-site at forty hours a week, five days a week. At the time of the annual compliance re-review, the program had one licensed mental health counselor (LMHC) serving as the designated mental health clinician authority (DMHCA) and one licensed clinical social worker (LCSW). The program did have another LCSW until November 4, 2019, whereby the clinician went from full-time to pro re nata (PRN). Reviewed documentation supported both licensed clinicians maintained a position description and/or agreement identifying the position expectations and essential functions. The DMHCA received the required course work which meets the standards for approval, as set forth in Florida Administrative Code, Approved Courses for Continuing Education. The LCSW does not meet this requirement, as vetted through the Department's Office of Health Services, leaving one juvenile sex offender therapist vacancy. The program has an established training plan for the DMHCA to maintain the qualified training requirements to practice juvenile sex offender therapy, as outlined in Florida Administrative Code. 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 maintains a current Chapter 397 outpatient substance abuse license through the Department of Children and Families with an expiration date of April 7, 2020. An interview with the regional compliance manager indicated the program has submitted the paperwork for a new license. The program's specialized mental health and substance abuse treatment services include monthly individual therapy and family therapy sessions and daily group therapy sessions. Juvenile sex offender therapeutic groups include Pathways a Guided Workbook for Youth Beginning Treatment and Health Sexuality Group. Mental health, substance abuse, life skills, gender-specific groups include Path to Self-Discovery, Strategies for Anger Expression, Healthy Male Relationships, Living in Balance, and Skillstreaming the Adolescent. Supportive counseling is available and provided on an as-needed basis. The program's clinical staff also provide initial screenings, clinical interviews, assessments and evaluations, record review, Bio-Psychosocial Evaluations, medical/psychiatric services, functional behavioral assessments, treatment plan development, daily therapeutic activities, and behavior modification. A review of five youth mental health and substance abuse records validated each youth received juvenile sex offender therapy, individualized mental health services, and substance abuse services. Each session addressed mental health and/or substance abuse needs and was documented on the Weekly Progress Note form. The documentation supported the types of service the youth received to include the clinical intervention and the youth's response. A review of the four non-licensed therapist's caseload assignments found one had ten assigned, one had six assigned, and two had five each assigned. The designated mental health clinician authority (DMHCA) had a caseload of two. The program's specialized juvenile sex offender treatment services, as well as mental health and substance abuse services, include individual therapy sessions on a weekly basis and family therapy sessions on a monthly basis, conducted on-site or by telephone conference calls. Juvenile sex offender therapy is provided by the DMHCA. Mental health and juvenile sex offender group therapy are conducted seven days a week.

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 made indicating the psychiatrist agrees 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 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 since May 2019 validated the psychiatrist has been providing on-site services 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 five youth mental health and substance abuse records found each youth entering the program received an initial diagnostic psychiatric interview within fourteen calendar days of admission. Reviewed documentation supported three youth entered the program with prescribed psychotropic medication. All initial psychiatric evaluations were completed on the Department's Clinical Psychotropic Progress Note (CPPN). The three 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 five reviewed youth mental health and substance abuse records validated this practice. Three 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 procedures. 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 mock 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 the constant supervision of the youth throughout the intake process. A review of five youth mental health and substance abuse records validated each youth was screened for suicide risk utilizing the Department's Assessment of Suicide Risk (ASR). All five ASRs were completed by a master's-level non-licensed therapist and approved by a licensed therapist within the required time frame. A review of staff training records validated the non-licensed therapists 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 five youth ASRs were identified with an elevated risk of suicide. The program had two applicable youth mental health and substance abuse records of youth

with an elevated risk of suicide since the last annual compliance review. Both applicable youth were placed on precautionary observation (PO) due to self-reporting and staff observations. The juvenile probation officer and parent/guardian notification was documented. 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. Each applicable youth received a Follow-Up ASR completed by a non-licensed therapist and prior to the removal from PO. Both Follow-Up ASRs were reviewed by the licensed therapist within the required time frame. Discontinuation of Close Supervision was documented in accordance with the program's suicide prevention plan. The program had two youth placed in secure observation since the last annual compliance review. A review of the two applicable youth mental health and substance abuse records indicated each youth was placed in secure observation. Placement was authorized by the facility administrator and designated mental health authority (DMHCA). Reviewed documentation supported the secure room was designated in writing and a Health Status Checklist was completed prior to placement. A staff member of the same gender conducted a visual check of the youth to determine if there were any observable injuries. The secure observation room was inspected prior to the youth's placement to ensure it is safe and secure. Suicide precaution observation logs were completed in full while each youth was in secure observation. Both youth were removed from secure observation within twenty-four hours. Both reviewed records documented written consent for continuation by the designated mental health clinician authority (DMHCA). Each youth was provided supportive counseling services while in secure observation. Documentation validated the DMHCA and the facility administrator concurred with the removal of suicide precautions for each youth. The facility administrator has approved an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The multidisciplinary review includes all required elements to include the circumstance surrounding the event, program procedures relevant to the incident, relevant training, pertinent medical and mental health services involving the victim, precipitating factors, and recommendations. Five interviewed staff indicated when a youth expresses suicidal thoughts, direct care staff are responsible for notifying mental health staff, search the youth and room for sharps, speak to the youth in private and notify the shift supervisor, and place the youth on constant sight and sound supervision. One staff indicated placing the youth in secure observation if needed. Four interviewed staff were aware of the program's suicide response kits located in master control, sub-control East, sub-control West, and the medical clinic, and each containing the knife-for-life, wire cutters, and needle nose pliers. One staff did not indicate a suicide kit was located in the medical clinic. All five staff did indicate a suicide kit was also located in the dormitory; however, a review of the inventory and interview with medical staff indicated the kit is located in each sub-control.

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 current youth in the program who had been placed on PO. There was one youth who was placed in secure observation during the annual compliance review week; however, the youth was arrested while in secure observation and went to jail before the annual compliance review team could conduct an interview.

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

The program maintains a comprehensive mental health and substance abuse plan outlining all staff will receive intensive training on suicide prevention. The training consists of a thorough review of the suicide prevention plan and includes detention techniques, behavioral cues, and recommended responses. During pre-service training, staff are provided a module on mental health and adolescent behavior, and within the module, the typical behaviors of youth with mental health needs, as well as the strategies for working with the youth, are outlined. Staff are provided with an overview of recognizing signs and symptoms of emotional disturbance and mental health illness in children and adolescents. Lectures and practical application are utilized to address suicide precautions, levels of supervision, crisis response, and documentation. Training includes signs, symptoms, and stages of suicide. Six hours of suicide precautions and prevention is provided as part of the annual in-service staff training. Mock drills in response to suicide attempt and/or serious self-injurious behaviors are conducted once a quarter on each shift. A review of five staff training records and nine mental health staff 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 A-shift conducted eight mock drills, B-shift conducted six mock drills, and C-shift conducted five mock drills since the last annual compliance review. Reviewed drills and staff roster supported staff with direct contact with youth on a day-to-day basis participated in a least one quarterly mock drill semi-annually. Documentation found each of the mental health staff participated in mock drills at least once semi-annually. Each reviewed drill documented the description of the mock incident, a synopsis of the response, any applicable deficiencies identified, and any applicable corrective action required. Reviewed documentation supported mock drills which demonstrated life saving techniques such as cardiopulmonary resuscitation (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. An interview with the designated mental health clinician authority (DMHCA) indicated they conduct and oversee monthly mental health drills to educate and train staff from all departments on situations such as suicide attempts and psychiatric crisis. Interview with the facility administrator indicated they ensure mock drills in response to a suicide attempt or incident of serious self-inflicted injury are conducted for each shift, at a minimum, on a quarterly basis. Some drill scenarios may not require CPR; however, all staff with direct contact, on a day-to-day basis, with youth must participate in at least one mock drill which includes the use of CPR annually. The Continuity of Operations Plan (COOP) drills are conducted monthly on each shift consisting of fire, chemical spills, severe weather, disturbances, riots, bomb threats, and hostage drills.

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. Five youth mental health and substance abuse records were reviewed and found none were applicable for a crisis assessment. The program reported having one applicable youth who required completion of a Crisis Assessment since the last annual compliance review and this record was reviewed. Reviewed documentation supported the Crisis Assessment was completed by the designated mental health clinician authority, who is a licensed mental health counselor, on the date the youth was determined to be in crisis. The youth was assessed and determined not be in crisis; therefore, an alert was not required to be entered into JJIS, and the youth remained on Standard Supervision. 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. Mock drills are utilized to review procedures for emergency responses to include suicide attempts and serious self-inflicted injury situations. The emergency care plan is reviewed with each staff member to ensure staff are aware of emergency identification and responses necessary to ensure the safety of the youth. On-site training includes egress plans and the location of all safety equipment to include the suicide response kits, suicide rescue tools, first aid kits, and automated external defibrillator (AED). The program utilizes New Horizons of Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Lawnwood Regional Medical Center in Fort Pierce, Florida for Marchman Act.

3.17 Baker and Marchman Acts (Critical)	**Satisfactory Compliance**
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 maintains a written comprehensive emergency mental health and substance abuse services plan addressing Baker and Marchman Act proceedings. The program reported having one applicable youth for Baker Act proceedings on two separate occasions since the last

annual compliance review. The reviewed applicable youth record supported the direct care staff immediately notified mental health staff and the youth was placed on elevated one-on-one supervision in both instances. In one instance, the psychiatrist was on-site and began the Baker Act proceedings and authorized the transport to New Horizons of Treasure Coast and Okeechobee, the facility the program utilized for Backer Acts. In the second instance, the designated mental health clinician authority (DMHCA), who is a licensed mental health counselor, began the Baker Act proceeding and authorized the transport. The youth was transported by law enforcement to New Horizons of Treasure Coast and Okeechobee in Fort Pierce, Florida in each instance. Upon return to the program from the Baker Act, the youth was placed on Constant Supervision and a Mental Health Status Exam was conducted in both instances. An Assessment of Suicide Risk was completed by the DMHCA in both instances and the youth remained on Constant Supervision until transitioned to Close Supervision and subsequently, Standard Supervision by the DMHCA and the facility administrator. The program did not have any Marchman Acts during since the last annual compliance review.

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on September 4, 2019. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of March 31, 2020 and is an osteopathic physician with specialty training in family practice. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately four hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly as required; however, on one occasion they were not on-site within nine days. Documentation reflected the DHA was on-site on August 6, 2019 and not again until August 16, 2019, one day beyond the required nine-day time frame. In the event the DHA cannot be on-site, duties have been delegated to another DO who holds a clear and active license in the State of Florida which expires on March 31, 2020 to act on behalf of the DHA. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments and evaluations, provide medication evaluation, and on-going monitoring of medications and chronic medical medications. Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans, as needed. An interview with the DHA confirmed their role includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and reviews healthcare policies and procedures and nursing protocols. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist's license expires on January 31, 2021 and the certificate of insurance expires March 21, 2020. The psychiatrist is on-site once a week and meets with the nursing staff, clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2022. The optometrist license expires February 28, 2021.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on July 2, 2019, the facility administrator documented a review on October 7, 2019, and the psychiatrist documented a review on July 8, 2019. The program maintains three full-time registered nurses (RN) which includes one RN position which was vacant from August 29, 2019 until January 27, 2020. In addition, the program has two part-time RNs. One full-time RN is the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed

healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by the HSA. Reviewed training curricula and plan reflected a new RN would receive the required pre-service and orientation training to include on-the-job training. The program hired one new nursing staff since the last annual compliance review and reviewed documentation supported they completed the require training. The program maintains a nursing protocol manual developed and approved by the DHA on July 2, 2019 and reviewed by the back-up DHA on October 1, 2019. Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures on various dates throughout the annual review period. Treatment protocols were reviewed by the DHA on July 2, 2019 and the back-up DHA on October 1, 2019 and remained effective without change to include admission standing orders, non-licensed medical and emergency protocol guide, body mass index protocol, and approved first aid kit content and designee.

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

The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent about the healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent(s) who have legal custody or by the legal guardian and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. A review of five youth healthcare records found four were applicable for a signed AET. Each of the four reviewed youth healthcare records contained a copy of the signed AET and the word "Copy" was clearly stamped on each. One of the four youth was involved with the Department of Children and Families; however, parental rights were not terminated. There were no original AETs reviewed. One youth was eighteen years old upon admission to the program and the youth healthcare record contained the required signed consent. Each reviewed AET and/or Release of Information form was filed in each youth's healthcare record in the appropriate section. An interview with nursing staff indicated the registered nurses review all admissions in the Department's Juvenile Justice Information System (JJIS) and validates the AET. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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

The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Five reviewed healthcare records

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

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted. A review of five youth healthcare records reflected 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 RN indicated a nursing assessment is conducted immediately following the initial search. The RN notifies the designated health authority (DHA) by telephone, by text, or verbally, if on-site, with the youth's history and identified chronic

condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. One of the five reviewed healthcare records was applicable for a change in custody and documentation supported the youth 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 whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The health education shall be provided by the healthcare staff, in writing and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. For youth with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review of five youth healthcare records reflected each youth received a healthcare orientation on the day of admission as documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay as documented in the healthcare record. Five reviewed healthcare records supported 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 practice is for the designated health authority (DHA) to be notified by telephone, by text message, or verbally, if on-site, of all admissions. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of five youth healthcare records supported the DHA was notified by telephone and the Notification of Admission form was filed in the practitioner's section of each healthcare record. In addition, the nurse documents the DHA notification on the Nursing Chronological/Notification Progress Note – Male Admission form and the form is filed in the nursing chronological notes section of the healthcare record.

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

The program maintains a written policy and procedures ensuring nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of five youth healthcare records supported a new HRH form was

completed for each youth within seven days of the youth's admission. Reviewed practice reflected the HRH form was completed on the same day of each admission. The nursing 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 nursing staff confirmed the practice and indicated the HRH form is also completed whenever any new significant medical event or change occurs and then annually, thereafter.

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

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

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases/infections. A review of five youth healthcare records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and was

performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for all five youth. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. Nursing interviews confirmed the program's practice. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, when necessary. A review of five youth healthcare records validated each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent or decline consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form indicating their choice. A review of five youth healthcare records reflected four consented for testing and one did not. The program utilizes the designated health authority (DHA) to conduct pre 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. The results were placed in a sealed envelope marked "confidential" with the youth's name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff also maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, post-testing date, and provider name. Five interviewed youth indicated they can request HIV testing.

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

The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's sick call process upon admission. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2020 and the optometrist license expires February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist. The psychiatrist is on-site one time a week and meets with the nursing staff, the clinical director, and case managers to discuss the needs of the youth and evaluate medication management. The program offers youth the opportunity to make a sick call request, seven days a week, two to three times daily, conducted by the registered nursing staff. Sick call is conducted from 6:30 a.m. to 6:55 a.m. and 2:00 p.m. to 4:00 p.m. Monday through Friday, and from 8:00 a.m. to 8:30 a.m., 9:30 a.m. to 9:45 a.m., and 2:00 p.m. to 4:00 p.m. on Saturday and Sunday. A review of five youth healthcare records found three youth completed a Sick Call Request form at least one

time during their stay. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. There was one applicable youth who presented a similar sick call complaint three or more times within a two-week period. Sick call logs and an interview with nursing staff validated there were no other applicable youth during this annual compliance review period who presented with the same complaint three or more times within a two-week period. The program procedures outlined the healthcare staff will automatically refer the youth to the designated health authority (DHA) for an evaluation and treatment, and documentation validated this practice. Reviewed healthcare records indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the program's electronic medical record as well as the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into a shift supervisor for review. The shift supervisor will determine if the sick call requires immediate attention. The DHA is on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. All staff supervisors received medical technician training delivered by the RN. An interview with the RN indicated refresher training is provided annually. The program maintains sick call boxes mounted to the wall in front of each sub-control. The boxes are monitored throughout the day by nursing staff and complaints are triaged for urgency to be evaluated. All youth are seen within twenty-four hours of submission. One sick call was observed with the youth's permission during the annual compliance review. Observation validated the youth was seen by a licensed medical professional in a confidential manner. A youth care worker was positioned outside the examination room in the medical clinic, allowing for privacy. Five interviewed staff indicated nursing staff responds to and conducts sick call. One of the five staff reported youth are seen by the doctor if they are on-site. Five youth were interviewed and four reported being seen within one day of a sick call request and one youth stated being seen within three days. In addition, each of the five interviewed youth stated they could see a dentist if they needed to.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of five youth healthcare records found two youth requiring episodic and/or first aid care during their stay in the program. One of the two youth had two separate incidents requiring episodic care. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff maintain an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews confirmed the program's practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Care Log. The program also maintains a written policy and procedure ensuring the program-based automated external defibrillators (AED) are properly managed and administered to

persons eight years of age and older who experience sudden cardiac arrest. The program maintains four AED located in master control, east and west sub-controls, and the medical clinic. Nursing staff ensure the AEDs are functioning adequately and include the inspection of the batteries and pads to ensure they are in working order. The AED procedures were observed as audio as demonstrated by the nursing staff. Reviewed AED batteries expire on August 2023 for each AED, and pads expire on June 30, 2020 for the west sub-control, August 2020 for the east sub-control, and December 2020 for the medical clinic and master control. Each were last changed on August 16, 2019. The program maintains eight first aid kits located in the medical clinic, east and west sub-controls, master control, controlled observation, the kitchen, and both vans used to transport youth. An inspection of three first aid kits, including the kits used during youth transport, supported each contained the required items and all items were current and within their expiration period. A list of the items contained in each first aid kit were maintained on an inventory log with the date of the weekly inspection along with nursing staff initials. The program also maintains four suicide response kits located in master control, east and west sub-control, and the medical clinic, and observation found each contained a knife-for-life, wire cutters, and needle nose pliers. The first aid kits are checked weekly and the AED and suicide response kits are checked monthly by nursing staff to ensure each are adequately supplied and in operating order. Reviewed training records found all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Nursing staff maintained current certifications in CPR and AED. Reviewed training records supported shift supervisors, the facility administrator, and assistant facility administrator have been trained in the administration of the epinephrine auto injector. The program conducts announced and unannounced mock emergency medical drills monthly on each shift. Reviewed documentation reflected an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in each sub-control and the medical clinic accessible to staff but inaccessible to youth. Five interviewed staff reported being allowed to call 9-1-1 if a youth has a medical emergency. In addition, one of the five staff stated they let the supervisor know to make arrangements for the transport or ambulance.

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

The program maintains a written policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth healthcare records found three youth requiring off-site care and/or emergency care. Each off-site care event was documented in the youth healthcare records. The reviewed youth healthcare records indicated each youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the healthcare record. Reviewed documentation reflected the DHA reviewed each completed Summary of Off-Site Care Form and discharge paperwork as evidenced by signature and date. Each youth required follow-up care and documentation supported they received services as prescribed. An interview with

nursing staff indicated the registered nurses track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call/Referral Log Form.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth healthcare records indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All three youth were classified with a medical grade of two through five. Each youth was currently undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, the chronic condition, date of last visit, and projected next visit date. Reviewed records reflected each youth received periodic evaluations as required. An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more frequency. An interview with nursing staff reported youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss treatment plans for youth. In addition, the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. In an interview, the psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations. Reviewed documentation validated each youth received a new Comprehensive Physical Assessment (CPA) within seven days of their admission. Reviewed documentation supported the Department's Problem List was updated as required.

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

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

records indicated three were admitted into the program on prescribed medication. Nursing admission notes documented each youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication and verbal notification or telephone was also documented. Program practice is to notify the DHA for all youth admissions. Reviewed documentation reflected the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The three-youth taking prescribed medication were placed in controlled observation at least once during this annual compliance review period and received their medication as prescribed. Each reviewed youth healthcare record reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications. Three reviewed youth healthcare records found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All three youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. Observations found the medications are procured through 1st Choice Pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order and procured medications are administered by nursing staff. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. Nursing staff maintain locked cabinets in the medical clinic with OTC medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on- site. A small amount of OTC medications are stored in the medical clinic accessible to trained non-healthcare staff to dispense in the absence of licensed medical staff. There were no indications of lapses and/or errors in the medication administration. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. One youth was applicable for a refusal of medication and it was clearly documented on the MAR and nursing staff completed the Department's Refusal of Treatment form when the youth refused the medication dosage. Observation of three medication administrations by nursing staff validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. The Six Rights of Medication Delivery / Administration was maintained for each youth. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. Program procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. Observations during the annual compliance review and an interview with the nursing staff validated the practice. Each 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 (RN). The program maintains one refrigerator in the medical clinic for the storage of medication. There was one applicable medication requiring refrigeration during the annual compliance review week which was stored in the refrigerator. Five youth were interviewed, and one reported not taking any medication. Four youth were taking prescribed medication and three stated it was administered by nursing staff and one stated it was administered by the doctor. Five interviewed staff reported medication is administered by nursing staff.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations during the annual compliance review found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter medications were placed in the locked medical clinic for trained authorized non-licensed staff to administer, if needed. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one refrigerator for medications. There was one medication requiring refrigeration during the annual compliance review week and was observed in the refrigerator. The program securely stored sharps and syringes separate from medications. The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses (RN). Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. The program maintains written procedures for the disposal of narcotics and other controlled substances. Program practice is for the consultant pharmacist and registered nursing staff to dispose of the medication by placing the medication in an All-Purpose RX Destroyer System bag and document the disposal on the Disposal Log and on the Controlled Medication Inventory Record. All non-controlled medications are sent back to 1st Choice Pharmacy for credit. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified. The program maintains a current agreement with Stericycle, Inc. for biomedical waste – treatment with a certificate of exemption issued on October 19, 2019 with the State of Florida, Department Health. Stericycle, Inc. picks up medical waste weighing less than twenty-five pounds monthly for proper disposal.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Center 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 2, 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's agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program maintains a current certificate of exception through the Department of Health for biomedical waste – state laboratory/clinic issued on October 19, 2019. 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 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. Five reviewed in-service training records and pre-service training records for five direct care staff supported each was trained infection and exposure control. The plan is accessible to all staff and is maintained in the medical clinic and master control.

4.18 Prenatal Care/Education	Satisfactory Compliance
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	Satisfactory Compliance
Program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff can account for the whereabouts of youth under their supervision at all times.	

The program has a written policy and procedures addressing the active supervision of youth. Youth and staff observations were conducted each day of the annual compliance review during various times and activities such as school, recreation, meals, breaks, groups, and line movements. The program promotes safety and security by maintaining supervision of youth which includes interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing the behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system. A review of the staff schedule coupled with observations indicated the program adhered to the program's one to eight awake staff-to-youth ratio requirement. In addition, video surveillance recordings during ten-minute checks of youth supervision reflected staff-to-youth ratios were observed to be compliant with the program's contract of one staff for every twelve youth during nighttime (sleep) activities. The program conducts formal and informal head counts various times a day. Prior to youth movement made, staff must inform master control, by way of two-way radio of the head count. Once the count is confirmed, permission is granted by master control to move the youth. All youth counts made throughout the day are documented in the facility logbook which is maintained by the program staff in master control. All staff providing supervision were aware of the youth under their supervision at the time. During outdoor activities, staff were taking positions where youth were always in sight and sound. Informal interviews were conducted with supervising staff and confirmed staff understood the procedures to take when there is a discrepancy in youth counts.

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 has a written policy and procedures regarding the behavior management system (BMS) and staff training. The program has a written description of the BMS in the youth handbook which offers a detailed explanation of the program's system. Program rules and expectations are addressed in the handbook. The youth handbook included a list of behavioral infractions and rewards youth can earn for demonstrating positive behavior. The BMS is a five tiered level system which is designed to decrease unwanted behaviors and increase desired behaviors. Rewards utilized by the program includes canteen, offering additional leisure time, honor room privileges, and/or special meals. Negative consequences are in direct relation to the severity or seriousness of inappropriate behavior exhibited. The BMS provides immediate on-going feedback to youth related to their behavior, promotes positive peer pressure, teaches

youth alternative ways and skills to solve problems, and outlines the program's rewards and privileges. The BMS provides opportunities for positive reinforcement and individual recognitions for prosocial behaviors and accomplishments, positive behaviors, and promotes conflict resolution while minimizing separation of youth from the general population and routine activities. A review of five youth case management records found each youth signed the youth handbook to acknowledge their receipt of the handbook upon admission into the program. The program has an annual in-service and pre-service training plan which includes the BMS for all staff. A review of five staff pre-service training records and five staff in-service training records confirmed each were trained in the BMS utilized at the program, as required. An interview with the program's compliance manager confirmed the program employs their own teachers who are also provided training. Observations of the facility while on the facility tour reflected the program has postings of the BMS posted in the module. Staff and youth interactions during the week of the annual compliance review confirmed staff adhered a ratio of four-to-one positive-to-negative consequences when redirecting the youth, as indicated in the program's policy. Five interviewed youth confirmed they were aware of the BMS, aware it is posted throughout the program, and were provided information on the BMS within their youth handbook. Each youth recognized the difference between each level and how they move from one level to the next. The five interviewed youth each confirmed rewards include weekly and monthly incentives such as extra snacks, special meals, and extra leisure time. All youth were aware of the consequences which would be imposed due to non-compliant behavior. Five interviewed staff explain their understanding of the BMS which reflected the program's policy. Each interviewed staff confirmed reward incentives may include later bedtimes, extra snacks, extra time for video games, and daily/weekly incentives. The facility administrator (FA) reported the program utilizes a token economy to reward the youth for positive behavior. They also address behavior through treatment teams and place youth on level based on their progression in the program. Also, rewards are monitored by the director of case management (DCM) and each morning, the DCM reviews negative and positive behavior reports written by the staff. The case managers also review the contact cards for each youth. The FA also indicated staff are recognized during performance evaluations for appropriately using the BMS system.

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 has a written policy and procedures in place pertaining to the behavior management system (BMS). The BMS includes a process where staff provide positive and negative consequences in a ratio of four-to-one positive to negative consequences. Staff explain to youth any infractions occurring; therefore, a youth does understand their actions and the consequences related to them. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and constantly imposed. Case managers are responsible for tracking youth violations and utilizing the BMS when

confronting the youth about their behaviors. Youth are given an opportunity to explain their behavior during treatment team. A review of the BMS does not indicate it is 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 does not utilize room restriction with youth. The program also utilizes "Let's Talk" forms where the youth may submit a "Let's Talk form to informally voice any concerns or requests with staff prior to filing a formal grievance. A review of randomly selected staff position descriptions were reviewed and reflected they specified implementation of the BMS as a job requirement. Five staff were interviewed and reported supervisors provide feedback to staff regarding the implementation of the BMS during daily briefings. One staff also reported the supervisor provides feedback during monthly meetings. Three interviewed youth rated the BMS as good. One youth rated the system as fair and another youth rated the system as poor. The facility administrator (FA) reported the program uses a token economy to reward the youth for positive behavior. They also address behavior through treatment teams and place youth on level based on their progression in the program. Also, rewards are monitored by the director of case management (DCM) and each morning, the DCM reviews negative and positive behavior reports written by the staff. The FA reported staff are recognized during performance evaluations for appropriately using the BMS system. Reviewed documentation confirmed staff receive an initial ninety-day performance evaluation followed by an annual evaluation thereafter which includes an evaluation of the staff's implementation of the BMS.

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

The program has a written policy and procedures in place to conduct and document ten-minute checks while youth are in their sleeping quarters, either during sleep time or at other times such as an illness or room restriction. A review of video surveillance confirmed the program's practice is to conduct five-minute intervals instead of the required ten-minute intervals. The program is equipped with 103 recording video cameras capable of recording at a minimum of thirty-days of video footage, all of which were operational at the time of the annual compliance review. The program utilizes the Guard One electronic system to document room checks when youth are in their sleeping quarters. The ten-minute checks are recorded electronically. Staff must ensure the youth's skin or a body part is seen to confirm the youth's presence. Staff are not allowed to enter a youth's room alone and must conduct a visual check from the door/window of the youth's room. The program's practice is to have master control staff notify staff of ten-minute checks by way of two-way radio communication of when checks are to be conducted. Supervisors are required to conduct three room checks each night and visibly see the flesh of each youth in their room. The program has three dormitories which include Alpha three, Bravo four, and Charlie five. A review of ten-minute checks for three different dates for two different shifts were reviewed for each dormitory, along with the corresponding video surveillance which indicated checks are conducted in real time. However, one check was conducted later then the Department required ten-minute timeframe. On January 23, 2020 on Alpha dormitory, the first check started at 9:55 p.m. and the next check was not conducted until 10:10 p.m. The program staff was made aware and was in agreement of the staff completing the ten-minute check outside of the Department's policy. Five interviewed staff reported room checks are conducted every five minutes when a youth is placed in their room for sleeping or non-punishment reasons.

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 has a written policy and procedures in place to track daily census information including at a minimum the total of new admissions, releases or direct discharges, transfers, daily census, and youth temporarily away from the program. The program conducts both formal and informal counts at various times throughout the day. Observations conducted during the annual compliance review confirmed master control announced each head count for direct care staff to complete. Master control was contacted by staff to inform them of the number of youth being moved and to what location. Staff waited for clearance from master control before moving the youth. A review of the program's facility logbooks for the past six months found appropriately documented youth movements, formal and informal counts, census counts daily, counts at scheduled and unscheduled times, releases, and any emergency situations. Additionally, the program utilizes a grease board located in master control for tracking purposes. Five interviewed staff confirmed they are aware of the program's policy and procedures regarding emergency counts and reconciling discrepancies.

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 entries. The program maintains a bound logbook with numbered pages which is stored within master control to document information and daily events at the facility. A review of random logbook entries for the past six months found all entries included the date and time of the event with the name of the staff and youth involved. The logbooks were bound with numbered pages and had entries completed with ink. There were no white-out areas observed while errors were struck through with a single line and initialed by the person correcting the error. Master control staff records all events, emergency situations, incidents, and activities in the logbook. Reviewed documentation found the program utilizes the shift report to summarize events, incidents, and activities, and a supervisor verbally briefs incoming staff using the shift report. Each staff is responsible for signing the shift briefing sign-in sheet to ensure information has been passed on to each staff.

Briefings are conducted at the beginning of every shift. Observations made during the week of the annual compliance review confirmed staff are briefed on all pertinent information prior to starting their shift. A review of the program's logbooks confirmed internal incidents reported to the Florida Abuse Hotline and/or the Department's Central Communications Center were documented.

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

The program has a written policy and procedures for key assignment, usage including restrictions on usage, inventory and tracking of keys, secure storage of keys not in use, procedures addressing missing keys, and the reporting and replacement of damaged keys. Observations found master control is responsible for the distribution and collection of program keys upon staff entering and exiting the program. Master control staff maintains a tracking log for tracking key distribution. Facility keys are stored on a key board located in a locked closet in master control. Keys are bound on a tamper resistant ring which includes a brass colored tag with a tracking number. Restricted keys are issued to teachers, case managers, therapist, and nursing staff by master control and reconciled daily. A 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. A key check of all facility keys is conducted monthly to ensure all keys are accounted for. 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. When staff arrive to the facility they are searched prior to the beginning of their shift. Staff gain access into the facility by way of master control. Staff submit their personal keys to the master control operator, receive a facility key in exchange, 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. During an informal interview, master control staff reported keys on the housing unit are active keys. The program maintains an active key ring reference log which list the key hook number, location where the keys are stored, and the key numbers on each key located on the key hook. A housing unit report is completed on each shift by the supervisor indicating the assigned keys for each dorm. Staff are required to sign the document to indicate the keys are assigned to them during their shift. A random check of the key inventory was made and reflected keys rings on the inventory matched the actual key rings in use. A random check of direct care staff with personal keys was conducted. Each program staff was found to only be in possession of the assigned program keys. Five staff were interviewed and each had knowledge of the program's policies concerning missing, lost, or damaged keys during a shift.

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 has a written policy and procedures in place for contraband. The policy outlines items considered to be contraband and consequences for both youth and staff if found in possession of contraband. The program provides all newly admitted youth a resident handbook of all program rules which includes a list of what is considered contraband. Visitors at the program are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor contraband list verified it contains a list of the required unauthorized items not permitted which includes personal cellular telephones or devices capable of taking photos and/or audio/video recordings. Observations conducted throughout the annual compliance review found all staff and visitors walk through a metal detector, were searched with an electronic wand, and bags or other items brought into the program were searched as well prior to entry. The program conducts weekly searches of the rooms and document on a shift manager shakedown report. A review of the reports for the past six months indicated checks are conducted and any contraband/unauthorized items found are documented. The facility administrator (FA) and assistant facility administrator (AFA) reported during an informal interview any contraband/unauthorized items are disposed of or turned over to the Department if requested, during the initial review. Any illegal contraband will be turned over to the local sheriff's department; however, the AFA reported contraband is not an issue in the facility.

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

The program has a written policy and procedures in place for searches and full body visual searches to be conducted in accordance with Florida Administrative Code. Searches are conducted upon admission, departure, after visitation, before and after any off-site activity, work projects, and movement from one area of the program to another. All youth suspected of contraband or a security risk are searched prior to returning to the general population. Observations during the annual compliance review verified the program's practice of full body visual searches following movement from one area of the program to another and transportation

to ensure the safety of the youth and staff in a controlled environment. Observations confirmed youth were given instructions regarding the search and were searched by a staff member of the same gender. The searches and full body visual searches were conducted in accordance with the Department's Protective Action Response (PAR) training policy. Five interviewed staff reported youth are searched when moved from one area of the program to another. Five interviewed youth confirmed the program's practice.

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

The program has a written policy and procedures in place for vehicles and vehicle maintenance. The program had two vans on-site at the time of the annual compliance review. Each van was observed to be equipped with a safety screen separating the driver's compartment from the back seat/rear passenger's compartment and doors to the youth passenger area which cannot be opened from the inside when locked. Both vehicles were observed and were found to be equipped with a fire extinguisher, first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each passenger. First aid kits are stored in master control until the vehicle is in use. Reviewed documentation of invoices confirmed both vans were found to have annual inspections completed. One van annual inspection was completed on August 20, 2019 and the other was completed on September 27, 2019.

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

The program has a written policy and procedures in place for the transportation of youth. Observations during the annual compliance review confirmed the program provides the appropriate minimum staff to youth ratios while youth are transported off facility grounds. Each van was observed to be equipped with a safety screen separating the driver's compartment from the back seat/rear passenger's compartment and doors to the youth passenger area which cannot be opened from the inside when locked. Both vehicles were observed and were found to be equipped with a fire extinguisher, first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each passenger. First aid kits are stored in master control until the vehicle is in use. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate program or staff vehicles. Reviewed documentation confirmed the program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted monthly by the human resources manager. An inspection of randomly selected personal vehicles was conducted throughout the week of the annual compliance review to determine if staff locked their personal vehicles while working on-site. All vehicles were locked during the time of the inspection. Five interviewed staff reported utilizing a cellular telephone issued by the program to take with them on transports to communicate during any emergency situations when transporting youth. All staff reported they are not permitted to transport youth in their personal vehicles.

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

The program has a written policy and procedures to ensure safety and security of the facility is maintained. The policy meets the Florida Administrative Code 63E-7.013(5) requirements. The program's assistant facility administrator (AFA), physical plant manager, or designee is responsible for conducting safety and security audits weekly. Reviewed documentation found any deficiencies or recommendations were documented on the inspection logs. If there are any deficiencies found, they are addressed on the form and discussed during the program's morning meetings. A review of the safety and security inspections forms for the past six months documented audits are conducted every seven days. The program also conducts perimeter checks which are documented in the facility logbook. Checks are conducted on each shift and after youth outside movement. An interview with the facility administrator (FA) stated TrueCore has developed a risk management and quality improvement system which involves collaboration and corporate oversite to ensure fidelity, addresses any arising needs, and program progress, as well as promotes 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 has a written policy and procedures outlining the tool management system. All tools are marked for easy identification. The program's policy identifies the physical plant manager as the designated tool control manager. All tools listed on the tool list were also displayed on the program's shadow board in the maintenance area, kitchen, and inventoried daily. The program maintains a log of the tools at the facility. Identified staff are required to sign tools in and out on the log. All observed tools were securely stored when not in use were stored and locked away in the assigned area. During a tour of the program, no tools were observed accessible to youth. Observations of the mechanic shop found all tools were organized and maintenance staff indicated youth are not allowed to utilize tools. Interviews with the program's assistant facility administrator (AFA), maintenance staff, and kitchen staff confirmed the program's practice regarding tool management and inventory. Five youth were interviewed and reported they are permitted to utilize Class B tools such as mops and brushes. Five interviewed staff confirmed youth are only permitted to utilize Class B tools. A review of five staff training records and five youth case management records indicated staff and youth are trained on the safe use of Class B tools only.

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

The program has a written policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries. The program completes a risk assessment on all youth to determine their eligibility to use Class B tools. Reviewed documentation confirmed assessments were completed on each youth prior to the youth utilizing Class B tools.

Observations during the annual compliance review revealed all tools were securely stored when not in use and the program provides the appropriate minimum staff-to-youth ratios during activities involving tools. One youth was observed sweeping the floor with a broom and wiping the tables while the staff sprayed the chemicals. The youth was being directly supervised by staff. A review of the youth's risk assessment confirmed the youth was trained prior to utilizing tools. Five youth were interviewed and reported they are permitted to utilize Class B tools such as mops and brushes.

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

The program has a written policy and procedures in place for outside contractors. Outside contractors are required to sign a contract agreement form which stipulates the guidelines and requires an inventory list of each tool brought into the facility. The program requires all outside contractors to review and sign a Contractor's Guidelines form with an attached copy of the visitor's contraband list. Contactors must also review and sign a Prison Rape Elimination Act (PREA) acknowledgment form to document their understanding and agreement with the rules, requirements, and guidelines to which the contractor must adhere to while working on-site at the program. The physical plant manager is responsible for contractor tool control procedures and inventory sheets. A review of project invoices, sign-in sheets, and signed contract agreement forms confirmed the program's practice. An informal interview with the physical plant manager indicated maintenance staff is assigned to supervise the contractor until the work is complete and no youth are allowed in the work area while outside contractors are on-site.

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 has a written Continuity of Operations Plan (COOP) which requires emergency drills to be conducted monthly, at random times and under varied conditions. The COOP was approved by the Department on April 24, 2019. Program staff document drills on a Facility Drill form which includes the beginning and ending time of the drill, the nature of the drill, participants, a brief scenario, and the findings/recommendations. Reviewed documentation of drills confirmed the program completed drills in accordance with the Department's policy. The program completed COOP drills each month on each shift relating to safety and/or evacuation involving a hurricane, flood, lightning in the area, terrorist threat, and a chemical spill. All staff participating in a drill signed an attendance sheet. An interview with the facility administrator (FA) confirmed fire drills are completed once every month on each shift. Five interviewed staff confirmed their participation in major disturbance, chemical spills, weather, escape, and fire evacuation drills. Five youth were interviewed and reported drills are conducted monthly. Each confirmed they had been instructed on what to do in the case of a fire.

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

The program maintains a Continuity of Operations Plan (COOP), which was signed and dated by the Department on April 24, 2019. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan also indicated alternative housing if the program has to be vacated due to an emergency or disaster. Observations during the annual compliance review coupled with an informal interview with the facility administrator (FA) and assistant facility administrator (AFA) confirmed the COOP is located within both sub controls, master control, AFA's office, and FA's office. Reviewed documentation confirmed the program maintains critical identifying information in an administrative hardcopy binder, which is easily accessible and mobile in the event of an emergency situation resulting in the program relocating quickly or in the event needed information cannot be accessed electronically for all youth in the program. The administrative hardcopy file included all required elements.

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

The program has a written policy and procedures in place regarding the storage and inventory of flammable, poisonous, and toxic items. A review of the program's storage area found flammable, poisonous, and toxic materials stored in a secured and locked metal cabinet located on the outside of the maintenance area which is inaccessible to youth. The program's physical plant manager maintains a list of materials and list of authorized staff with access to chemicals posted on the outside doors along with a permanent log to indicate the sign-out and sign-in of chemicals. All caustic materials are stored according to type and use. A review of the flammable, poisonous, and toxic items lists for the past six months compared with actual inventory verified the items stored. A Safety Data Sheet (SDS) binder is maintained with a picture of each material and a number corresponding to the SDS for each chemical. The program records the daily use of chemicals on a daily chemical usage log. A perpetual chemical inventory list is maintained. A review of the inventory list for the past six months verified the chemicals are stored and checked daily. The program maintains a list of staff who are authorized to use chemicals. The program also has a chemical daily usage log used to track all toxic when in use by authorized staff. When comparing the chemicals stored in the secure and locked cabinet with the SDS records, there were no inconsistencies noted. Reviewed documentation reflected chemicals are inventoried one time a week by the program's physical plant worker.

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 has a written policy and procedures which prohibits youth from handling flammable, poisonous, and/or toxic items and materials. The program maintains strict control of these items. Youth are restricted from the area where toxic items are stored. Youth do not use, clean, or dispose of any bio hazardous material, bodily fluids, or human waste. Observations during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. The program utilizes a Preventive Maintenance Checklist to ensure maintenance schedules and repairs are being conducted. One youth was observed sweeping the floor with a broom and wiping the tables while the staff sprayed the chemicals. The youth was being directly supervised by staff. Five youth were interviewed and reported they utilize chemicals further explaining staff spray the chemical and youth wipe it up.

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

The program has a written policy and procedures for disposing chemicals. The policy was developed in accordance with Occupational Safety and Health Administration (OSHA) standards. The physical plant manager is in charge of the disposal of such chemicals. The program's practice for the physical plant manager is to dispose of unused flammable, poisonous, and toxic materials during Okeechobee County's free Amnesty Day. However, the physical plant manager reported during an informal interview all flammable, poisonous, and toxic materials are used completely. Kitchen liquid waste except grease, is disposed of in the kitchen. Used kitchen grease is disposed of by KRK Enterprises, Inc. The company comes on-site and pumps out the grease trap for disposal and performs maintenance on a quarterly basis. Reviewed documentation in comparison with an interview with the physical plant manager confirmed this practice. The facility administrator also indicated the program does not dispose of flammable, toxic and poisonous items.

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.

This 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 has a written policy and procedures pertaining to visitation and communication for youth. The visitation and communication procedures are explained and outlined in the youth's resident handbook. The program encourages communication and visitation from the parent/guardians by sending out a welcome letter upon the youth's admission to notify the parent/guardian of the days and times for visitation, who can visit, incoming and outgoing mail rules, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in each youth's case management record within a single binder. Visitation is conducted each Saturday and Sunday. Morning sessions are from 9:00 a.m. to 11:30 a.m. and afternoon sessions are from 1:00 p.m. to 3:30 p.m. A review of chronological documentation and telephone logs confirmed youth contacted their family members or parent/guardian. A review of visitation sign-in and sign-out logs for the past six months documented youth visitation

with family members. Five interviewed youth reported they can communicate with family members by mail, telephone, or at 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 has a written policy and procedures in place in reference to controlled observation. The program has a designated area with controlled observation rooms which meet the size and construction requirements required by Florida Administrative Code. The program had a total of fifty-nine controlled observation reports within the last six months. Four of five random controlled observation reports verified room inspections and a staff member of the same gender as the youth completed each search completed prior to youth placement in controlled observation. One report did not document if a room inspection was conducted. This information was shared with the assistant facility administrator during the week of the annual compliance review.

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

The program has a written policy and procedures in place in reference to controlled observation. The program had a total of fifty-nine controlled observation reports within the last six months. A review of five control observation reports and documentation verified supervisory or higher-level staff authorized placement of youth in controlled observation, youth was placed in controlled observation due to active aggression, violent behavior, physically out of control, and staff need to quickly gain control. Reviewed documentation of each Controlled Observation Safety Check form confirmed the program conducted safety checks every ten minutes for each youth which exceeded the fifteen-minute requirement. Each controlled observation report contained a completed Health Status Checklist form as well. Reviewed documentation confirmed the facility administrator or designee granted two-hour extensions without exceeding twenty-four hours when applicable.

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 has a written policy and procedures in place in reference to controlled observation. A review of five Controlled Observation Safety Check form confirmed the program conducted safety checks every ten minutes for each youth which exceeded the fifteen-minute requirement. Each entry indicated the time, code explaining youth's behavior while observed in controlled observation, and the staff's initials of who observed the youth. Each controlled observation report was reviewed and supported each youth was released from controlled observation with the approval of the facility administrator (FA) or a supervisor with delegated authority. Each report was reviewed and approved by the FA or assistant FA within fourteen days of the youth's release from controlled observation to determine if placement was warranted and handled appropriately.

5.26 Safety Planning Process for Youth	Limited 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 safety plans for each youth in the program in a safety plan binder which is maintained in master control. A review of five youth case management records was conducted regarding safety planning process for each youth. Safety plans are developed to identify warning signs, youth baseline behaviors, crisis recognition, coping strategies to include people and health environments, and intervention strategies. The initial planning process is initiated by each youth's case manager within fourteen days of the youth's admission to the program. Four of five initial plans were initiated by each youth's case manager within fourteen days of the youth's admission to the program. One was completed a month later. Each youth had an initial safety plan which was jointly prepared with the youth, parent/guardian, clinical staff, and contained the required topic areas. Each reviewed plan incorporated recommendations form collateral sources, previous clinical assessment, reviewed monthly during treatment team meeting, and updated, as required. One youth's safety plan were reviewed and was updated every thirty-days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment. Four youth's safety plans found various issues regarding the plan being updated every thirty days. One youth did not have a plan completed in October 2019. Another youth did not have a plan completed in September 2019, and the plan was completed twenty days late in January 2020. Another youth did not have a plan completed for the months of October 2019 and November 2019. Another youth initial was completed late and was applicable for a thirty-day review. Four of five interviewed youth reported they were involved in the development of their safety. One youth could not remember if they participated in the development of the safety plan. Five staff were interviewed and were unaware of the process. This information was shared with the administration department.