STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Girls Academy

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

Review Date(s): August 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 Accountability and Program Support, Lead Reviewer (Standards 2 & 5)
Christine Calvert-Joyner, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Camelia Daley, Office of Accountability and Program Support, Regional Monitor (Standard 2 & Interviews)
Tonya Gittens, Office of Accountability and Program Support, Regional Monitor (Standard 1)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Shakela Minns, Office of Accountability and Program Support, Regional Monitor (Standard 4)

Program Name: Okeechobee Girls Academy
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): August 4-7, 2020

MQI Program Code: 1209
Contract Number: R2103
Number of Beds: 32
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
3.08 Specialized Treatment Services*	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Non-Applicable
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Limited
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
4.19	Licensed Medical Staff*	Satisfactory

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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	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Okeechobee Girls Academy is a thirty-two-bed program for thirteen to eighteen-year-old female youth, located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides Mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). Youth with a substance abuse diagnosis are offered substance abuse treatment through Seeking Safety, Living in Balance, Pathways to Self-Discovery and Change, and Project Towards No Drug Abuse. The program offers mental health treatment through Voices – A Program of Self-Discovery and Empowerment for Girls, The Teen Relationship, Skillstreaming, Anger Management for Substance Abuse and Mental Health, Anxiety Workbook for Teens, and The Anger Workbook for Teens. The program provides Thinking for Change and Impact of Crime as the criminogenic and restorative justice curricula. In addition, SAVVY Sisters is offered as the program's gender-specific programming. Additional treatment services provided include recreational, individual, group, and family therapies.

Program administration is comprised of a facility administrator, assistant facility administrator, and four shift managers. Case management services are provided by the transition services manager and two case administrators. Mental health staff at the program includes the director of clinical services serving as the designated mental health clinician authority (DMHCA), the contracted psychiatrist, a contracted psychologist, three master's-level therapists, and a recreation therapist. Medical services are offered seven days a week and are provided by the contracted designated health authority, a health services administrator, two licensed practical nurses, a contracted optometrist, a contracted gynecologist, and a contracted dentist. The layout of the program includes two youth dormitories, two administrative buildings, a Home Builders Institute workshop and classroom, a library, a classroom building, a theatre room, a recreation building, a maintenance building, and a storage room formerly used as a shower room. The program shares a warehouse with the Okeechobee main campus, also managed by TrueCore Behavioral Solutions, LLC. The program has fifteen closed circuit cameras. Thirteen of the fifteen cameras were fully operational during the annual compliance review week. At the time of the annual compliance review, the program had five vacant positions which included four youth care workers and one licensed practical nurse (LPN). In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of specific indicators or elements were unable to be completed during this fiscal year.

Standard 1: Management Accountability

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

The program has a written policy and procedures requiring initial background screenings in compliance with the Department's Background Screening (BSU) and Clearinghouse. The program had one newly hired staff since the last annual compliance review. There were no new applicable contracted staff or volunteers requiring a background screening. A review of documentation supported the newly hired staff received a background screening completed by the Department's BSU and Clearinghouse, before the staff's date of hire. There were no applicable staff who required an exemption prior to working with youth. There was documentation in the reviewed staff record indicating the hiring specialist reviewed the Department's Central Communications Center (CCC) system, Staff Verification System (SVS), and the Florida Department of Law Enforcement's Automatic Training Management System (ATMS) as part of the pre-employment background screening process. The program requires all direct-care staff to complete the Berker Assessment, which is a pre-employment assessment. The assessments are scored as low, medium, or a high fit for the role, and a job fit percentage is provided. Staff scoring at a medium or high may be provided a job offer. The program hired no new direct-care staff since the last annual review in May 2020. The program submitted the Annual Affidavit of Compliance with Level 2 Screening Standards, along with the school board annual screening, to the Department's BSU on December 04, 2019, meeting the annual requirement.

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

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

staff. The program had no staff, contracted staff, or volunteers applicable for a five-year background re-screening since the last annual review in May 2020.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program maintains a written policy and procedures to establish an environment in which youth, staff, and others feel safe, secure, and without the threat of any form of abuse or harassment. Upon hire, each staff electronically signs the employee code of conduct and handbook, which is maintained in the agency's electronic system. A review of three staff records showed each staff signed a code of conduct. Youth are provided with a handbook during the admission process. The handbook includes the youth's rights, the Department's Central Communications Center (CCC), and Florida Abuse Hotline telephone numbers. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of CCC and Florida Abuse Hotline postings was conducted through photographs, and validated the postings were located in the youth living areas, and throughout the program.

The program had one abuse allegation reported to the CCC and/or the Florida Abuse Hotline since the last annual compliance review in May 2020. The allegation was reported by a youth. The allegation was investigated and found to be unsubstantiated. The program's Trauma Responsive and Caring Environment (TRACE) assessment was completed on April 7, 2020. Three interviewed youth stated they feel safe while in the program, and have never been stopped from reporting abuse to the Florida Abuse Hotline. All three youth stated staff are respectful when talking with youth and to other youth, and have never heard staff use profanity when speaking to them or other youth. Three youth stated they have not exchanged emails, telephone numbers, or social media contact information with staff. Three interviewed staff explained the process for allowing staff and youth to call the Florida Abuse Hotline or CCC. Three staff stated they have not observed a co-worker telling a youth they could not call the

Florida Abuse Hotline, or heard a co-worker using profanity when speaking with youth. An interview with the facility administrator (FA) stated the employee code of conduct states staff are expected to interact with youth in a manner promoting emotional and physical safety. If staff use profanity towards youth, the staff will be reported to the Department and necessary disciplinary actions will follow to include immediate removal from youth contact. The FA stated there are postings of the Florida Abuse Hotline telephone number for youth under the age of eighteen and CCC of youth over the age of eighteen throughout the program. All allegations of abuse and suspected child abuse must be reported immediately to the Florida Abuse Hotline. The FA stated youth are made aware of contacting the Florida Abuse Hotline and/or CCC through facility postings, daily meetings and Abuse Hotline phone placed in both housing units. Staff are made aware of their responsibility to ensure all youth requesting a call are allowed to make the call, staff are to complete an incident report and document it in the facility logbook. This information is communicated in staff briefings and "All Staff" meetings. Abuse calls are tracked on incident reports and facility logbook entries. Florida Abuse Hotline and CCC incidents are incorporated into the management meetings and follow-up actions, if needed, are discussed.

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

The program maintains a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff from youth contact, when necessary. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. A review of all incidents since the last annual compliance review found one incident which involved a complaint against staff for physical abuse. Reviewed documentation found management took appropriate and immediate action by initiating an internal investigation regarding staff on the allegation of abuse. Documentation confirmed the staff was not required to be removed from youth contact. The reviewed report was found to be unsubstantiated for abuse. An interview with the facility administrator stated all staff shall immediately report any knowledge or suspicion regarding an incident of abuse or sexual harassment which may have occurred in the program. Staff are required to report any retaliation against youth or other staff who reported an incident, and any staff neglect or violation of responsibilities which may have contributed to an incident or retaliation.

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

The program maintains a policy and procedures regarding the reporting of incidents to the Department's Central Communications Center (CCC). The program is required to notify the CCC within two hours of a reportable incident or within two hours of notification of the incident. The program had twenty-five CCC reports since the last annual compliance review. Twenty-one of twenty-five calls were related to the COVID-19 pandemic. Four CCC reports were reviewed, and all four incidents were reported within the required two-hour time frame. Each incident was

documented in the program's master control logbook. A review of the program's internal incident reports found there were no additional incidents which were required to be reported to the CCC. The program had an increase of six reportable incidents to the CCC compared to the last annual compliance review in May 2020. The program stated the increase is due to the increase of incidents related to the COVID-19 pandemic. The facility administrator (FA) stated there are postings of the Florida Abuse Hotline telephone number for youth under the age of eighteen and CCC for youth over the age of eighteen throughout the program. All allegations of abuse and suspected child abuse must be reported immediately to the Florida Abuse Hotline. The FA stated youth are made aware of contacting the Florida Abuse Hotline and/or CCC through facility postings, daily meetings, and an abuse hotline phone placed in both housing units. Staff are made aware of their responsibility to ensure all youth requesting a call are allowed to make the call, staff are to complete an incident report and document it in the facility logbook. This information is communicated in staff briefings and all staff meetings. Abuse calls are tracked on incident reports and facility logbook entries. Abuse calls and/or CCC incidents are incorporated into the management meeting, where any follow-up action items are discussed.

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

The program maintains a written policy and procedures regarding Protective Action Response (PAR) physical intervention techniques, in accordance with Florida Administrative Code. A PAR report shall be completed any time a PAR incident occurs. All PAR reports should include statements from every staff member involved and be completed by the end of the staff member's workday. A PAR certified instructor or a supervisory staff should review the report along with the review from the program's facility administrator (FA) or designee within seventy-two hours of the incident. The program had a one PAR since the last annual review in May 2020, which was lower than the last annual compliance review. There were no reported instances of excessive force since the last annual compliance review. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which are submitted to the Department monthly.

A review of the PAR report was conducted. The report was completed by the end of the staff member's workday, with each staff involved completing a statement. The report contained documentation of a review by a PAR certified instructor, which was completed within seventy-two hours by all required parties. A post-PAR interview was conducted with the youth by the administrator within thirty minutes of the incident. There were no reports which required calls to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth requested or made a report to the Florida Abuse Hotline. The program's PAR rate during the annual compliance review period was 0.14, which is below the statewide Residential PAR rate of 2.28. An interview with the FA stated PAR reports are completed and filed in a binder by the month. An incident report is written in reference to the PAR report and logged in the program's logbook. An interview with three staff stated they have used PAR, but there was no response as to the program's process and procedures.

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

The program has a written policy and procedures regarding pre-service training. The program maintains a pre-service training plan for all newly hired staff which was approved and signed by the Department's Office of Staff Development and Training on February 17, 2020. A review of the program's pre-service orientation training plan shows staff are required to be certified within 180-days of hire. Staff are required to be certified in cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED), and complete trainings in Protective Action Response (PAR), suicide prevention, professionalism and ethics, emergency procedures, and child abuse reporting. All trainings are required to be documented in the Department's Learning Management System (SkillPro) reflecting completion of training hours, and all training must be delivered by qualified trainers. The program had no new direct-care staff since the last annual review in May 2020.

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

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

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

The program maintains a policy and procedures regarding the youth grievance process. The program maintains a written pre-service training plan, which indicates all staff will be trained in the program's grievance process. The program had no applicable staff who required pre-service

training during the annual compliance review period. A review of the program's pre-service training orientation training plan shows grievance training will be completed in the first week of training. The program's grievance process consists of informal, formal, and appeal phases. The program also uses "Chatty Cathy" forms before completing a formal grievance, which allows youth an opportunity to voice an objection and informally resolve a complaint. All informal grievances must be responded to within forty-eight hours. The program maintains a binder of "Chatty Cathy" and grievance forms for at least twelve months. The program had five "Chatty Cathy" forms and no formal grievances since the last annual review in May 2020.

An interview with the facility administrator (FA) stated there is an informal phase where youth complete a "Chatty Cathy" and address the complaint with the staff to attempt to resolve the complaint or concern within seventy-two hours. The formal phase where the youth complete a grievance form addressing complaints. Each grievance form is assigned a number and a written response is provided to the youth by the supervisor. If the youth disagrees with the outcome, then the youth can appeal the grievance, send it to the next level, and it will be forwarded to the FA. Each of the three interviewed youth explained the process on how to submit a grievance. All three youth stated they are able to ask for assistance when completing the grievance form. Three interviewed staff explained the program's grievance process.

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

The program has a written policy and procedures regarding interventions and facilitator training. The program's contract outlines Thinking for a Change (T4C) as the program's required evidence-based delinquency intervention, and Impact of Crime (IOC) as a required restorative justice curriculum. The program has two staff trained to facilitate bothT4C and IOC, and one staff trained to facilitate IOC. The first facilitator, trained for both T4C and IOC, holds a bachelor's-level degree, and the second holds a high school diploma. The facilitator trained only in IOC holds an associate's-level degree. All three staff have over ten years of experience working with youth and have completed all required facilitator trainings. The program prescribes delinquency interventions to each youth based on identified needs.

A review of the program's activity schedule and sign-in sheets since the last annual compliance review showed groups were provided, as scheduled. The program is currently conducting an IOC group which started on June 8, 2020 with three youth. A review of three youth records found each youth is participating in an IOC group. The last T4C group started on October 31, 2019 and ended May 6, 2020 with eight youth. A review of three youth records showed each youth had goals in their performance plan to address their individualized delinquency needs. An interview with the facility administrator (FA) revealed the program provides T4C and IOC interventions. Staff are trained to deliver the curriculum. The FA stated youth are matched to case managers and intervention groups through a classification meeting which is conducted to identify the youth's physical and emotional safety needs through dormitory and room assignments, and case manager, therapist, and group assignments which will best meet the youth's needs. This meeting includes participation of the designated mental health clinician authority, assistant facility administrator, medical staff, living unit designee, case manager, youth, parent/guardian, and assigned juvenile probation officer. Three interviewed youth

reported participation in groups, and they practiced new skills learned in group through role play.

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

The program has a written policy and procedures to address life skills training for youth. The program provides life skills training utilizing Skillstreaming the Adolescent, Living in Balance, Teen Relationship Workbook, Pathways to Self-Discovery and Change, and Anxiety Workbook for Teens curricula. The social skill intervention groups specifically address communication, interpersonal relationships and interactions, anger management, and critical thinking. The program has a policy and procedures which determines how services are provided and how youth are placed in groups. A review of the activity schedule confirmed life skills training groups are provided to youth daily. A review of group sign-in sheets during the annual compliance review period verified youth are receiving life skills training as scheduled. The program had their last annual compliance review in May of 2020.

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

The program has a policy and procedures for the provision of restorative justice awareness to the youth. The program's contract indicated Impact of Crime (IOC) is a required service provided to all youth in the program. A review of the program's training records confirmed three staff were trained to facilitate IOC groups. A review of the program's activity schedule and group sign-in sheets determined IOC groups were conducted, as required. The program is currently conducting an IOC group which started on June 8, 2020 with three youth. A review of three youth records found each youth is participating in an IOC group.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19 pandemic, this review was conducted off-site; therefore, observations of a restorative justice awareness group was not possible. An interview with the facility administrator revealed youth receive IOC as the restorative justice group, and the primary goal of the curriculum is to assist youth offenders in accepting responsibility for the harm they have caused by their criminal actions and reducing the risk of future criminal activity. The IOC groups help to educate offenders on the impact of crime on victims, their families, and their communities, increasing offenders' awareness, empathy, accountability for their actions, and to provide a safe and healthy forum for crime victims to share their experiences with offenders in a manner which is restorative. The groups provide direction for offenders in developing methods to restore their victims, families, and communities both inside and outside the residential commitment program.

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

The program's contract requires Savvy Sisters and Voices-A Program of Self-Discovery and Empowerment for Girls as the gender-specific curricula to be provided. The Savvy Sisters curriculum focuses on areas youth may need assistance on discovering in their lives. The Voices curriculum advocates a strength-based approach using a variety of gender responses and therapeutic approaches. A review of the program's activity schedule and sign-in sheets since the last compliance review confirmed gender-specific programing was provided to the youth, as required. An interview with the facility administrator confirmed all youth in the program receive the same gender-specific care. The program ensures youth who are identified as a targeted gender group receive the same culture of care as any other youth. The program provides youth with alternative undergarment and haircut options. Three interviewed youth stated they participate in groups, and they practiced new skills learned in group through role play.

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

The program has a written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. The program's alert board, which is located in the shift supervisor's office, identifies youth who are identified with an escape risk, special alerts, and/or gang affiliation alerts. The alert board identifies youth placed on any type of mental health alert or sports/activity restriction. Documentation showed the program reviews the internal alerts during the shift briefings.

A review of three youth records for medical, mental health, and case management alerts showed alerts were entered into JJIS. When comparing JJIS alerts to the program's internal alert list, there were no discrepancies. Alerts in JJIS matched the program's internal alerts. All reviewed internal and JJIS alerts were downgraded or discontinued by a licensed medical staff, the director of case management, and/or the licensed mental health staff. An interview with three staff stated they are notified of youth alerts by the alert board in the shift manager office, and during shift briefings. An interview with the facility administrator determined medical staff present information at "all staff" meetings when information needs to be reviewed or new information needs to be covered. Any direct-care, supervisory, or clinical staff may place a youth on an alert status if the youth meets the criteria. All alerts are reviewed during the daily morning

management meeting for any changes. The medical department maintains the daily tracker and alerts are added in the JJIS system when needed by each department.

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

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

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

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

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

The program has a community advisory board, which serves all Department's residential programs located in Okeechobee County. The advisory boards were combined due to a limited amount of people living in this rural community and the number of boards and local representatives whom participate. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the facility administrator (FA) mailing a letter, thirty days in advance of the scheduled meeting to increase attendance. Reviewed documentation from the last annual

compliance review supported the program's community advisory board meetings were held at least quarterly. The meeting minutes are shown to be documented with an agenda and sign-in sheets.

The program scheduled a quarterly meeting for June 2020; however, due to the COVID-19 pandemic and the Department canceling all visitation to residential programs, the FA stated the advisory board meeting was canceled. The program was unable to show any attempts at conducting the meeting utilizing alternative virtual platforms such as Zoom, Teams, or conference calling. The program maintains a list of thirty-eight community advisory board members consisting of representatives from local law enforcement officials, school board officials, the judiciary community, community partners, faith-based organizations, a mentoring agency, victim advocacy representatives, business community, and parents/guardians of former residents. Reviewed documentation for the program's last meeting in March 2020, supported the attendance of the advisory board members. An interview with the FA confirmed the community advisory board meetings are held quarterly, the time varies, and members are from local business/groups. The FA reported invitations are sent by mail and email, and a telephone call for a reminder maybe conducted. The advisory board provides and receives feedback regarding how to improve services provided to the youth, along with systems successful with other programs.

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

The program maintains a written policy and procedures identifying service, employment recognition, and tuition reimbursement. The program conducts daily morning management meetings Monday through Friday, daily shift briefings, and monthly All Staff meetings to discuss issues affecting the program's operation and to keep staff informed of important corporate information, and weekly meetings with the regional compliance manager. The program's daily morning management meetings follow a pre-set agenda and includes discussions regarding Protective Action Response (PAR) incidents, calls to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), grievances, youth behaviors, admissions and discharges, and any upcoming events. The program administration conducts comprehensive quarterly youth and staff surveys. The results of the surveys are discussed in detail at the corporate office and the results are reviewed and shared with staff during All Staff monthly meetings. The program has incentives for staff which include tuition reimbursement, staff appreciation, and staff celebrations.

Three staff were interviewed regarding program planning. All three staff stated meetings are held monthly. Each of the staff stated meeting topics range from new information from Department , upcoming training, mental health, safety and security, and attendance. All of the staff stated they are briefed on annual reports and youth and parent/guardian surveys. Two of the three staff stated the communication in the program is good and one of the three stated it is fair. All three staff stated they are able to provide feedback and input into program operations. An interview with the facility administrator (FA) revealed the morale at the program has a lot to do with the program's changes in leadership. The changes were made due to the closing of other programs within the company. Once this was explained to staff, staff understood and embraced the changes in a positive way. Staff are given awards on a monthly basis which include employee of the month, caught doing good, most improved staff, helping hand, above and beyond, and unsung heroes. The FA stated the program utilizes staff and youth surveys, outcome measurements of incident reports, grievances, CCC reports and the use of the positive

performance system to develop an understanding in the culture of the program to ensure treatment services are provided. The FA stated the Department's Comprehensive Accountability Report (CAR) report is shared with staff during all-staff meetings. Additionally, management meetings are held during the weekdays, and briefings and debriefings are conducted on each shift daily to discuss all important information needing to be communicated timely.

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

The program has a written policy and procedures ensuring the evaluation of staff performance. The program conducts ninety-day performance evaluations for newly hired staff and annual evaluations for all staff completed during the fourth quarter (October to December) each year. A review of three staff performance evaluations showed each evaluation was completed timely. All three staff performance evaluations were reviewed by the program's facility administrator (FA). The evaluations rated the staff's quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff's job-specific responsibilities. Three interviewed staff reported receiving a formal evaluation yearly. An interview with the FA determined each staff of the program shall be evaluated once annually, as well as the completion of a ninety-day evaluation, after the introductory period. The FA reported the program strives to complete annual evaluations by the fourth quarter of each year.

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

The program has a written policy and procedures regarding recreation and leisure activities. A review of the program's contract indicated the contract requires a recreational therapist (RT) with a bachelor's-level degree in recreational therapy or a related field with at least one-year experience working with youth. A review of the RT's record confirmed the RT has met the required educational and work experience requirements for the contract. The RT maintains a master's-level degree in athletics administration. The program's contract indicated the RT is also required to have one-year related experience working with youth. The reviewed résumé indicated the RT had five years of experience working with youth. Documentation showed the program maintains a monthly calendar of indoor and outdoor recreation activities which consist of football, basketball, card games, and board games. Youth are provided at least one hour of activity daily. Documentation indicated activities were planned to support social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. When the heat index is above the approved temperature, or when there is inclement weather, the youth are provided one hour of recreation time inside the program.

A review of the program's logbooks found the program consistently documents recreation time. A review of three youth records documented recreational therapy activities are provided and are incorporated into goals on each youth's individualized treatment plan. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of youth recreational activities was not possible. Three interviewed youth stated they are allowed to the opportunity to exercise, play outside, or down time to read a book. Two of the three interviewed youth stated they receive at least one hour of physical and leisure activities each day. The one remaining youth stated they do not receive at least one hour of activities, because

some shifts do not want to go outside; therefore, the youth do not have recreation every day. A review of documentation confirmed youth did receive at least one hour of recreation each day. Three staff were interviewed, and each staff stated youth receive one hour of recreation and leisure activities daily, which consist of volleyball, kickball, basketball, and board games.

Standard 2: Assessment and Performance Plan

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

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

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

The program has a policy and procedures addressing youth orientation. A review of three case management records supported each youth was provided an orientation within twenty-four hours of admission. Each reviewed record documented a signed checklist and signed receipt of youth handbook acknowledging the youth received an orientation packet and information regarding the program's daily schedule, expectations and youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, behavioral management system, zero-tolerance policy regarding sexual misconduct, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers, contraband, dress code, hygiene procedures, community access, visitation, mail, the use of the telephone, grievance procedures, emergency procedures, and assigned living units. Three interviewed youth reported orientation included program rules, procedures, schedules, and all other pertinent information. Each interviewed youth confirmed the orientation was conducted on the day they were admitted to the program.

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Three case management records and three youth

closed records were reviewed, none were applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian as none of the youth were eighteen years of age or older. The program did not have any additional youth applicable since the last annual compliance review dated May 15, 2020.

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

The program has a policy and procedures addressing the classification process. The policy outlines the effective delivery of treatment services based on determination of each youth's individual needs and risk factors. The program's policy addresses when reassessments are warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and behavioral concerns. A review of three case management records found each youth had an admission classification completed for the purposes of assigning youth to a living/sleeping area and staff advisor. Each reviewed admission classification form was completed on the date of admission for each youth. A classification meeting is conducted which includes the designated mental health authority, assistant facility administrator, medical, living unit designee, case manager, youth, parent/guardian, and juvenile probation officer. Case management assigns group assignments which will best meet the youth's needs. Three admission classification forms were reviewed, and none were applicable for having an alert entered into the Department's Juvenile Justice Information System (JJIS) at time of admission. The program has an internal alert system. During an interview, the program's staff reported all program alerts are maintained and updated, as needed, on an alert board which is accessible to all staff. Staff revealed alerts are discussed during the daily debriefings.

The program's policy and procedures addressing reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other actives which involve the use of tools, and a youth's participation in any off-campus activities. Each reviewed record documented the completion of a reassessment which included a review of the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. Documentation confirmed reassessment results were discussed during treatment team meetings. It is the program's practice to complete a reassessment each month for each youth and documentation supported this was completed in each of the three youth case management records reviewed.

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

The program has a policy and procedures addressing gang identification which includes notification to law enforcement. The program assesses each youth at admission for suspected gang involvement. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS) and an e-mail is sent to the local law enforcement gang liaison who notifies the youth's home county, if applicable. Three active case management records and three closed records were reviewed, and none were applicable for gang involvement or association. Since the last annual compliance review dated May 15, 2020, the program did not have any additional youth applicable.

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

The program has a policy and procedures addressing gang prevention and intervention activities. Three youth case management records were reviewed for participation in gang prevention and intervention activities; however, none were applicable. The program did not have any additional youth applicable. Documentation provided validated the program utilizes Gang Resistance and Drug Education (GRADE) curriculum, when applicable. The GRADE curriculum includes eight lessons and gang agreement for after discharge.

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

The program maintains a written policy and procedures to address assessments. A review of three case management records found each contained a Residential Assessment for Youth (RAY) completed within thirty days of the youth's admission to the program. Each RAY was completed in the Department's Juvenile Justice Information System (JJIS) and was used to identify criminogenic risk and protective factors and prioritized the youth's criminogenic needs. A copy of the RAY overview report was maintained in each youth's case management record. Three reviewed case management records found each was applicable for a Ray Reassessment. Documentation supported all three RAY Reassessments were completed within ninety-days of the initial RAY. Each RAY Reassessment was maintained in the youth's case management record. There were other updates or reassessments deemed necessary by the intervention and treatment team.

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

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

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

The program has a policy and procedures addressing performance plan development. The treatment team, including the youth, meet and develop the individualized performance plan (IPP), based on the findings of the initial assessment of each youth within thirty days of the youth's admission. Three youth case management records were reviewed, and each documented the IPP was developed within thirty days of the youth's admission. The treatment team members who participated in the development of the IPP for each youth included a case management representative, the youth, an administration representative, living unit representative, mental health treatment staff, and education staff. Treatment team members participation was verified by each member's signature and date on the IPP. The reviewed performance plan for each youth was developed after the initial assessment. Three interviewed youth confirmed each participated in the development and received a copy of their IPPs. The IPP is a document developed by the treatment team, including the youth, which stipulates goals the youth must achieve prior to release from the program. The goals are measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include delinquency interventions, targeted court-ordered sanctions, and identifies transition activities.

Three youth IPPs were reviewed and each included individualized goals based on prioritization needs. All goals included specific interventions which were measurable, included youth and staff responsibilities to complete the goals, and included projected target dates for completion. All three reviewed records indicated each youth was enrolled in education and career programing. Each of the IPPs addressed the youth's top three criminogenic needs. All three IPPs documented transition activities, as required. All three interviewed youth determined each youth

was familiar with their IPP goals and were able to explain the treatment process. Each interviewed youth confirmed they received a copy of the initial IPP. The IPPs are signed by each youth and treatment team leader, as well as all parties with significant responsibility in goal completion within ten working days of completion of the IPP, the program sends a transmittal letter, and a copy of the IPP to the committing court, each youth's juvenile probation officer (JPO), and each parent/guardian. Each youth record indicated a transmittal letter and a copy of the performance plan was sent within ten working days to the committing judge, JPO, parent/guardian, and Department of Children and Families (DCF) worker, when applicable. All three IPPs were signed by the youth, treatment team leader, and all significate parties responsible for the goal completion. The program mailed all three IPPs to the parents/guardians or DCF worker to sign and return to the program. Reviewed documentation indicated each of the signature pages were returned to the program. Three interviewed youth confirmed each received a copy of their IPP.

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 three youth case management records documented each performance plan had revisions either based on the Residential Assessment for Youth (RAY) Reassessment 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. Three closed youth records were reviewed. Each youth record 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 has a policy and procedures addressing performance plan summaries and transmittals. Three case management records were reviewed, and each was applicable for requiring a performance summary. Documentation validated each performance summary was completed every ninety-days following the signing of the initial performance plan. All performance summaries included the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peer and staff, the status of each goal, and significant positive or negative events. Each reviewed performance summary

was signed by each youth and included comments, and each original performance summary was filed in the youth's case management record. Each of the three reviewed youth records contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and the parent/guardian or Department of Children and Families worker, when applicable. Three closed youth case management records were reviewed for completion of a release summary. Documentation supported a release summary was completed and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least ninety-days prior to each youth's planned release, and a signed copy was maintained in each youth's record.

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

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

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site and one day on-site; therefore, observation of the center's treatment team meeting was not possible. Furthermore, there were no treatment team meetings conducted during the annual compliance review week. Parents/guardians are invited to participate in the youth's formal treatment team meetings by telephone. Documentation in the three reviewed records indicated the program reached out to parents/guardians to facilitate involvement by mailing an admission letter within forty-eight hours of admission which includes the dates of upcoming treatment team meetings. Three interviewed youth each confirmed their parents/guardians are involved in case management services.

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

The program has a policy and procedures addressing treatment team and its members. At a minimum, treatment team includes the youth, representative from program administration, a living unit representative, education, and others responsible for providing or overseeing the provision of intervention and treatment services. Three youth case management records were reviewed, and each contained an initial individual performance plan signed by all required members of treatment team inclusive of each youth's case manager, a representative from administration, a living unit representative, educational staff, mental health staff, the assigned juvenile probation officer (JPO), and the youth's parent/guardian or Department of Children and Families. All required staff provided information to the treatment team meetings verbally when required, as well as written input when not in attendance. Reviewed documentation confirmed

the youth's JPO, parent/guardian, and any other pertinent parties were invited and were encouraged to participate through advance notification to participate in treatment team meetings and if participation cannot be arranged, the opportunity to provide input verbal/written will be arranged.

2.14 Incorporation of Other Plans Into Performance Plans	Satisfactory Compliance
The youth's performance plan shall reference or incorporate the youth's treatment or care plan.	

The program maintains a policy and procedures indicating when a youth has been identified with a mental health, substance abuse, or physical health need, the care treatment plan shall be coordinated into the youth's performance plan. When a youth has a current behavior support plan or case plan through the Department of Children and Families (DCF) and/or the Agency for Persons with Disabilities (APD), the program coordinates the youth's performance plan with the youth's DCF/APD care plan for related issues. Three youth case management records were reviewed. Each had separate academic and mental health treatment plans which were incorporated into the performance plan for all three youth. One youth, under the supervision of DCF, had a separate DCF plan which was incorporated into the youth's performance plan. There were no youth with an APD plan.

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

The program maintains a written policy and procedures pertaining to formal and informal treatment team meetings. Each youth participates in a formal treatment team meeting at least every thirty-days. A review of three youth case management records documented each was applicable for receiving a treatment team meeting. A review of each youth's formal performance plan included the youth's name, date of review, any comments from treatment team members, a brief synopsis of the youth's progress, performance plan revisions, and progress on performance plan goals. The formal review also included positive and negative behaviors, and behaviors resulting in physical interventions. Each youth is provided an opportunity to demonstrate skills acquired in the program, their treatment progress, and a review of the Residential Assessment for Youth (RAY) Reassessment results. A review of each youth's informal performance reviews determined meetings were held biweekly and included the youth's name, date of review, any comments from treatment team members, a brief synopsis of the youth's progress in the program, performance plan revisions, progress on performance plan goals, positive and negative behaviors, and behaviors resulting in physical interventions. Each youth is provided an opportunity to demonstrate skills acquired in the program and treatment progress, and reviewed the RAY Reassessment results.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site and one day on-site; therefore, observations of a treatment team meeting was not possible. A review of the Department's Juvenile Justice Information System (JJIS) reflected the youth's anticipated release date, ninety-day updates, and the sixty-day transition conference. Three interviewed youth were provided the opportunity during treatment team meetings to demonstrate any skills learned in the

program. Each interviewed youth confirmed the staff review performance plans to include progress on the youth's performance plan goal, positive and negative behavior, and treatment progress.

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

The program maintains a written policy and procedures relating to career education. The program provides Type 2 educational programming. The Type 2 programming includes the instruction of personal accountability skills including interpersonal communication skills, decision making skills, financial skills, and literacy skills. The skills are designed to be both age and intellect appropriate for employment seeking. The program's vocational programming provides an orientation to the various occupations directly related to the individual abilities, aptitudes and skill levels of the youth. Course work offerings include career investigation, résumé writing, the completion of employment applications, and participating in mock interview exercises. The program completes a career education services assessment for all youth.

The program's career education curriculums include O-Net Interest Profile, Virtual Job Shadow, and My Florida Shines. The program offers certifications in tourism and hospitality, as well as building construction technology through the on-site Home Builders Institute (HBI). The program ensures all youth admitted to the program have access to HBI programing, if eligible and interested. The program maintains a contract for educational services to include vocational services with the Okeechobee County School District. Reviewed transition plans and exit portfolios supported the program provided application, interview, and job placement assistance. Three youth's exit portfolios were reviewed and showed assessments, community service, certifications, résumés, and employment applications were professionally printed and provided to youth to keep upon release. A review of three closed youth records validated each youth had the completed employment application and résumé, and all three youth had an appointment with a Career Source Center. All three youth records documented the youth's parent/guardian and assigned juvenile probation officer (JPO) were aware of the established vocational plan. An interview with the facility administrator (FA) reported youth are able to earn certifications and complete their high school diploma prior to returning to the community while at the program.

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

The program operates an educational program in partnership with the Okeechobee County School District on a year-round basis. The youth are required to participate in educational and vocational career-related instruction for a minimum of 250 days distributed over twelve months, with a minimum of twenty-five hours of weekly instruction. Also, within this schedule are ten days set aside for teacher planning and professional development. The program provides Type 2 educational programming. Three interviewed youth indicated there are no interruptions during the educational instruction. A review of program logbooks since the last annual compliance review dated May 15, 2020, and an interview with the program's lead educator verified educational programing is provided with minimal interference.

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

The program maintains a written policy and procedures outlining transition, release, and discharge. A review of three active youth case management records showed one record was applicable for a youth in transition. A review of three closed and one active youth records confirmed each record contained a detailed transition plan. Each plan was developed based upon the youth's post-release goals beginning at the youth's admission to the program, as required. Each reviewed plan documented the key participants related to the youth's transition plan including the youth, the parent/guardian, the educational representative, post-release staff, certified school counselor/program counselor responsible for providing guidance services, and a registrar or designee for the youth's assigned school district. Each reviewed transition plan documented development by the youth, education staff, counselors, and after-care staff members, outlining a specific plan for continuation of education and/or employment following the youth's release from the residential program.

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 maintains a written policy and procedures regarding transition planning, conferences, and Community Re-Entry Team (CRT) meetings. Three closed case management records were reviewed for a transition planning conference and a CRT meeting. Reviewed documentation found each transition conference was conducted at least sixty days prior to the youth's release date. All pertinent parties were invited to attend the transition conference through advanced notice and encouraged to provide written input, if unable to attend. Reviewed documentation in all three transition conferences supported the youth, case manager (who also acted as the treatment team leader), the facility administrator or designee, educational staff, mental health staff, and medical staff participated in person, and the parent/guardian and the assigned juvenile probation officer (JPO) participated by telephone. Each transition conference included a discussion of all transition activities including persons responsible for completing the activities and targeted completion dates. The three reviewed closed records contained documentation indicating the CRT meetings were conducted. There was documentation in all three closed records to support the program received an invitation to the CRT meetings.

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 assembles an exit portfolio for each youth to assist the youth upon release back into the community. A review of three closed case management records found the exit portfolios were discussed and signed by each youth during the transition conference. Each youth's exit portfolio included a copy of the transition plan, calendar with dates/times/locations of follow-up appointments in the community, social security card or certification of social security number, birth certificate, vocational certificates, school transcripts, résumé, and a sample job application. Two of three closed records contained a State of Florida identification card. The program was unable to obtain a State of Florida identification card for one youth due to the COVID-19 pandemic. Reviewed documentation confirmed educational staff forwarded information to the receiving school board and program staff sent a copy to the juvenile probation officer (JPO). Documentation indicated each youth was given a copy of the exit portfolio upon release. Youth were provided with completed forms and clear instructions on how to obtain relevant information. All responsible staff were identified during the transition conference to assist the youth in obtaining the required information to successfully complete goals.

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 re-entry into their home community. Three closed case management records were reviewed for completion of the exit conference. Reviewed documentation found each exit conference was conducted within the required timeframe, were held separate from the Community Re-Entry Team meeting, and documented all the participants signed and dated the conference form. The program staff noted telephone participants on the signature line, when applicable. The date of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS) for each of the reviewed records. The case manager, parent/guardian, education staff, assigned juvenile probation officer (JPO), youth, and other pertinent parties participated in the exit conference in person or by telephone. The status of transition activities was discussed in each of the three conferences.

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

The program has a policy and procedures addressing safety planning process for each youth. The program maintains a safety plan for each youth which is in a centralized location for all staff. Three interviewed staff confirmed all youth safety plans are located in the point book for staff access. A review of three youth case management records documented all safety plans

were completed within fourteen days upon youth's admission. Documentation in the three reviewed records indicated all safety plans were jointly prepared by the youth, parent/guardians, and program clinical staff. All three case management records documented the safety plans were updated every thirty days or following significant behaviors. Three interviewed youth each confirmed involvement in the development of their safety plan.

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's contract outlines the position requirements of the designated mental health clinician authority (DMHCA) to be accountable for ensuring appropriate coordination, implementation and oversight of mental health and substance abuse services in the program. The DMHCA is required to be on-site forty hours each week, on-call twenty-four hours each day, and responsible for providing weekly face-to-face clinical supervision to the program's seven master's-level non-licensed therapists. The DMHCA is a licensed mental health counselor (LMHC). A review of the DMHCA's license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021. A review of the program's schedule reflected the DMHCA is scheduled on-site Monday through Friday from 9:00 a.m. to 5:00 p.m. and on-call twenty fur hours each day. An interview with the DMHCA confirmed the responsibility for clinical department oversight to ensure services are provided. A review of the job description also verified the roles and responsibilities.

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

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

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

The program has three master's-level non-licensed therapists. A review of caseload assignments reflected each non-licensed therapist was below sixteen, as contractually required. The program's therapists offer mental health and substance abuse treatment. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida

Statute, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2021. The program's designated mental health clinician authority is responsible for providing clinical supervision to the non-licensed clinical staff. The reviewed documentation found the clinical supervision logs included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. Reviewed direct supervision logs included all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form.

A review of the training records for the non-licensed clinical staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation 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 was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. Clinical supervision was applicable for all three non-licensed therapists. Reviewed clinical supervision since the last annual compliance review showed each therapist received weekly clinical supervision for all weeks where services were provided, with one exception. One therapist did not receive clinical supervision for the week of Jul 22, 2020. The program explained the staff member did not come to work on the day supervision was scheduled. The supervision was rescheduled; however, a makeup supervision session was unsuccessful.

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 written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the pre-screen process by which a youth's individualized history is reviewed and an admission screening is completed. A review of three mental health and substance abuse records showed the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening on the day of admission. A review of three mental health records showed each documented a review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems on the program's Document Review Form. Each of the three mental health and substance abuse records reflected each MAYSI-2 screening was completed on the day of admission by the program's designated mental health clinician authority (DMHCA).

A review of training records indicated the DMHCA completed the required MAYSI-2 training. Two of the three reviewed MAYSI-2s reflected the screenings were completed in the Department's Juvenile Justice Information System (JJIS), as required. One reviewed MAYSI-2 was completed on paper March 3, 2020 and not entered in JJIS until April 30, 2020. There were no instances where a staff member believed the youth needed further evaluation contrary to the MAYSI-2 results or where a need for a crisis intervention or emergency services. One reviewed record indicated the need for further assessment based on screening results and the need for further assessment was clearly checked on the MAYSI-2 form. The program's practice is to

refer all newly admitted youth for a biopsychosocial comprehensive evaluation and an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results; therefore, the program does not utilize a separate mental health referral form. An interview with the program's facility administrator (FA) reported the program adheres to a standardized screening process which includes reviewing the commitment packet and the administration of the MAYSI-2 by the licensed mental health professional.

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 plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the process by which all youth are referred for the completion of a Comprehensive Mental Health and Substance Abuse Evaluation. The program policy is to complete a new Comprehensive Mental Health and Substance Abuse Evaluation regardless of identified needs for each new admission. The master's-level non-licensed therapist is responsible for completion of the evaluation, recommendations, and to provide a provisional diagnosis. The program's licensed clinical staff is then responsible for reviewing each Comprehensive Mental Health and Substance Abuse Evaluation and indicating a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review.

A review of three mental health and substance abuse records reflected the program also completed the Reynolds Adolescent Depression Scale - Second Edition, Adolescent Psychopathology Scale™ Short Form, Trauma Symptom Checklist for Young Children™, Trauma Symptom Inventory™, Substance Abuse Subtle Screening Inventory, and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessments upon admission and throughout treatment, as indicated by the therapist. A review of three records showed each was applicable for a new Comprehensive Mental Health and Substance Abuse Evaluation. Each evaluation was completed within thirty days of admission, as required. Each of the reviewed records documented the non-licensed staff completed the evaluation, and each was signed by the licensed staff within ten calendar days, as required. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021. Each of the three reviewed records contained a signed consent obtained for substance abuse services and urinalysis dated the day of admission. Each of the three completed Comprehensive Mental Health and Substance Abuse Evaluations documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, recommendations, and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use. Two of the three completed evaluations documented accurate original referral reasons indicated on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) and one documented incorrect information. An interview with the program's designated mental health clinician authority (DMHCA) reported the information utilized for the completion of the Comprehensive Mental Health and Substance Abuse Evaluation includes initial screenings, the review of records provided by the Department, behavioral observations of the youth, and interviews with the youth, the youth's parent/guardian, and the assigned juvenile probation officer (JPO).

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 plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's plan for mental health and substance abuse services indicated all youth are prescribed treatment based on individualized identified needs, and at a minimum, all youth shall receive monthly individual therapy sessions, monthly family sessions, and daily clinical group services. The delivery of services at the program include supportive counseling, and substance abuse treatment and education groups to include prevention, intervention, and relapse prevention. Each newly admitted youth is assigned to a multidisciplinary intervention and treatment team within the admission intake and classification process.

A review of three youth mental health and substance abuse records documented each youth was assigned to a treatment team upon arrival to the program which was comprised of representatives from administration, education, medical, mental health, and substance abuse departments, in addition to the youth and parent/guardian. Each youth record contained an admission card and an Initial Mental Health and Substance Abuse Treatment Plan created the day of arrival. Each youth's mental health and substance abuse treatment is prescribed by an Individualized Mental Health and Substance Abuse Treatment Plan. The primary therapist develops the youth's treatment plan based on identified needs, and treatment is provided by qualified staff. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021. Each of the three reviewed records contained a signed consent obtained for substance abuse services and urinalysis dated the day of admission. The program's group facilitators and master's-level therapists facilitate mental health and substance abuse groups. Two of the three reviewed records contained an Authority for Evaluation and Treatment (AET) form. One youth record reflected the youth was under the care of DCF and a court order was observed. Each of the reviewed mental health and substance abuse treatment records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Weekly progress notes are maintained by an assigned counselor for each youth. Each reviewed weekly progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and the primary counselor's signature.

A review of prescribed services for three youth since the last annual review ending May 15, 2020 showed youth received services, as prescribed, by their corresponding treatment plans, except for one family session missing for one youth. Reviewed sign-in sheets reflected mental health groups had no more than ten youth and substance abuse groups had no more than fifteen youth as required. Three interviewed youth reported participating in group, family, and individual therapy at the program. Three interviewed staff reported the program's therapists facilitate all mental health and substance abuse groups. An interview with the program's

designated mental health clinician authority (DMHCA) reported all mental health staff are assigned groups. The therapists are responsible for providing groups and handing in completed sign-in sheets to DMHCA who then ensures services are documented on the program's billing tracker.

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 plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse treatment services and planning. A review of three youth mental health and substance abuse records showed each contained an Initial Mental Health/Substance Abuse Treatment Plan documenting development on the day of admission. Each Initial Treatment Plan was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021. Each of the three reviewed records contained a signed consent obtained for substance abuse services and urinalysis dated the day of admission. Each reviewed initial plan included signatures of the master's-level non-licensed therapist, all treatment team members, and the youth. Each plan was signed by a licensed clinician within ten days, as required. One of the three reviewed records was applicable for a youth prescribed psychotropic medication upon admission and documented the frequency of medication management and details regarding the prescribed medication. The remaining two records documented the need for an annual and initial psychiatric evaluation. The program practice is to refer all youth for an initial psychiatric evaluation, which was also documented on each of the three reviewed records.

A review of three youth records found each contained a completed Individualized Mental Health and Substance Abuse Treatment Plan which was developed within thirty days of the youth's admission. Each individualized plan was documented on the program's form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy. Each reviewed individualized plan was completed and signed by the clinical staff person creating the plan. One plan clearly documented signature of all treatment team members. The second plan was missing the signature of the living unit representative, and the third plan was missing signatures of the living unit representative and administration staff. Department Rule outlines treatment team members to include the youth, representatives from the program's administration and residential living unit, and others directly responsible for providing, or overseeing provision of, intervention and treatment services to the youth. Each reviewed individualized plan documented signature by the licensed staff within ten days of completion as required. The program's DMHCA reported the Comprehensive Mental Health and Substance

Abuse Evaluation is used as a guide in developing the youth's Individualized Mental Health and Substance Abuse Treatment Plan. Additionally, the assigned therapist meets with the youth and team prior to completing the plan.

A review of three youth records showed each was applicable for Individualized Treatment Plan Reviews to be completed every thirty days. The program documented reviews on the program's form containing all elements of the Department's Individualized Mental Health/ Substance Abuse Treatment Plan Review form. The three youth were applicable for a total of nine treatment team reviews. Each plan review included signatures of the master's-level non-licensed therapist, all treatment team members, and the youth. Two of the nine applicable plan reviews were not signed by a licensed clinician. The program explained the treatment team review occurred by telephone due to the COVID-19 pandemic and the designated mental health clinician authority (DMHCA) participated in the meeting; however, overlooked signing the hard copy after the call. An interview with the DMHCA reflected services are updated, as needed, during the monthly formal treatment team meetings. During the review meetings, a discussion regarding behavioral observations, applicable medication responses, progress in treatment, and psychiatrist findings are discussed. The DMHCA reported all youth goals and objectives on the treatment plan are reviewed during the formal monthly meeting and revisions are made to the treatment plan as indicated.

All reviewed Individualized Mental Health/Substance Abuse Treatment Plans and Individualized Mental Health/ Substance Abuse Treatment Plan Reviews documented the prescribed services. A review of prescribed services reflected two youth were prescribed bi-weekly individual therapy and one youth was prescribed monthly individual therapy. All youth were prescribed daily group services. Two youth were prescribed monthly family therapy and the third youth was under the care of DCF and was not prescribed family therapy. Two youth were prescribed monthly psychiatrist services and the third youth was not applicable for the prescription of psychotropic medications.

Three closed records were reviewed for the completion of a Mental Health and Substance Abuse Discharge Summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

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

The program provides mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). The program has seventeen MHOS slots for youth diagnosed with

mild to moderate mental health disorders, who may have a co-occurring substance abuse diagnosis. The program has fifteen SAOS slots for youth diagnosed with substance abuse related disorders. The program provides the youth with group therapy services seven days a week. The program's contract outlines six mental health treatment, three substance abuse treatment, and one substance abuse prevention groups to be provided to youth at the program. Mental health treatment groups include The Anger Workbook for Teens, Skillstreaming, The Teen Relationship, Anger Management for Substance Abuse and Mental Health, Anxiety Workbook for Teens, and the Passport Program: A Journey Through Emotional, Social, Cognitive, and Self-Development. Substance abuse treatment groups include Seeking Safety, Living in Balance, and Pathways to Self-Discovery and Change. The program's substance abuse prevention group is Towards No Drugs. The program identified both Savvy Sisters and Voices as the gender-specific group programming. A review of case notes, sign-in sheets, and group schedules for the past six months supported mental health groups were scheduled and provided, as required; however, the Passport Program ended on June 9, 2019, and The Anxiety Workbook for Teens ended on May 6, 2019. An interview with the facility administrator (FA) and the designated mental health clinician authority (DMHCA) reported the Passport program is scheduled to resume in August 2020. A review of case notes, sign-in sheets, and group schedules for the past six months supported substance abuse treatment groups were scheduled and provided, as required. The program's substance abuse prevention group, Towards No Drugs, ended in September 2018. An interview with the FA and the DMHCA explained there have not been enough youth without a substance use diagnosis enrolled at the program to effectively complete this group as designed.

All clinical groups are facilitated by the program's DMHCA and/or trained master's-level mental health staff. The program also provides each youth with monthly individualized and family therapy, as prescribed by each youth's Individualized Treatment Plan. The program's therapeutic services include psychosocial skills training, psycho-education, and supportive counseling tailored to each youth's identified needs. The psychiatrist is on-site bi-weekly and participates in a clinical meeting with the DMHCA and the non-licensed master's-level therapists to discuss each youth receiving services. The program maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services, as needed. According to the DMHCA, no youth were referred to the psychologist since the last annual compliance review ending May 15, 2020. A review of therapy caseload assignments reflected each non-licensed clinical staff was below sixteen, as contractually required. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment, with an expiration date of April 7, 2021. The program completes a monthly American Society of Addiction Medicine (ASAM) level one continued stay document for all youth with a substance abuse diagnosis. The program also carries an active outpatient and residential treatment accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). Interviews completed with the DMHCA and facility administrator confirmed the program's participation in the specialized MHOS and SAOS clinical services. Three interviewed youth reported participating in group, family and individual therapy at the program.

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

The program maintains a contract with a licensed psychiatrist who is board certified in psychiatry, as well as child and adolescent psychiatry, to provide services to the youth at the program. A review of the license showed the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program does not utilize an advanced practice registered nurse (APRN). A review of the program's contract revealed the psychiatrist is to be on-site bi-weekly for two hours, in addition to on-call availability for emergencies and consultation twenty-four hours a day, seven days a week. The program's practice is to complete a new psychiatric evaluation on all youth within fourteen days of admission. A review of three youth mental health and substance abuse records showed each youth received an initial diagnostic psychiatric interview within fourteen days of admission. One of the three reviewed records was applicable for a youth admitted on prescribed psychotropic medications and one youth was prescribed psychotropic medications subsequent to admission. An interview with the designated mental health clinician authority (DMHCA) and the facility administrator reported there were no additional youth applicable for the prescription of psychotropic medications at the program.

Each reviewed initial psychiatric interview documented the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) documented diagnosis, and treatment recommendations. All reviewed records documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN. The two records applicable for prescribed medications clearly documented the medication, dosage information, and the explanation of the need for psychotropic medication related to the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, as well as risks and benefits of taking the medication. Each record applicable for the prescription of psychotropic medications supported the youth was seen a minimum of every thirty days, as required. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. Reviewed documentation supported the psychiatrist participated in a bi-weekly treatment team meeting and was on-site at least two hours bi-weekly as contracted. The interviewed psychiatrist reported completing psychiatric evaluations on all youth admitted to the program, providing monthly medication management for all youth on psychotropic medications, reviewing charts for any prior psychological and psychiatric records as well as medical reports and laboratory results. The psychiatrist also reported working closely with the treatment team regarding the progress, treatment, potential medical issues, and side effects. The psychiatrist confirmed the program practice of contacting the parent/guardian whenever any psychotropic medication is being considered and to obtain appropriate consents.

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 policy and procedure and an attached suicide prevention plan. The policy and plan are reviewed annually. The policy was last signed by the facility administrator on July 2, 2020. The plan was last revised and approved by the psychiatrist and the designated mental health clinician authority on May 4, 2020. The plan outlines all required elements to include the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process.

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 policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program maintains an attached suicide prevention plan. The prevention plan outlines provisions for screening, staff observation, assessment, documentation, levels of supervision, and staff training. The program's practice is to complete the Department's Assessment of Suicide Risk (ASR) on the day of admission. A review of three youth mental health and substance abuse records validated each youth was screened for suicide risk utilizing the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) and the ASR, regardless of the MAYSI-2 results. Each ASR was completed by the licensed mental health counselor. All assessments documented a conference with the licensed mental health professional and the program director or designee. None of the three reviewed ASRs were identified with an elevated risk of suicide. An interview with the facility administrator (FA) and designated mental health clinician authority (DMHCA) confirmed the program had no referrals for the completion of an ASR since the last annual compliance review ending May 15, 2020.

There were six youth attending the program during the annual compliance review, and two youth were transferred during the review. One of the transferred youth was applicable for a history of precautionary observation (PO) placement; however, all previous ASRs were reviewed during the annual review ending May 15, 2020. Additionally, the youth was transferred prior to becoming available for interview. The program maintains one complete suicide response kit located in the shift supervisor's office. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observations of the program's suicide response kit could not be observed. A review of the three master's-level non-licensed therapist's training showed completion of the

required twenty hours of ASR training under the direct supervision of a licensed professional. The program does not utilize secure observation. The program utilizes New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization under Chapter 394 Florida Statute (Baker Act). An interview with the DMHCA reported mental health staff are notified of ASR referrals verbally and through a referral form. It was reported all program staff are trained to immediately place youth exhibiting suicidality on PO. The DMHCA reported staff contact the shift supervisor. The shift supervisor is then responsible for supervisory oversight, associated documentation, notification to master control, notification to the FA and DMHCA, and direct-care staff notification. Three interviewed staff reported the program's suicide response kit is located in the shift supervisor's office. Three staff were interviewed regarding direct-care responsibilities when a youth expresses suicidal thoughts. Three staff reported documentation and constant sight and sound supervision. Two staff reported they would notify the mental health staff, and one staff reported they would search the youth and room for sharp objects.

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 policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for staff observation and documentation. An interview with the program's designated mental health clinician authority and facility administrator confirmed the program had no applicable youth requiring precautionary observation since the last annual compliance review ending May 15, 2020.

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 written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for staff training and the completion of mock suicide drills. The policy dictates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, in addition to participation in suicide and emergency drills. A review of three in-service training records showed each staff completed all required training. Reviewed mental health drills reflected clinical drills simulating a youth suicide attempt and/or self-harm were conducted on each shift approximately each month. The program has two shifts, A and B, which operate from 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m., respectively. Reviewed documentation supported direct-care staff participated in drills during the last twelve months. Documentation presented for review supported direct-care staff, including the maintenance staff, participated in a semi-annual suicide drills, as required. A review of the staff list and drill sign-in sheets documented sixteen of twenty-six applicable staff participated in drills for the first quarter and nineteen participated in the second, third, and fourth quarters. Each reviewed emergency drill documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. Participating staff signed the Facility Emergency Drill Log indicating their understanding and compliance with the procedures. The program

practice is to review all suicide drills during morning management meetings, which occur Monday through Friday, at all shift briefings with oncoming staff, and during monthly all staff meetings. An interview with the facility administrator reported the program provides training and/or mock drills for staff monthly, which includes emergency response to suicide attempts or self-inflicted injury. Three interviewed staff reported participating in medical emergency and suicide drills monthly.

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 policy and procedure and an attached crisis intervention plan. The policy and plan are reviewed annually. The policy was last signed by the facility administrator on July 2, 2020. The plan was last revised and approved by the psychiatrist and the designated mental health clinician authority on May 4, 2020. The plan detailed crisis intervention procedures inclusive of verbal de-escalation and Protective Action Response, as set forth in Florida Administrative Code, notification and alert system, referrals including self-referral, Crisis Assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, and documentation and review.

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 policy and procedures to establish a method in which crisis intervention services shall be provided to all youth. The program also maintains a written crisis intervention plan, which includes provisions for the completion of Crisis Assessments. The program's mental health crisis intervention plan includes a notification and alert system, means of referral inclusive of self-referral, communication, supervision, documentation and review. An interview with the program's designated mental health clinician authority and facility administrator confirmed the program had no applicable youth requiring a Crisis Assessment since the last annual compliance review ending May 15, 2020.

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 policy and procedure and an attached emergency mental health and substance abuse care plan. The policy and plan are reviewed annually. The policy was last signed by the facility administrator (FA) on July 2, 2020. The plan was last revised and approved by the psychiatrist and the designated mental health clinician authority (DMHCA) on May 4, 2020. The plan detailed emergency procedures inclusive of immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training and mock drills, and review.

An interview with the FA and DMHCA indicated there were no youth applicable for emergency mental health and/or substance abuse services since the last annual compliance review ending May 15, 2020. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act to New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilizes the emergency services through Raulerson Medical Center in Okeechobee, Florida for Marchman Act. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. Three interviewed staff acknowledged the ability for all program staff to call 9-1-1 in the event of an emergency.

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

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

Standard 4: Health Services

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

The program has a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. The program currently has an independent contract with a licensed osteopathic physician (DO) who has a specialty training in family practice to serve as the designated health authority (DHA) signed on September 4, 2019. The DHA holds an unrestricted clear and active license in the State of Florida with an expiration date of March 31, 2021. The DHA is contracted to be on-site at a minimum of two hours weekly with no more than nine days passing between site visits. Reviewed physician logs for the past three months supported the DHA was on-site weekly, as required.

The program has a contract with a licensed medical doctor (MD) for coverage in place for scheduled absences, emergency services, and vacations. The backup MD has an active license to practice in the State of Florida with an expiring on January 31, 2021. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. Documentation related to healthcare services and the review of youth healthcare records showed the DHA provides oversite for all healthcare provided at the program. An interview was not submitted by the DHA during this annual review period. However, a review of the DHA's interview from the previous annual compliance review in May 2020 confirmed the DHA performs Comprehensive Physical Assessments (CPA), chronic clinics, sick calls, periodic evaluations, and reviewing/signing healthcare policies and procedures and nursing protocols.

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 designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation found the DHA and facility administrator (FA) signed the healthcare policies and procedures and treatment protocols. Reviewed documentation validated the DHA and FA signed the healthcare policies and procedures on June 23, 2020. The DHA and FA signed the treatment protocols on June 16, 2020 and remained effective without change to include admission standing orders, non-licensed medical and emergency protocol guide, body mass index protocol, and approved first aid kit content and designee.

The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2021. The psychiatrist signed the healthcare polices on July 5, 2018 and June 22, 2020. The designated mental health clinician authority signed the health care policies on May 4, 2020. A review of the facility operating procedures cover-page documented signatures of all medical staff on February 25, 2020. The program reported not hiring any nursing staff since the last annual compliance review in May 2020. However, the program

maintains a training requirement which requires newly employed healthcare personnel to complete a comprehensive clinical orientation to the Department's healthcare policies and procedures.

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 has a written policy and procedures regarding the authorization of treatment (AET) for all youth admitted into the program. The AET form is signed by the parent/guardian and serves as informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter (OTC) medications which can be treated by healthcare staff. A review of three youth Individual Healthcare Records (IHCR) found two youth were applicable for a signed AET. Each applicable IHCR had a parent/guardian signature along with a witness signature. Each applicable IHCR included a copy of a completed parental notification behind the AET. Both reviewed AETs were copies stamped with the word "COPY" in red. There were no original AETs reviewed during the annual compliance review. The remaining youth was under the supervision of the Department of Children and Families where parental rights have been terminated and the healthcare record contained a signed Order of the Court authorizing treatment.

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. There were no applicable youth eighteen years of age or older at the time of the annual compliance review. During an interview, nursing staff reported all youth should have a valid AET upon admission to the program. If the youth do not have an AET, the health care staff will collaborate with both the case manager and juvenile probation officer (JPO) in obtaining a new and/or current 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 has a written policy and procedures to inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed. Three youth Individual Healthcare Records (IHCR) were applicable for parental notifications. Each applicable IHCR confirmed the parents/guardians were notified when significant changes to existing medication occurred and when changes in condition and/or medication for youth identified with a chronic condition. All three IHCRs included parental notifications for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET). One youth was applicable for off-site emergency care and reviewed documentation supported the parents/guardians were notified.

Reviewed documentation confirmed verbal notifications and witnessed by another staff with a written follow up was sent by mail when applicable. One youth was receiving services in the care of the Department of Children and Families (DCF). The youth's IHCR contained a signed Order of the Court authorizing treatment as needed. The program's practice is to complete a comprehensive psychiatric evaluation within fourteen days of each youth's admission. The program utilizes page three of the Department's Clinical Psychotropic Progress Note (CPPN)

form, as required. The program's practice is to also complete page three of the CPPN regardless of prescribed medications. Two of the three reviewed youth IHCRs supported the youth were prescribed a psychotropic medication. When applicable, parent/guardian consents were obtained, and telephone consent was conducted by the psychiatrist and witnessed by the nurse. The parent/guardian also 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. All three youth IHCRs reflected vaccinations were verified within thirty days of the youth's admission. Each record contained a copy of the youth's immunization record received from the Department, the Florida Shots website, and/or school records. There was no evidence of a youth's parent/guardian refusing to consent to a vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. An interview with the nursing staff confirmed this practice.

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 has a written policy and procedures regarding healthcare screening for each youth upon admission into the program. The program's practice is to complete a rescreening and complete the Department's Facility Entry Physical Health Screening (FEPHS) form anytime a youth is admitted into the program or returns to the program following a physical custody change. A review of three youth Individual Healthcare Records (IHCR) validated each youth received an admission screening utilizing the Department's FEPHS form. All admission screenings were completed by a license practitioner nurse (LPN) on the date of the youth's admission to the program. There were no applicable youth with a change in physical custody greater than twenty-four hours. Reviewed Chronological Progress Notes documented consent and results of a pregnancy screening for applicable youth who were sexually active. Reviewed documentation confirmed the practice. An interview with nursing staff found medical staff completes healthcare screenings. Youth are re-screened, when applicable, by licensed health care staff utilizing the FEPHS form during nursing hours. If a youth is admitted after hours, non-licensed staff complete the FEPHS form and licensed health care staff will review and reassess the youth within twenty-four hours of the re-screening.

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 has a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. The program's practice is to have the nurse or a medical staff knowledgeable with the health care delivery system provide healthcare orientation upon each youth's admission. A review of three youth Individual Healthcare Records (IHCR) documented each youth received a general healthcare orientation on the day of admission conducted by a registered nurse (RN). Each youth received a health education packet which covered all required topics, including: how to access sick call, what constitutes an emergency, how medication is administered, the right to refuse care, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the health care provider. Youth and nursing staff signed the health education packet acknowledging the orientation was conducted and the youth reviewed and understood the information. In addition to the admission

health orientation, youth received health education throughout their stay documented in the healthcare record. A review of the Health Education form validated this practice.

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

The program has a written policy and procedures to notify the designated health authority (DHA) of all youth admitted into the program identified with chronic health conditions or youth in need of emergency care. The program's practice is to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. The DHA is notified by telephone, text message, or verbally, if on-site, of all admissions. Three youth Individual Healthcare Records (IHCR) were reviewed. Each of the youth IHCRs reflected telephonic notification to the DHA of the youth's admission into the program. None of the youth presented a condition requiring an emergency response. All records documented in the youth's chronological progress notes contained in each IHCR. Reviewed documentation confirmed nursing staff updated the Chronic Conditions Log after the notification was completed.

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 has a written policy and procedures to address the completion of the Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA) upon each youth's admission to the program. A review of three youth Individual Healthcare Records (IHCR) found two youth had a new HRH form completed within seven days of the youth's admission. One youth's HRH form was updated within the required timeframe. Reviewed documentation supported the HRH form was completed on the day of admission. The nursing staff provided signed electronically on the HRH form. A review of the CPA reflected the designated health authority (DHA) reviewed the HRH form in each IHCR. The program's nursing staff reported the program's practice is for a licensed healthcare staff to complete the HRH form on the admission date for all youth.

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 has a written policy and procedures ensuring each youth shall receive, or have on file, a current Comprehensive Physical Assessment (CPA) no later than seven calendar days of admission into the program. A review of three youth Individual Healthcare Records (IHCR) validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority (DHA) and/or designee. 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 three reviewed CPAs did not complete section numbers twenty-three, twenty-four, twenty-five, or twenty-six (pelvic and rectum examination) and each documented "deferred by clinician due to age" on the CPA. One youth refused the gynecological examination and signed the refusal form. A review of each youth IHCR validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year

to determine exposure to tuberculosis. 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 TB screening. All tier I TB 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. There were no current youth with symptoms suggestive of active TB. The program's policy indicates youth will not be placed into the general population until healthcare needs are identified are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. Nursing staff reported during an interview, TB screenings are conducted on the same day of admission. An updated TST or Chest X-ray is given within seven days of the youth's admission.

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 (STI) and HIV risk factors.	

The program has a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The STI screening form was signed by the youth and nurse at the time of the youth's admission. A review of three youth Individual Healthcare Records (IHCR) found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Each youth was referred to the designated health authority (DHA) for further evaluation. Testing was ordered and was performed for each youth within twenty-four hours. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. The program maintains a written policy and procedures ensuring all youth at risk for Human Immunodeficiency Virus (HIV) are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated.

A review of three youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. One youth consented to have HIV testing completed and two did not consent testing. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. The program's designated health authority (DHA) is authorized to provide pre-counseling, testing, and post-counseling. Reviewed IHCRs validated when youth receive pre-counseling, testing, and post-counseling, the youth's health education record was updated in the healthcare record. The results were placed in a sealed envelope marked 'Confidential' with the youth's name, program name and address, date of test, and youth signature documented on the outside of the envelope. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not include HIV status as part of the internal alert system. Three interviewed youth indicated they could request a HIV/AIDS test.

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 has 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. Sick call care is provided by licensed medical staff, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). Youth are informed of the sick call process at the time of their admission to the program during orientation. The program's two dorms and cafeteria have sick call forms located on the wall and a deposit box is located inside of the cafeteria accessible to all youth, as reported by nursing staff. The box is monitored throughout the day by nursing staff and complaints are organized based upon the urgency to be evaluated. The program offers youth the opportunity to make a Sick Call Request, seven days a week, once daily, conducted by the licensed nursing staff. Each day sick call is conducted from 12:00 p.m. to 2:00 p.m. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA).

The program maintains DHA-approved protocols for non-licensed staff to deal with healthcare situations. The program also maintains an independent contractor agreement with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist and license optometrist hold an unrestricted clear and active license in the State of Florida with expiration dates of February 28, 2022 and February 28, 2021. A review of three youth Individual Healthcare Records (IHCR) found each applicable youth completed a Sick Call Request form at least once 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 were no applicable youth who presented a similar sick call complaint three or more times within a two-week period.

All reviewed sick call incidents were 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 the supervisor for review. The supervisor is required to review the sick call complaint promptly but no longer than two hours after the request was submitted. The supervisor will determine if the sick call requires immediate attention. The DHA and the health services administrator (HSA) are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Reviewed documentation confirmed all supervisors received medical technician training delivered by the program's RN. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore; observations of the program's sick call process could not be observed. Three interviewed staff indicated nursing staff conducts sick call. Three interviewed youth indicated they are allowed to see a dentist and doctor immediately and medications are administered by the nurse. Three interviewed staff indicated nursing staff conduct sick call.

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 has 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. Episodic care is provided by the nurse and documented in the progress chronological notes and tracked on the episodic log. Any episodic care provided by a non-licensed staff must have a follow-up evaluation by a licensed healthcare professional the next time this person is on-site, or sooner, if indicated. The healthcare staff then documents the follow-up evaluation on a nursing chronological note. A review of three youth Individual Healthcare Records (IHCR) found all three-youth required episodic and/or first aid 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 documented all episodic, first aid, and emergency care incidents by date, name of youth, Department identification number, injury or emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA) on the log. An interview with the program's nursing staff confirmed this practice.

The program maintains an automated external defibrillator (AED), suicide kit, and a knife-for-life located in various locations. The program maintains one AED located outside the medical office in the hallway. The program maintains eleven first aid kits. The first aid kits are located in administration, supervisor office, Home Builders Institute (HBI), van one, van two, the computer lab, classroom one, classroom two, both dorms, and the education building. The first aid kits are checked weekly, and AED and suicide response kits are checked monthly by nursing staff to ensure the kits are fully stocked and do not have any issues. The AED provides audio instructions on step-by-step procedures. The AED batteries expire in December 30, 2023 and were last changed in December 30, 2019. The AED pads expire in July 16, 2022 and were last changed April 2, 2020. Three reviewed in-service and pre-service training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED, and administration of an epinephrine auto-injector. The registered nurses each maintained current certifications in CPR/AED and basic first aid.

The program conducts mock medical drills monthly on each shift. The program conducts announced and unannounced emergency medical drills monthly on each shift. Reviewed drills supported an annual calendar is maintained identifying the drill conducted. A review of drills conducted for the three months supported drills were conducted monthly on each shift and included CPR and AED demonstration at least quarterly. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore; observations of the program's AED, first aid kits, and suicide response kit could not be observed. The program reported emergency telephone numbers were located in each office and the medical clinic accessible to staff but inaccessible to youth. Three interviewed staff reported they are allowed to call 9-1-1 if a youth has a medical emergency.

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

The program has a written policy and procedures ensuring 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 three youth Individual Healthcare Records found one youth required off-site care and/or emergency care; therefore, two additional applicable records were reviewed. The program reported there were no additional records available. Parental notification was documented, when applicable. The Summary of Off-Site Care Form was completed for the youth and was filed in the healthcare record. Reviewed documentation supported the DHA reviewed and completed the off-site care form and applicable discharge paperwork, as evidenced by the DHA signature and date. One youth required follow-up care and was scheduled to receive services as prescribed. Reviewed documentation validated the DHA documents the review on the off-site care form and nursing staff track any follow-up appointments through 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 has a written policy and procedures ensuring youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the period evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of three youth Individual Healthcare Records (IHCR) indicated one youth was admitted with an identified chronic condition, as documented on the Facility Entry Physical Health Screening form, and another youth was identified upon admission into the program. One additional applicable record was reviewed. The program reported there were no additional applicable records available. All youth were classified with a medical grade of two through five. There were no applicable youth undergoing treatment for physical health condition which included a body mass index (BMI) greater than thirty.

The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations, as required. There was no indication of lapses in care or missed periodic evaluations in each of the reviewed records. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. Both youth IHCRs documented updates to the Department's Problem list as changes occurred. At the time of the annual compliance review, the program did not have any youth taking anti-TB medication or who were pregnant. The designated health authority (DHA) reported youth with chronic conditions are evaluated every sixty days and as needed. The DHA also indicated writing orders for youth to follow-up for chronic clinic within sixty days to ensure youth are being evaluated in accordance to policy. An interview with the nurse also confirmed this practice. The nurse also confirmed monthly and quarterly meetings between the administration staff, medical staff,

psychiatrist, consultation pharmacist, and DHA to discuss the care and conditions of youth at the program.

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 has 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 education is verified and indicated. Nursing staff complete the Facility Entry Physical Health Screening form 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.

A review of three youth Individual Healthcare Records (IHCR) found two youth were admitted into the program on prescribed medication. One youth was later placed on medication after admission to the program. One additional record was requested during the annual compliance review. The program reported there were no additional applicable records available. A review of the nursing admission notes documented both youth's current medication and the designated health authority (DHA) Notification of Admission documented current prescribed medication. The nursing staff notified the DHA on the day of the youth's admission. The DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed documentation validated each was applicable for medication management and each documented a current and valid prescription order. The medication was administered in accordance with the approved protocols and physician's order.

Reviewed Medication Administration Records (MAR) 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. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. Three of the applicable youth IHCRs 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. 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. The initial MAR for each record matched the medication(s) listed. The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventories of controlled medications are conducted by conducted by two licensed practical nurses (LPN). If there is only one LPN on-site, the inventory is completed by the LPN and a shift supervisor. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. When applicable, refusals of medication were clearly documented on the MAR. Nursing staff maintain locked cabinets in the medical clinic with over over-the-counter (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. The program's practice is to ensure the Six Rights of Medication Delivery and Administration is maintained for the youth. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore; observations of medication administration could not be observed.

The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program's procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. In compliance with the CDC guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, storage of controlled substances and other medication could not be observed. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the temperature is monitored daily. Three staff were interviewed and all three confirmed the nurse provides youth with medication. Three youth were interviewed and reported medication is administered by the nurse.

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 has 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. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Medications such as injectables, topicals, drops, and liquids are stored separately. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, medication inventory was unable to be observed. All medications are securely stored in the medical clinic inaccessible to youth. The program's practice is for over-the-counter (OTC) medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substances with a shift-to-shift inventory conducted by two licensed practical nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly.

The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. Reviewed documentation and nursing interviews confirmed all OTC medications were inventoried perpetually and weekly. The program also maintains a with Stericycle, Inc. for biomedical waste treatment with a certificate of exemption issued on October 19, 2019 with the State of Florida, Department of Health. Stericycle, Inc. picks up medical waste weighing less than twenty-five pounds monthly for proper disposal.

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

The program has a written policy and procedures ensuring there is an approved plan for infection control. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan also includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. The plan was reviewed and approved by the facility administrator on September 10, 2019, and designated health authority (DHA) on April 6, 2020.

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 reported applicable incidents to the Department's Central Communications Center (CCC) involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The plan includes risk assessment and methods of compliance. In the event of an incident, the facility administrator (FA) has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. An interview with the program's FA revealed the program's Exposure Control Plan/Infection Control Plan is located in the medical office located in the administration building.

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

The program does not accept pregnant youth based upon its proximity to the nearest hospital with maternity/neo-natal care; therefore, this indicator rates as non-applicable.

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program has a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. Daily clinical care is performed by licensed medical staff such as a registered nurse (RN), or a licensed practitioner nurse (LPN) in accordance to developed authorized protocols. An interview with the program's medical staff confirmed this practice. At the time of the annual compliance review, the program had two RNs, three LPNs, and one health service administrator (HSA). Reviewed documentation confirmed all licensed nursing staff holds an unrestricted clear and active license in the State of Florida. Reviewed documentation confirmed the program's licensed healthcare professional reviews medical cases with the LPN in accordance to the Department's policy. A review of all nurses' training records confirmed each nurse maintains a current cardiopulmonary resuscitation (CPR) certification.

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 maintains a written policy and procedures regarding youth supervision. The program staff promote safety and security by maintaining active supervision of youth including interacting positively with youth, engaging youth in a full schedule of meaningful activities, monitoring youth behavior and changes in behavior, and applying the program's positive performance system. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, youth and staff observations were conducted for one day during the annual compliance review week. The observations included youth movement from school to the indoor recreation area, from school to Home Builders Institute (HBI) vocational class, and during mental health group. During each observation, staff were actively supervising the youth and, when requested, staff immediately provided an accurate count of youth in their supervision.

A review of the program shift logs since the last annual compliance review dated May 15, 2020, verified formal and informal youth counts were documented in the shift log within every twenty-four-hour period. Youth-to-staff ratios were observed in compliance with the program's contract. The program's head counts are maintained in the program shift logbook, which is maintained by the program's shift managers. The shift managers document all youth and staff movement throughout the day in the program's shift logbook. Youth counts are consistently conducted during each shift and the shift manager calls for a count from each youth care worker. Observations determined program staff interactions with the youth were positive and followed the program growth and change positive performance system. The program has a daily schedule posted in each dorm area.

Informal interviews with three staff revealed their knowledge of the process for reconciling discrepancies in youth counts. Staff interviews confirmed staff were aware of procedures which would be implemented when youth count could not be reconciled to include performing a recount, performing an emergency count, notification to the shift manager and assistant facility administrator, securing youth, conducting a program and perimeter search, and notification to law enforcement and the Department's Central Communications Center (CCC).

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

The program maintains a written policy and procedures which indicates all consequences and sanctions for the violation of program rules. Consequences shall be directly related to the seriousness of the inappropriate behavior exhibited, consistent with the sanctions detailed in the youth handbook, and applied immediately. The program's behavior management system (BMS) is known as the growth and change positive performance system (GCPPS), which was designed to help youth manage their behavior and learn ways to deal with situations. The program's GCPPS is a multi-level system designed to increase desired behaviors using reinforcements and decrease unwanted behaviors through a menu of appropriate consequences. The written description is provided to each youth within the youth handbook provided at orientation, to allow easy access for youth, and includes rules governing conduct, and positive and negative consequences for behavior. In three reviewed youth records documentation of acknowledgement receipts was found confirming each youth received the youth handbook at orientation. The GCPPS is reviewed with the youth by the staff completing the orientation phase.

The youth handbook includes a list of behavioral infractions and rewards the youth can earn for positive behavior. The GCPPS is a level system and rewards are generated through a point system which youth earn daily. The program has an annual in-service and pre-service training plan, which includes the GCPPS for all staff. A review of three staff in-service training records found staff are trained on the GCPPS. There were no staff applicable for pre-service training. Three interviewed youth explained the GCPPS and what rewards could be earned with positive behavior. The youth indicated a variety of rewards are provided to them which consist of purchases from the program boutique store, extra snacks, and special food.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site one day on-site; therefore, observations of staff implementing the GCPPS for three of the four days review during interactions with the youth was unable to be conducted. Three interviewed youth reported staff give rewards and consequences correctly and on a consistent basis. All three youth rated the GCPPS as fair. Three staff were interviewed regarding types of rewards provided to the youth as part of the BMS. Each staff described different types of rewards provided to youth which includes extra games, boutique, and rents water slides. According to the facility administrator interview, the program uses five levels within the GCPPS based on youth positive days, daily performance base on point card, and weekly incentive pass which includes a risk assessment for participate in off campus activities.

5.03 Behavior Management System Infractions and System Monitoring	Satisfactory Compliance

The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population.

Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.

The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline, positive and negative consequences, and to encourage youth to meet behavior expectations. The program's BMS is known as the growth and change positive performance system (GCPPS). The program's GCPPS requires all staff to be responsible for monitoring and addressing behavior. Case managers are responsible for tracking youth violations and utilizing the GCPPS when confronting the youth about behaviors. The youth handbook informs each youth of the program's responsibility to the youth and the youth's responsibility and expectations to the program. According to the facility administrator interview, the GCPPS reminds the youth of their responsibility to follow all rules, exhibit appropriate behavior at all times, and ensure all staff having direct contact with youth are trained.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of youth and staff interactions for three of the four days review, and exchange of open communication, could not be observed. The program does not use room restrictions for any infractions as part of the GCPPS. Youth length of stay is not increased subsequent to engaging in negative behavior, nor are youth denied basic rights or services. The program has an annual in-service and pre-service training plan, which includes the GCPPS for all staff. A review of three staff in-service training records found staff are trained on the BMS. There was no staff applicable for pre-service training. Youth grievances and the "Chatty Cathy" process are mechanisms through which youth may voice concerns regarding the fair and consistent implementation of the GCPPS. The program's facility administrator reviews youth level and points, grievances, and youth feedback at the team daily meetings as a means of monitoring fair and consistent application of the GCPPS. Three interviewed youth indicated youth are never allowed to punish other youth. Three staff were interviewed regarding staff receiving feedback on the use of the BMS. All three staff indicated receiving feedback from supervisors regarding the BMS system.

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 maintains a written policy and procedures regarding ten-minute checks. The program has fifteen cameras, of which thirteen were operational during the annual compliance review week. Two cameras were reportedly frequently inoperable since June 25, 2020. The

digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days. A review of ten-minute room checks sheets and video footage for July 14,15, 24, and 26, 2020, during various times, was completed for “A” and “B” shifts from two cameras in the dormitory area was conducted. Each of the ten-minute checks were conducted, as required. All times were documented in real time. An interview with three staff reported room checks are conducted every seven-minutes when a youth is placed in their room for sleeping reasons and one staff also reported room checks are conducted every five-minutes.

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

The program maintains a written policy and procedures for tracking counts and maintaining a census. A review of the program’s logbooks since the last annual compliance review dated May 15, 2020, revealed a daily count of youth in the program. The program has one program shift logbook, which the shift manager oversees and maintains. The staff document head counts at the beginning and end of each shift and outdoor activities. All formal counts in the logbook include the time of the count, location, and number of youth accounted. Emergency counts were observed in the logbooks and accounted for the reason of the count, time, location, and number of youth accounted. A review of the logbook indicated the documentation of daily counts, head counts, youth movements, admissions, releases, and youth temporarily away from the program. The staff write in red ink for Prison Rape Elimination Act (PREA) situations.

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of headcounts for three of the four days of the review were not able to be observed. During the day on-site, three of the annual compliance review the team members observed headcounts being called several times during the day on a two-way radio. There is a tracking board in the administration office with the daily census for the program which keeps the daily totals, admissions, the youth’s photograph with their name, date of birth, Department identification number (DJJID), releases, and youth temporarily off-site. An interview with three staff reflected staff are aware of the program’s policy and procedures on adequate supervision of youth, and the procedure for reconciling discrepancies in youth counts as well as conducting counts during an emergency. Staff reported active sight and sound supervision of youth must be maintained at all times.

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

The program maintains a program logbook containing a chronological record of events, incidents, and activities. The program logbooks were reviewed since the last annual compliance review dated May 15, 2020, and revealed the logbooks were bound with no loose or missing pages and all pages were numbered. All logbook entries were brief, legible, written in ink, and included the date and time of the event. The entries consistently included the full name and signature of the staff making the entry. All entries had consistent color-coded highlighting. Any errors were struck through with a single line and initialed by the staff making the correction. The program conducts shift briefings prior to each shift with significant issues identified on the previous shift. The shift briefing information is documented in the shift reports and all staff signed the report at the end of the briefing to reflect they were briefed about its contents. The shift supervisor is assigned to maintain the report and make entries regarding chronological events for the shift. Shift entries were inclusive of population counts, perimeter, and other security checks. A review of the program's shift reports verified information is shared with incoming staff prior to the beginning of the shift. The program logbook was reviewed for reporting incidents to the Department's Central Communications Center (CCC) and all three CCC report numbers were documented in the logbook.

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

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

Restricted keys are maintained in a separate key box located in the administration office. Only medical staff and the assistant FA have access to the restricted key box. A random check of three staff keys was conducted for the program's FA, a shift manager, and one youth care

worker during the annual compliance review and each staff had the appropriate number-coded key. A review of the program's daily key logs since the last annual compliance review dated May 15, 2020, revealed the program's sign-in and out for keys was consistently tracking keys and assigning keys. A review of the Department's Central Communications Center (CCC) showed the program has not had any incidents of missing or lost keys since the last annual compliance review dated May 15, 2020. An interview with three staff confirmed all staff are aware of the program key control protocols regarding lost/missing, damaged keys, and restricted keys.

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

The program maintains a written policy and procedures regarding contraband. The policy includes items considered contraband and consequences for having contraband. The program's policy regarding contraband aligns with the Department's recommended guidelines for contraband. The policy states unannounced random searches of youth sleeping rooms shall be done on an irregular, unpredictable basis, but at a minimum, must be done weekly. Youth are provided a resident handbook which outlines the behavior management system known as the growth and change positive performance system (GCPPS) and includes a list of items considered as contraband. Youth's parents/guardians are mailed a handbook which outlines a list of items considered as contraband and the program visitation procedure. The program staff stated all searches are conducted unannounced daily on each shift.

A random review of daily search reports since the last annual compliance review dated May 15, 2020, documented the following contraband items have been found including pens, trash, and empty hygiene bottle. Documentation of the contraband is found in the contraband/unauthorized item logs. Youth who are found with contraband will have a behavior report and a special treatment team meeting for the violation. A review of the program's logbooks and safety perimeter check inspection reports since the last annual compliance review dated May 15, 2020, confirmed searches and program checks are conducted daily on each shift. An informal interview with the facility administrator reported contraband not considered illegal is immediately removed and must be given to the facility administrator for disposal.

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 maintains a written policy and procedures referencing the proper procedures for conducting searches and full body visual searches to include when and how. An interview with three staff confirmed all staff had knowledge of how and when to conduct youth searches, and reported searches are conducted on youth for every movement. An interview with three youth confirmed searches occur when items are missing, after meals, after outdoor activities, and when returning from off campus. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of searches and full body visual searches were unable to be completed.

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

The program maintains a written policy and procedures regarding transportation, vehicles equipment, and maintenance. The program has two vehicles to transport the youth.
The first van received an annual safety inspection on September 23, 2019, and the second van inspection was completed on October 28, 2019, both vans meeting the annual maintenance requirement, with documentation of services completed on each of the vehicles. Observations confirmed first aid kits were maintained inside the administration office until the vehicles are in use, and then transport staff bring the designated first aid kits with them on all transports. A random check of both transport vehicles at the program found one vehicle was locked when not in use and both vehicles have an inspection sheet. One of the transport vehicles was not locked and secured when not in use. Observations of the two vehicles used to transport youth are found to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. A random check of five staff personal vehicles at the program found each was locked when not in use. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, transportation of youth was not able to be observed.

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

The program maintains a written policy and procedures regarding transporting youth and the use of communication devices. The program has two operable vans utilized to transport youth. A review of the vehicle inspection sheet dated for since the last annual compliance review dated May 15, 2020, indicated the program met the Department's requirement for each vehicle used

to transport youth, passed an annual safety vehicle inspection. The program's policy states staff are not allowed to transport youth in their personal vehicles, nor are youth allowed to operate program or staff vehicles. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observation of a transport was not able to be conducted.

Observations of both vans used for transporting youth included a rear and side doors, and one of the vans was equipped with a safety screen separating the driver's compartment from the passenger's compartment. The program maintains a driver list which includes staff names and titles. The list was approved by the program's facility administrator and human resource department. All staff on the driver's list since the last annual compliance review dated May 15, 2020, have a current driver's license. The program's human resource staff checks each staff driver's license and updates the list monthly. An interview with three staff confirmed due to the COVID-19 pandemic, youth are not transported. Three interviewed staff confirmed a cellular telephone is provided during transports and if there is an emergency, they have cell phones to communicate with their supervisor. Three youth were interviewed regarding seeing anyone place contraband in a transport vehicle, and if they feel safe during transport when staff are driving. All three youth reported feeling safe during transport and did not witness anyone place contraband in a transport vehicle.

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

The program maintains a written policy and procedures regarding weekly safety and security audits. The program's policy meets all the requirements of Florida Administrative Code. The program's facility administrator (FA), assistant facility administrator (AFA), and physical plant worker are responsible for conducting the weekly security audits, documenting the outcome, and recommendations on the inspection logs. The weekly security audits and safety inspections address camera surveillance, digital video recorder (DVR), radios and communication devices, perimeter, and fencing to ensure all areas are secure. A review of the program's security audit and safety inspection logs showed the program is conducting weekly safety and security audits since the last annual compliance review dated May 15, 2020. An interview with the program's FA indicated there is a facility walk through each week with the physical plant worker to identify and track completion of deficiencies identified. Documentation showed the program addresses any deficiencies found and documents the course of action needed to correct the deficiency.

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

The program maintains a written policy and procedures regarding tool management, preventative, and corrective maintenance which provides instructions and procedures regarding storage and tracking of tools. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department had one building which housed tools and other supplies needed for maintenance. An informal interview with the program's facility administrator (FA) stated all tools stored in the building are Class A tools. The tools are secured and locked inside the building. The physical plant staff are the only workers assigned keys to unlock the building. Inventory of the tools are completed daily and weekly.

Documentation of the maintenance building supported the practice of daily and weekly inventories. The physical plant worker maintains a perpetual inventory of all tools, which is attached to the wall near the door on a clipboard inside the building. The staff sign-out and sign-in the tools as they use them. The program has a list of Class B tools to be maintained in a locked room on each dorm area away from the youth. Inventory of the Class B tools are maintained by the program's shift manager. The program utilized the main campus kitchen at a different location; therefore, there were no kitchen tools used at the program. Youth are trained to use mops and brooms. A review of three staff in-service training records found staff are trained on Class A and Class B tools. There was no staff applicable for pre-service training. Three staff were interviewed regarding youth access to tools. Two staff reported youth in the program are allowed to use mops and brooms and one staff reported youth have access to screwdriver and hammer in Home Builders Institute (HBI) vocational class.

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

The program maintains a written policy and procedures regarding supervising youth handling tools. Youth are only allowed to use Class B tools under direct supervision of staff. The staff-to-youth ratio during work detail activities is one-to-five. Documentation showed youth are searched to ensure no contraband has been removed upon completion of the work activity. The program daily cleaning schedule is set for early morning before school and late at night before bedtime; therefore, observation of staff-to-youth ratios when youth are using tools and youth searched after each work period could not be observed. A review of three youth case management records found risk assessments were completed monthly. Documentation indicated certain youth are qualified to use Class A tools; however, the program's practice does not allow youth to use Class A tools unless if they are a part of the vocational program. Three interviewed youth reported youth can use mops and brooms.

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

The program has a written policy and procedures in place regarding outside contractors and requirements the contractor must adhere to while working on-site at the program. The program's practice is all contractors will sign a yearly contractor's guideline to include the visitor contraband list and the Prison Rape Elimination Act (PREA). Thereafter, the contractor will only sign-in and sign-out the contractors log each time when a repairman enters the program grounds to perform a work project. A review of the program's outside contractor binder documented the provider signed and dated the required forms once a year in all three occasions. The program's policy states all contractors, while on-site, must be in direct supervision of the physical plant worker or authorized staff.

A random review of three of the outside contractor's sign-in and sign-out logs confirmed the program's practice. Documentation supported the contractor's tools were checked upon their arrival and departure from the program. There were no reports of missing contractor tools since the last annual compliance review dated May 15, 2020. According to the program's facility administrator, whenever an outside contractor arrives on-site to perform a work project, a physical plant worker is always with them to ensure direct supervision and monitor the

contractor's movement. The program's policy outlines who is responsible for providing approval/permissions if a contractor's personal cellular telephone and/or equipment/electronic devices are required.

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

The program maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on April 7, 2020. The COOP requires the program to conduct safety, disaster, fire, and evacuation drills on a random basis, for each shift, monthly, and under varying conditions when the majority of the youth are available. Furthermore, the COOP requires the program to conduct unannounced fire drills once a month for each shift. An interview with the program's facility administrator (FA) revealed fire drills are conducted monthly and unannounced on double shift. Reviewed documentation of drills confirmed the program completed drills in accordance with their COOP. The program conducted three COOP drills relating to safety, evacuation, escape, disturbance, disaster, and chemical spill since the last annual compliance review dated May 15, 2020. Three interviewed youth reported the program conducted fire drills all the time. Three interviewed staff indicated they have participated in fire, escape, weather-related drill, and evacuation drills. An interview with the FA determined fire drills are completed once a month on a double shift and all other drills are conducted one time a month on each shift monthly.

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

The program maintains a written policy and procedures regarding the Continuity of Operations Plan (COOP). The COOP included all required elements of Florida Administrative Code 63E-7. The COOP was submitted and approved by the Department on April 7, 2020. An interview with the facility administrator (FA) revealed the COOP is available to all the program staff and located in the FA's office and administration building at the program. A review of three staff in-service training records found staff were trained on the COOP. All completed training was documented in the Department's Learning Management System (SkillPro). There was no staff applicable for pre-service training.

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

The program maintains a written policy and procedures in place regarding the control of hazardous materials. These items are stored at the main campus in a metal cabinet inside building number thirty-two identified as flammables and are inaccessible to the youth. The physical plant assistant maintains a perpetual inventory of all chemicals at a different location and not on the same property with the program. The program only kept cleaning products at the program. These items are stored in a lock room in the first administration office identified as flammables, poisonous, toxic items, and are inaccessible to the youth in the program. The Safety Data Sheets (SDS) book is located with the chemical items, which includes a photograph of the item along with the perpetual inventory for each item. A review of three chemicals and the inventory sheet matched the actual chemicals stored. The program's facility administrator (FA) maintains a list of materials and a list of staff authorized to access chemicals posted on the inside of the door, along with a permanent log to show the sign-out and sign-in of chemicals. The program records the daily use of chemicals on a daily chemical usage log to include the initial of the authorized staff using each chemical. Only authorized staff are permitted to sign-out and sign-in chemicals and hold a key to the chemical room.

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

The program maintains a written policy and procedures prohibiting the handling of flammable, poisonous, and toxic items and materials by youth. The program's physical plant workers maintain strict control at the main campus over the flammable, poisonous, toxic items and materials in sheds not accessible to the youth. The facility administrator (FA) stated the program does not keep any flammable, poisonous, and toxic items at the program, with the exception of cleaning products. All the flammable items are kept at another program in building thirty-two. In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, part of this annual compliance review was conducted off-site and one day on-site; therefore, observations of youth during daily cleaning activities could not be completed. Three youth were interviewed regarding the types of chemicals they have handled since being at the program. All three youth reported they do not use any chemicals and/or cleaning products.

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

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

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures to ensure youth are provided opportunities to participate in visitation and family reunification activities. Upon admission to the program, a letter and a copy of the parent/guardian handbook was mailed to each parent/guardian, which contains information about visitation, telephone calls, and letter writing. The program maintains a visitor list in a single binder. Each youth has an approved list for visitors, as well as telephone and written contacts. The program holds quarterly family days and visitation is conducted on Saturday and Sunday from 11:00 a.m. to 2:00 p.m. Due to the COVID-19 pandemic, as of April 9, 2020, visitation is scheduled through Facetime until further notice. Youth letters are mailed daily, and youth are not limited in the number of letters they can mail or receive. Documentation showed all incoming and outgoing mail are monitored and searched by case managers. A review of chronological documentation and telephone logs confirmed youth contacted their family members or parent/guardian one time a week. A review

of visitation sign-in and sign-out logs documented there was no youth visitation with family members or parent/guardian since the last annual compliance review dated May 15, 2020; however, the program has offered youth and families to utilize FaceTime for visitation purposes. Observations of the program's posted visitation schedule reflected no visitation due to the COVID-19 pandemic. Three youth interviews confirmed youth have been given the opportunity to communicate with their family members by mail, during visitation, or by telephone.

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

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

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

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

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

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