STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Intensive Halfway House

TrueCore Behavioral Solutions, LLC

(Contract Provider)
7200 North Highway 441
Okeechobee, Florida 34972

Review Date(s): September 17-20, 2019

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:

Paula Friedrich, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, Technical Assistance Specialist (Interviews)
Jenny Hickox, DJJ Probation, Circuit 19, Senior Probation Officer (Standard 2)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Gabriel Medina, Office of Program Accountability, Regional Monitor, (Standard 3)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 4)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Okeechobee Intensive Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): September 17-20, 2019

MQI Program Code: 1159
Contract Number: 10188
Number of Beds: 30
Lead Reviewer Code: 139

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.19 Staff Performance	5.04 Ten Minute Checks *
1.20 Recreation and Leisure Activities	5.10 Vehicals and Maintenance
4.01 Designated Health Authority/Designee *	5.22 Visitation and Communication

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	Limited
1.20	Recreation and Leisure Activities	Limited

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Failed
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	Failed
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	Failed
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable
5.26	Safety Planning Process for Youth	Satisfactory

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Program Overview

The Okeechobee Intensive Halfway House is a thirty bed, non-secure residential program, for males age thirteen to eighteen years old located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides services to youth committed by the juvenile criminal court who are in need of residential mental health overlay services (MHOS). Youth receive daily mental health group treatment within a general offender correctional setting. The program's services are designed to address criminogenic risk factors according to the youth's needs and risks. At the time of the annual compliance review, the program had twenty-one youth in census. The length of stay depends on the youth's progress in the program by completing their performance plan goals, decreasing their criminogenic rsik factors, and addressing the youth's individual treatment goals. The program provides comprehensive case management, medical, mental health, and parenting skills (when applicable) which meet the individual needs of youth. Goals of services include a trauma focused and restraint free environment promoting normalcy, the implementation of promising and evidence-based practices which positively mitigate the risk to reoffend, the integration of community mental health, social services and other agencies early in the treatment process to minimize the risk to reoffend, maximize support, and reduce length of stay. Among the evidence-based interventions offered by the program are Thinking for a Change (T4C), Impact of Crime (IOC) Restorative justice, Thinking, Feeling, Behaving, Teen Relationships Workbook, The Passport Program, Skillstreaming the Adolescent, Independent Living Skills, Anger Management for Substance Abuse and Mental Health Clients, and Living in Balance. The program supports each youth by providing additional treatment services which include individual, group, recreational, and family therapy, coupled with transitional services. The program also provides the gender-specific services of Young Men's Work to all youth, and 24:7 Fathering Handbook to youth who are a parent. Program management is comprised of a facility administrator (FA), a unit manager, a clinical director, and a director of case management. Case management services are provided by a lead case manager, a case manager, and the transitional service manager. Mental health staff positions required by the contract include the clinical director, one full-time licensed therapist, and two master's-level therapists working under the direct supervision of the clinical director. The program subcontracts services with a licensed psychologist and a licensed psychiatrist. At the time of the annual compliance review, the program had four volunteers who assist the program with educational, social, and/or spiritual motivation and encouragement. Medical services are offered seven days a week and are provided by a full-time lead registered nurse and a part-time registered nurse. A health services administrator serves all three programs co-located on the same campus. The program contracts with a licensed medical doctor (MD) to serve as the designated health authority (DHA) who is to be on-site at least weekly for two hours, with no more than nine days passing between site visits. Medical services provided by the program includes screening of youth for medical concerns and assisting youth with medication when the youth are prescribed medication while at the program. The program also subcontracts with First Choice Pharmacy, which provides all pharmaceuticals services. The program's educational staff are TrueCore Behavioral Solutions, LLC employees. The program has an active agreement with the Okeechobee County School District for curriculum offerings and oversight. The program provides transportation services as needed. At the time of the annual compliance review, the program reported a total of five vacant positions including the licensed therapist position, the recreational therapist position, one non-licensed therapist position, one unit manager position, and one youth care worker position. The physical design of the program includes two buildings, the first building number eighty-four encompasses three youth housing dormitories each with a group room/area, as well as a restroom and showers, the program's medical office, a small

room used for meetings, staff offices, and a staff break room. The shift supervisor office and a laundry area are located in building number eighty-four. Building number eighty-four is adjoined by a sidewalk to building number eighty-five which contains three classrooms, a café where meals are served, and daily meetings are held. The program is located within a secure fenced perimeter and has an outdoor recreation area including a paved basketball court and shaded pavilion. The program has fourteen security cameras positioned in various locations throughout the facility. At the time of the annual compliance review, all cameras were reported to be operational. The staff work on two twelve-hour shifts each day.

Standard 1: Management Accountability

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

The program maintains a written policy and procedures to address required background screenings upon hire, as well as the submission of an Annual Affidavit of Compliance with Level 2 Screening Standards. Since the last annual compliance review, the program hired twelve new staff who were all applicable for an initial background screening. A review of documentation for the twelve newly hired staff found the program received background screening clearances from the Department's Background Screening Unit (BSU)/Clearinghouse prior to each staff's date of hire. Each of the records also contained a copy of the pre-employment assessment tool with a passing score. Reviewed documentation and an interview with the program's human resources coordinator, confirmed the hiring authority reviewed the status of the Department's Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, and the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS). Three staff and two volunteers were included on the Department's BSU/Clearinghouse employee roster while seven of the newly hired staff had not been added. The provider's Clearinghouse roster was updated during the week of the annual compliance review to include the seven staff. The program submitted the Annual Affidavit of Compliance with Level 2 Screenings standards to the Department's BSU on December 10, 2018, 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 maintains a written policy and procedures requiring five-year background re-screenings. A re-screening is required every five years, calculated from the staff's original hire date with the program or five years from the date the staff was screened through the Department's Background Screening Unit (BSU)/Clearinghouse. Five staff were applicable for the five-year re-screening. In four of the applicable records, a rescreening/resubmission was submitted to BSU/Clearinghouse at least ten business days prior to the five-year anniversary or retained prints expiration date. One rescreening was submitted only five days prior to the five-year anniversary date. However, the background screening clearance was received prior to the anniversary date. One rescreening request was submitted fifty-three days after the five year

anniversary date with clearance received fifty-seven days late. There were no volunteers eligible for a five-year background rescreening.

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 trama responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program maintains a written policy and procedures for abuse reporting and for providing an abuse-free environment. The policy stipulates youth and staff are to have unhindered access to report alleged abuse to the Florida Abuse Hotline without intimidation or reprisal. Observations during the facility tour revealed postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers throughout the program. The program's policy outlines the reporting procedures for all staff to follow when a youth would like to report abuse. Upon hire, all staff signed a form located in the employee handbook acknowledging their understanding of the code of conduct. A resident handbook is provided to each youth upon admission. The handbook includes the youth's rights, the program's grievance process, and the Florida Abuse Hotline and CCC telephone numbers. A review of documentation from the previous six months was conducted for allegations of abuse to the Florida Abuse Hotline or CCC; seven reports alleging abuse was found. Documentation confirmed a report was made by staff to the Florida Abuse Hotline and CCC within two hours of staff being made aware of each incident. A child protective investigator reported to the program in each instance to follow-up on the allegation and there were no findings of abuse. Five interviewed staff and an interview with the facility administrator (FA) confirmed the program's abuse reporting practice. The program's abuse reporting process includes immediately reporting any knowledge or suspicion regarding abuse to the Florida Abuse Hotline and the CCC for youth eighteen years of age or older, verbally notifying the on-duty supervisor once the call to the Florida Abuse Hotline has been completed, and completion and submission of an incident report form to the assigned supervisor. Any youth's refusal to make the abuse call themselves does not relieve the staff from their mandate to call the Florida Abuse Hotline if the staff has reasonable suspicion abuse has occurred. Five interviewed staff were all able to state the

program's process for allowing a youth to make a call to the Florida Abuse Hotline and all five reported never observing a co-worker denying a youth access to make such a call. None of the five staff reported ever hearing another staff use profanity when speaking to a youth. Five interviewed youth indicated all staff are respectful to them.

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 to address allegations of physical, psychological, and emotional abuse. Five staff training records were reviewed and documented receipt of training on child abuse reporting requirements. An interview with the facility administrator indicated the program did not have any substantiated findings of abuse since the last annual compliance review; however, if allegations were to be found true the employee would be suspended or terminated. A review of five incident reports occurring over the previous six months was completed specific to allegations of abuse. Reviewed documentation indicated management staff acted immediately in each instance to address the incidents by removing each staff from youth contact while investigations into the allegations were conducted. One staff was suspended and another staff was terminated.at the conclusion of the investigations.

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

The program maintains a written policy and procedures to address required reporting of incidents occurring at the program to the Department's Central Communications Center (CCC) in accordance with the Florida Administrative Code. Reviewed documentation confirmed the program had twenty-five incidents reported to the CCC since the last annual compliance review and five were reviewed. All five incidents were reported to the CCC within two-hours of the incident or the program becoming aware of the incident. An interview with the program's investigator revealed one reviewed internal incident involving a staff using profanity towards youth had not been reported to the CCC, as they did not believe it was reportable; however, the staff was terminated as a result of the program's internal investigation. The program reported the incident to the CCC during the annual compliance review and the incident was accepted and categorized as improper conduct of staff. Reviewed documentation indicated the program experienced a twenty-five percent increase in the number of reportable incidents as compared to the previous six months. The increase was attributed to an increase in the number of non-work related staff arrests as well as one youth returning to the program from adult jail who was involved in seven reported incidents.

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 to address the use of Protective Action Response (PAR) techniques. The program's PAR plan was approved by the Department's Office of Staff Development and Training on December 21, 2018. The program had nineteen PAR reports in the past six months and five PAR reports were reviewed. All five reports were completed by staff prior to the end of the shift. Four of the five reports included statements from all staff members who were engaged with the youth during the incident. However, one report was missing a statement from a staff who responded to the incident from the southside of the campus, as the name of the staff was not known to the other PAR participants nor identified in the report. All PAR reports were reviewed by the program's management staff as required, within seventy-two hours and included a post-PAR interview with the youth which was conducted within thirty minutes of each incident. Documentation indicated medical reviews were not needed for any of the reports completed. The program's PAR rate during the annual compliance review period was 2.68, which is above the statewide Residential PAR rate of 1.59.

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

The program maintains a written policy and procedures regarding pre-service training. The program's pre-service orientation training plan was submitted and approved by the Department's Office of Staff Development and Training on January 16, 2019. Five new hire training records were reviewed for pre-service certification training within 180 days of hire. All five staff completed at least 120 of pre-service training within the 180-day time frame, as required. All staff completed cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR), suicide prevention/intervention, child abuse reporting, emergency procedures, as well as professionalism and ethics prior to having contact with youth or confidential records. All training was documented in the Department's Learning Management System (SkillPro) and was conducted by qualified trainers.

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

The program maintains a written policy and procedures to address annual in-service training. The program had an in-service annual training plan which was submitted and approved by the Department's Office of Staff Development and Training on January 16, 2019. Reviewed documentation validated the program updates the training plan as changes occur. Five staff

training records including two supervisory records were reviewed for completion of in-service training. All five staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR), as well as completed training in suicide prevention/intervention, professional ethics and standards of conduct, and active shooter training. Each of the five staff exceeded the twenty-four hours of required in-service training. The program's contract requires management staff to complete sixteen hours of training in areas of management leadership, personal accountability, employee relations, and communication skills in addition to the twenty-four hours of in-service training. The records for both reviewed supervisors validated each had completed sixteen hours or more of management topics specified in Florida Administrative Code. All training was documented in the Department's Learning Management system (SkillPro). The two licensed nursing staff were also validated to have a current certification in CPR with AED.

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 written policy and procedures to address annual grievance process training, which is included within the program's pre-service training plan. A review of five staff training records confirmed all five staff completed training on the program's grievance process and procedures during pre-service training. Additionally, each youth is introduced to the program's grievance process during orientation and the process is also outlined in the youth handbook which each youth receives. The program has a written grievance policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances within the program related to the violation or denial of basic youth rights. The procedures require youth to be treated fairly, respectfully, without discrimination, and have their rights protected. The procedures for the grievance process include specific time frames to ensure timely feedback to youth and rectification of situations or conditions when grievances are determined to be valid or justified. The process allows a youth to submit an informal or formal complaint and file an appeal, if necessary. Review of the program's policy and procedures and an interview with the facility administrator (FA) indicated the program has an informal phase for the grievance where youth completes a "Let's Talk" form and is address with the staff who assist the youth to resolve the complaint or concern within forty-eight hours. The program had eighty-one "Let's Talk" forms submitted over the previous six months. The FA also indicated the program has a formal phase where the youth completes a grievance form describing their complaint. Each submitted grievance form is assigned a number and a written response is provided to the youth by the grievance officer. The youth signs to acknowledge their agreement with the findings and action taken, or to disagree with the findings, and request an appeal to the next level which is forwarded to the FA for response within seventy-two hours of receipt. The program utilizes a grievance form which delineates the informal, formal, and appeal phases. The locked, wall-mounted grievance box and grievance forms are accessible to all youth. The program maintains a binder and tracking logs in chronologic order for all grievances submitted, which was reviewed. The program had a total of eighteen grievances logged over the previous twelve months. A review of five randomly selected grievances indicated four of the five reached a resolution with which each youth agreed and no grievances were appealed. One reviewed grievance indicated the grievance was received on March 27, 2019; however, the grievance officer response was dated three weeks prior to the submission of the grievance. Additionally,

the signature of the youth was not obtained on the grievance findings section of the form and neither the youth or grievance officer dated the findings section of the form. The program indicated the grievance officer input the incorrect date on their response to the grievance. Five interviewed staff and five interviewed youth were accurately able to explain their understanding of the program's grievance process. All five interviewed youth indicated they may request assistance in completing a grievance form, if needed.

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.	

An interview with the facility administrator (FA) indicated each youth is matched with a case manager based upon the individualized needs and the level of treatment required. In addition, the clinical director and therapists review each youth's clinical supervision history and match each youth with a therapist based upon their presenting history, symptoms, and treatment needs. The program provides delinquency interventions through the evidence-based delinquency intervention model of Thinking for a Change (T4C) and Impact of Crime (IOC) which is a practice with demonstrated effectiveness. T4C uses a problem solving program with both cognitive restructuring and social skills interventions to bridge the identification of thinking, beliefs, attitudes, and values to behavior. IOC is based on the restorative justice belief in which crime is more than just a legal definition but rather crime affects the victim, the offender, their families and the community leading to the offenders understand of the harm they caused and the need to take personal accountability for their actions. Reviewed documentation and interviews with the program's clinical staff indicated the delinquency intervention groups were held, as required with minimal interference and were facilitated by case managers. A review of training records for staff who facilitated the groups found each completed training for their respective applicable intervention. A review of five youth case management records, the program's activity schedule, and the group sign-in-sheets validated each youth received delinquency intervention groups and each youth had an intervention service goal included as part of their individualized performance plan.

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 provides life and social skills intervention services which address communication, interpersonal relationships and interactions, non-violent conflict resolution, critical thinking, problem solving, decision making and anger management. The program utilizes several interventions to develop life and social skills competencies in youth. A review of the program's activity schedule and documentation confirmed youth received services and groups including Skillstreaming the Adolescent, Teen Relationship Workbook, Thinking Feeling Behaving, and independent living Skills as outlined in the program's contract. An interview with the facility administrator (FA) indicated consideration is given to staff's intervention training, education, and work experience to determine which staff deliver the life and social skills groups to the youth. A

review of the training records for staff who facilitate the groups, validated they were trained to deliver the applicable curriculum and each had the applicable educational background for the group practices. Reviewed group documentation validated groups were delivered according to the program's daily schedule. Five interviewed youth indicated they learn coping skills, anger control, to avoid following negative peers, and to think before acting in the program's groups.

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.	

A review of the program's daily activity schedule and an interview with the facility administrator, indicated the program provides restorative justice activities intended to increase youth awareness of and empathy for crime victims and survivors, as well as to increase personal accountability for youth's criminal actions and harm to others. A review of the program's contract indicated the Impact of Crime (IOC) curriculum is provided to all youth. IOC is designed to assist youth in accepting responsibility for harm they have caused by their past criminal actions. It is designed to expose youth to the victim's perspectives through victim speakers speaking in person or on digital video recordings. IOC also provides opportunities for youth to participate in reparation activities such as community service projects. The daily program schedule indicates IOC to be provided on Tuesdays and Thursdays. A review of the groups sign-in sheets confirmed groups were held according to the daily schedule. A review of the Department's Learning Management System (SkillPro), reflected the staff facilitators of IOC completed IOC training prior to facilitating groups. An interview with the facility administrator (FA), indicated the program also utilizes the youth's daily meeting as an opportunity to utilize restorative justice practices within the program by encouraging youth to accept responsibility for their actions and behavioral choices within the program. Interviews with five youth and a review of their case management records, confirmed restorative justice programming was included in each individual performance plan.

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.	

Gender-specific programming targeting a male population is provided at the program utilizing the Young Men's Work curriculum which teaches males ages fourteen to nineteen, how to work together and solve problems without violence. Young Men's Work addresses a range of gender-identity topics including power, violence, bullying, anger, fear, frustration, the interpersonal relationships between men and women, dealing with loss, creating family, and the future. All groups are facilitated by a trained direct care staff or licensed health practitioner. A review of the program's daily schedule and group documentation indicated the Young Men's Work groups are provided on Wednesdays. The program also has the 24:7 Fathering Handbook curriculum available for provision to youth who are parents; however, the program has not admitted any youth who are parents since the last annual compliance review. An interview with the FA indicated gender-specific training is provided to all staff and the program's policy and procedures are written in accordance with gender-specific practices.

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 maintains a written policy and procedures regarding security, medical, and mental health alerts to ensure all staff are made aware when medical or mental health issues are identified which may affect the security and safety of the youth in the program or may necessitate the need for emergency medical and mental health services. The program's policy and procedures detail the roles and responsibilities for healthcare staff, clinical treatment staff, and program staff as well as instructions on not including information considered to be confidential. The program utilizes the detailed Juvenile Justice Information System (JJIS) alert report for licensed healthcare or clinical staff and also has a daily one page internal medical alert roster which is maintained by the healthcare staff and is distributed to all program staff which is reviewed during each shift briefing and daily morning management meetings. The internal medical alert roster lists all open alerts including allergies and restrictions, physical limitations, possible medical complications or side effects as well as medical grade, and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment status for each youth in the program. The Department's Office of Health Services indicates no diagnosis of any kind should be on the program's internal alert list other than allergies.. A review of five youth healthcare records in comparison with the Department's JJIS, reflected each applicable and current youth alert was consistent with the program's internal alert system. A review of five youth medical and mental health and substance abuse records found all applicable medical, mental health, and gang alerts were entered in JJIS, as required. An interview with the registered nurse confirmed the program's practice for only authorized medical and mental health staff having the authority to enter, adjust, downgrade, or discontinue alerts which was also supported by the logbooks updates to alerts. A review of five youth medical records confirmed all youth with medical grades of two through five were placed on the program's medical alert system. An alert board with a photograph of each youth is maintained within master control and copies of the printed internal daily alert roster are available in master control for all oncoming staff. An interview with the facility administrator (FA) indicated the responsibility for entering, updating, and closing alerts in JJIS is dictated by the type of alert. Mental health alerts are maintained by the clinical director, gang alerts are maintained by the lead case manager or director of case management, and medical alerts are maintained by healthcare staff under the direction of the health services administrator. Program administration determines the placement of youth on security alert based upon new admissions to the program and/or any indication of possible escape ideation. A review of all alerts for five youth validated the applicable alerts were removed or downgraded from alert status by the appropriate staff and logbooks documented the updates to alerts. Five interviewed staff confirmed they are made aware of alerts through the alert board and the daily alert rosters.

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 maintains a written policy and procedures to address record management to ensure the management of all records is consistent across operations and programs consistent with the program's philosophy, goals, and objectives, and consistent with legal and contractual requirements. The policy reaffirms the Department's requirements of the organization and maintenance of records. The program maintains an official case record for each youth which consists of an individual healthcare record (IHCR), an individual case management record, and a mental health and substance abuse record. A review of five IHCRs for youth active within the program found each record was labeled "Confidential" and secured in the medical office behind a locked office door, within locked cabinets which were not accessible to youth and which were also marked "Confidential." Each mental health and substance abuse record was secured in the therapist's office and was organized with tabs dividing information into specific sections for legal information, correspondence, and documentation of case management and treatment activities. Each individual case management record was divided into the five required sections and maintained in the case management office behind a locked door within a locked cabinet. A review of the youth program's case management records confirmed the program's practice is following the tab requirements, records, and confidential information provisions pursuant to Florida Statute. Observations of the filing cabinet storing mental health records revealed the cabinet was also marked "Confidential".

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

A review of documentation and observations made during the annual compliance review and five youth interviews, validated the program has a formal process to improve communication between administration and youth at the program, and allow youth an opportunity to provide input into the program's operations and their living environment. The program utilizes the "Let's Talk" form which provides individual youth the opportunity to address issues, problems, or concerns they may have which are not necessarily grievances. Daily cottage debriefings are scheduled to take place each afternoon which can identify issues arising with the youth. The program also maintains a youth advisory board consisting of youth leader representatives from each dormitory. The youth leaders solicit recommendations, issues, or concerns from the youth on their assigned living unit to be presented to the program's facility administrator (FA) during advisory board meetings. An interview with the FA indicated the youth advisory board meetings are to occur biweekly. A review of the board binder confirmed youth meetings were conducted at least once a month; however, there were no meetings documented for April or July 2019. Interviews completed with five randomly selected youth confirmed the program has a process allowing youth to provide input on what happens at the program. Additionally, the program conducted formal surveys in February and August 2019 with a total of twenty youth which were questioned about a variety of program related areas. An interview with the FA indicated anonymous surveys are conducted with youth at least quarterly by the regional compliance staff.

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 provided a contact list for their thirty-five member community advisory board consisting of representatives of the Okeechobee Sheriff's Office, the Okeechobee Police Department, the fire chief, city council members, the business community, Okeechobee County School District members, volunteers, faith community, a local victim services agency, and two parent/guardians of a former youth. The program's facility administrator (FA) provided copies of recruitment letters to different individuals and indicated the program has been working to find parent/guardians of youth formerly under the Department's supervision. A review of the community advisory board agendas and sign-in sheets validated the program hosted quarterly advisory board meetings since the last annual compliance review in December 2018, March, June, and September 2019. The program maintains a community advisory board binder which was reviewed. An interview conducted with a current board member confirmed the board's involvement with the board. An interview with the FA clarified the invitations to the program's quarterly community advisory board meetings are sent by mail or email.

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 to provide a system of staff communication, opportunities for providing input, and feedback on the program's operations. An interview with the facility administrator (FA), revealed the program holds a daily morning management meeting and shift briefings at the start of each shift. Morning management meetings include a review of program census, incidents, physical interventions, grievances, behavior management system status of youth, finding of video reviews, alerts, staffing, and reports from mental health and medical staff. The FA also reported shift supervisors meet biweekly in addition to attending monthly leadership meetings and campus-wide all staff meetings each month. Once a month the morning management meeting is expanded to include review of data tracking from the program's Lauris on-line case management and counseling system. Internal monthly management reports and process outcome reporting information is analyzed by corporate staff and followed by communication to the program regarding any areas of concern relating to performance outcome measures. Staff are recognized during monthly all staff meetings with employee of the month awards and recognition of staff who have gone above and beyond. The program administration and regional compliance manager conduct comprehensive quarterly youth and staff surveys. The program practice is to mail an invitation for parent/guardian surveys with the program's welcome letter and to personally solicit survey participation in parent/guardian surveys during quarterly family day activities. An interview with the regional compliance manager reported parent/guardian surveys are received by the corporate office and then disseminated to the FA. The results of the surveys are discussed in detail at the corporate office and subsequently the results are reviewed during staff meetings. Interviews with five staff indicated they can communicate with management to provide input and feedback.

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

The program maintains a written policy and procedures to address staff performance to ensure the evaluations of staff are conducted based on established performance standards. A review of five pre-service staff records revealed three staff received ninety-day performance evaluations; however, the evaluations were respectively completed three, four, and six months late. Two staff had not received a ninety-day performance evaluation with the expiration of the ninety-day period less than one week away; however, both evaluations were completed during the week of the annual compliance review which included performance rating calculations, supervisor comments, signatures, and dates. Additionally, five in-service staff records were reviewed which revealed each staff received an annual evaluation. A review of five staff pre-service and five staff in-service records validated the program maintains position descriptions for each position title which outline the position expectations and essential functions, requirements, knowledge, skills and abilities, physical requirements, and work environment of each position. Five staff were interviewed and three responded to indicate staff receive formal evaluations of their performance based on performance standards every six months. One indicated the evaluations were conducted monthly. Interviews completed with five staff revealed the program conducted ninety-day evaluations and yearly evaluations. An interview with the facility administrator indicated staff evaluations are completed annually.

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

The program is to provide daily physically challenging, educational, and constructive recreational and leisure time activities which teach youth healthy ways to maintain their own physical wellbeing as well as to provide alternative ways of spending leisure time. A review of the program's logbooks and observations during the annual compliance review week, revealed the program conducts outdoor recreation and indoor leisure activities in accordance with the program's daily schedule. Interviews completed with five randomly selected youth revealed the youth play football or basketball outdoors and during indoor recreation the youth play cards, chess, board games, and video games as well as watching television under the supervision of direct care staff. Reviewed documentation validated the program's recreational therapist position has been vacant since May 20. 2019. The program's contract requires a qualified recreation therapist with a bachelor's-level degree in recreational therapy or a related field such as recreation, leisure studies, or physical education as well as a minimum of one-year related experience working with youth. A review of five youth case management records revealed the program included clinical goals related to overall mental, physical, and emotional health within the treatment plan for each of five reviewed youth records, which was monitored for progress by the therapists. However, none of the therapists possess the qualifications required of the recreational therapists nor did the therapists facilitate structured and organized physical activities. The contract additionally requires recreational activities to be separate and distinct from mental health and substance abuse treatment services. An interview with the human resources coordinator, indicated the program hired a recreational therapist the week of the annual compliance review who was scheduled to begin new hire orientation training immediately.

Standard 2: Assessment and Performance Plan

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

The program maintains a written policy and procedures to ensure all youth are properly admitted into the program which includes parent/guardian notification procedures. A review of documentation in five youth case management records indicated each parent/guardian was notified by telephone within twenty-four hours of admission. Additionally, all five youth case management records included documentation the parent/guardian was notified in writing of the youth's admission within forty-eight hours with parent/guardian letters having been mailed out on each youth's day of admission. All five records also documented the juvenile probation officer, committing court, and/or post residential services were notified of each youth's admission within five working days.

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

The program maintains a written policy and procedures ensuring all youth successfully complete the program's orientation, including all required elements required by Florida Administrative Rule within twenty-four hours of admission. Five reviewed youth case management records included youth acknowledgment forms confirming receipt of orientation. All documentation was in accordance to the policy time frames. During the annual compliance review, there were no new admissions to the program. Five youth were interviewed and each verbalized receipt of orientation within twenty-four hours of admission.

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

The program maintains a written policy and procedures to ensure written consent is obtained for any youth eighteen years of age or older prior to discussing or providing the youth's parent/guardian information related to the youth's physical or mental health status. None of the five reviewed youth case management records were applicable for a youth over the age of eighteen. Therefore, three additional applicable records were reviewed and each included a consent form signed by each youth prior to any release of information.

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

The program maintains a written policy and procedures regarding the classification system to promote safety and security as well as effective delivery of treatment services. Five youth case management records were reviewed and all five reflected each youth had an initial classification form completed upon admission. Each reviewed record confirmed the program utilized a classification system in accordance with Florida Administration Code, promoting safety and security as well as effective delivery of treatment services. Each reviewed initial classification form documented the physical characteristics including sex, height, weight, general physical stature, age, maturity level, special needs including medical, mental health development, or intellectual and physical disabilities, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, suicide risk, medical risk, escape risk, and security risk. A reassessment of youth needs and risk factors is completed prior to increasing youth privileges including work projects, offsite activities, and home visits. A review of five youth case management records documented each youth received a reassessment for activities, monthly. The program enters classification alerts in the Department's Juvenile Justice Information System (JJIS) to promote safety and security, medical, mental health and/or special needs identified during the classification process. The facility administrator stated during the classification and intake process the treatment team collectively makes a decision regarding youth living arrangements by a review of youth history and all associated documents..

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

The program maintains a written policy and procedures to address gang identification and notification. During the admission and classification process youth are asked about possible gang involvement. The program identifies youth who are suspected gang members at intake and enter any applicable alert in the Department's Juvenile Justice Information System (JJIS). Five youth case management records were reviewed, and one was applicable for gang involvement. Two additional youth records were requested and reviewed. Reviewed documentation reflected all gang alerts were maintained in JJIS. All three applicable records documented the youth's home county local law enforcement agency was notified of the youth's gang involvement/affiliation. The Martin County Sheriff's Office serves as the law enforcement gang liaison for all residential programs located in Okeechobee County; however, only two of three applicable reviewed records included documentation of gang notification to the Martin County Sheriff's Office by electronic mail. Information on a youth's gang status is shared during monthly treatment team meetings with the educational providers, the youth's juvenile probation officer and, when applicable, the youth's post-residential counselor.

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

The program maintains a written policy and procedures regarding gang member identification. The program's practice is to provide intervention strategies when youth are identified as a gang member, affiliated with a criminal street gang or at high risk of gang involvement during the initial intake process. Five of the records provided only one record was applicable. Two more records were provided during the review process. All three records identified youth as a gang member or affiliation. Each youth record contained documentation of youth participation in gang prevention and intervention strategies with their assigned case manager. All three records contained a performance plan which included relevant goals and objectives relating to gang intervention strategies for the youth to complete prior to release from the program. The program uses the Gang Resistance and Drug Education (G.R.A.D.E.) curriculum, which is sponsored by the Coral Springs Police Department Youth Liaison Unit, as the selected gang prevention and intervention curriculum. The seven lesson curriculum consists of group activities, homework, essays, questionnaires and readings.

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 regarding Residential Assessment for Youth (RAY), Assessments and Re-Assessments. A review of five youth case management records indicate all five youth had a RAY Assessment completed within thirty days of admission as required. Each reviewed initial assessment was completed in the Department's Juvenile Justice Information System (JJIS) and a copy was printed and maintained in each reviewed record. Two case management records were applicable for a ninety-day reassessment and both documented a ninety-day reassessment was completed within the required time frame and a copy was placed in each case management record. Three records were not yet due for a ninety-day reassessment. One additional record was reviewed to meet the sample size requirement and documentation supported a ninety-day reassessment was completed within the required time frame and a copy was place in the youth's case management record.

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

The program maintains a written policy and procedures requiring a Youth Needs Assessment Summary (YNAS) is completed within thirty days of each youth's admission. A review of five active case management records showed the program documented each reviewed assessment in the Department's Juvenile Justice System (JJIS) within thirty days of admission. All applicable documentation and the original YNAS's were maintained in the Department's Juvenile Justice Information System (JJIS).

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

The program has a written policy and procedures regarding performance plan development. A review of five active youth case management records documented all five initial performance plans were developed within thirty days of the youth admission, as required. Each of the five reviewed youth performance plans were developed following the completion of an initial assessment. Each reviewed youth record documented the youth's plan was developed with the treatment leader, youth, administrative representative, living unit representative, treatment staff, and educational staff. Only one reviewed record was applicable for involvement of the Department of Children and Families (DCF) and documentation revealed the DCF caseworker was included in the development of the youth's case plan. Each reviewed goal included specific measurable interventions, identified the responsibilities the youth and staff members to complete the goals, and projected target dates for completion. Only one reviewed youth case management record did not include court ordered sanctions on the performance plan. All five reviewed records identified specific timelines for the completion of each goal. Each of the five reviewed performance plans addressed the youth's top three criminogenic needs, documented a transmittal letter, and a copy of the performance plan was sent within ten working days to the committing court, juvenile probation officer, parent/guardian, and/or DCF counselor. All five performance plans were signed by the youth, treatment team leader, and all parties determined to have a significant responsibility in goal completion. Reviewed documentation indicated the program mailed all five plans to the parent/guardian to sign and return to the program. Two reviewed records included plans which were signed and returned by a parent/guardian, confirming this practice. Five youth were interviewed regarding their participation in the development of their performance plan and each confirmed their participation in the development of their plan. It is the program's practice to review each youth's performance plan

every thirty days during treatment team meetings. All five interviewed youth acknowledged their current performance plan goals, while only four youth acknowledged receipt of their performance plan.

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

The program maintains a written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY). Five reviewed youth case management records revealed performance plan revisions were completed in three of the five records based upon reassessment results. Two records did not warrant revisions. Three youth records documented the individual performance plans (IPP) were revised. All five records documented the youth demonstrated progress toward completing a goal. One youth was applicable for transition and IPP revisions during the last sixty days of the youth's stay. A review of three closed records, indicated the intervention and treatment team revised the youth's IPP as needed to facilitate transition activities targeted for completion during the last sixty days of each applicable youth's stay in the program based on the transition conference,.

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

The program maintains a written policy and procedures to address performance summary completion and transmittal. A review of five active youth case management records found two were applicable for being in the program for more than ninety days from the signing of the youth's performance plan. Therefore, one additional closed youth case management record was reviewed. Documentation supported a performance summary was completed every ninety days following the signing of the performance plan in each of the three applicable records. Each completed performance summary included the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peer and staff, significant positive or negative events, and the status of each goal. Documentation indicated the youth reviewed and was able to add comments to their performance summary prior to signing it. Additionally, all three performance summaries were dated and signed by the treatment team leader, facility administrator/designee, and the youth. Reviewed documentation validated a copy of each performance summary was sent to the committing court and the assigned juvenile probation officer (JPO) within ten working days. Documentation in two records evidenced a copy was sent to the parent/guardian and in one record to the Department of Children and Families (DCF). Three youth case management records were applicable for Pre-Release Notifications (PRN) and release summaries, all three were sent to the committing courts and assigned JPO at least forty-five days prior to each youth's scheduled discharge date. Each of three closed youth records included a signed copy of the PRN and all three records contained written

notification to each youth's parent/guardian of the planned release. The court did not object to the release on any of the reviewed PRN's. Each of the three closed records included a completed exit Residential Positive Achievement Change Tool. None of the reviewed records were applicable for the Sexually Violent Predator Program (SVPP). Five youth were interviewed and two acknowledged receipt of their performance summary which was sent to the court. One youth reported not receiving a copy of their performance summary and two were not applicable.

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's practice is to forward a welcome letter to each youth's parent/guardian within forty-eight hours of the youth's admission to the program. A review of five youth case management records documented the program mailed a welcome letter to each youth's parent/guardian within forty-eight hours of admission. Each of the five records had documentation of the written letter encouraging the parent/guardian to participate either in writing, in person, or by telephone in the assessment process, development of the performance plan, program reviews, and formal treatment team meetings. Observation of a treatment team meeting during the annual compliance review week included the youth acknowledging they received a copy of their performance plan. The youth's parent/guardian and assigned juvenile probation officer were called to participate in the meeting but were not available; therefore, messages were left for a return call. During the treatment team meeting, discussion included a review of the youth's performance goals, education goals, mental health, individual and group treatment, medical, behavior reports, access to the abuse hotline, grievance procedure, and visitation. The youth acknowledged feeling safe in the program and denied any current threats from staff or peers. The youth's treatment goals were updated to include recent behavior reports. An interview with the facility administrator, indicated parent/guardians participate in monthly formal treatment team meetings, monthly family sessions with program therapists, and meetings with the transition services manager for re-entry into the community. Five youth were interviewed and four reported their parent/guardian was involved in their case management. One youth had not yet had a treatment team meeting.

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

The program maintains a written policy and procedures outlining the treatment team process as well as the members of the treatment team. A review of five youth case management records indicated a formal review was conducted once a month in each record. Treatment team members were documented on the treatment team form and signatures were captured from the youth, case manager, medical staff, therapist, a representative of program administration and education staff provided written input in all records. Parent/guardian participation was noted by telephone in some instances. A treatment team meeting was observed during the annual compliance review. Treatment team members in attendance included the youth's case manager who serves as the treatment team leader, therapist, shift supervisor, lead teacher, and healthcare staff. Treatment team members consist of a case manager, the youth, a representative of program administration, a living unit representative, mental health treatment staff, education staff, medical staff. Assigned juvenile probation officers (JPO) and the

parent/guardian typically participate in the treatment team process by telephone. The assigned JPO and the parent/guardian were both notified and called during the youth's treatment team but neither was available to participate by telephone.

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

The program maintains a written policy and procedures for the intervention and treatment to reference or incorporate each youth's treatment plan into the youth's performance plan. Five reviewed youth case management records indicated the performance plan incorporated each youth's mental health/substance abuse treatment plan. All five education plans were also incorporated into the performance plan. One record indicated the youth was involved with the Department of Children and Families (DCF). The youth's performance plan was developed to include the dependency case manager recommendations. None of the reviewed records were applicable for youth receiving services from the Agency for Persons with Disabilities (APD).

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 to address formal and informal treatment team meetings requiring the case manager to meet informally with each youth at least biweekly and formal treatment team meetings are to occur at least once every thirty days. A review of five youth case management records validated formal treatment team reviews were conducted at least once every thirty days. Formal performance reviews documented the youth's name, date of review, meeting attendees, comments from treatment team members, performance plan revisions, progress on performance plan goals, positive and negative behaviors, behaviors resulting in physical interventions, treatment team progress, Residential Assessment for Youth (RAY) reassessment results, and opportunities for the youth to demonstrate skills acquired in the program. Documentation indicated all required staff were present during treatment team meetings including the youth and representatives of the youth's living unit, case management, clinical, education, and medical staff. Each youth's juvenile probation officer (JPO), parent/guardian and other pertinent parties were invited to participate in person, by telephone, and/or written input. Each of the five reviewed formal treatment team created performance plans reflected the youth's anticipated release date. A review of the Department's Juvenile Justice Information System (JJIS) reflected the anticipated release dates are updated at least every ninety days as well as at the sixty-day transition conference. All five records also contained documentation of biweekly informal treatment team reviews focusing on each youth's progress in the program, performance plan revisions, and progress on the individual performance plan goals. Five interviewed youth indicated staff review their performance to include progress on performance plan goals, positive and negative behavior, and treatment team progress. Four of the five interviewed youth reported staff reviewed youth performance, progress on goals and treatment, as well as positive and negative behaviors while the fourth youth had not yet had a treatment team meeting. All four youth who had treatment

team meetings, stated they were provided the opportunity during the meetings to demonstrate skills the youth learned in the program.

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

The program operates a year round school providing educational services and vocational services. An interview with the lead teacher indicated youth attend school for 312 minutes each weekday. The program provides Type 2 career education services, personal accountability skills and behaviors leading to appropriate work habits for employment and living standards, program content, and an orientation to the broad scope of career choices. An interview with the facility administrator, reported the youth take hospitality classes and can receive professional hospitality certifications in the areas of breakfast attendant, kitchen cook, restaurant server, front desk representative, maintenance employee, guest service gold and guest room attendant. These certifications are issued by the American Hotel and Lodging Association. Youth also can earn a Safe Staff Food Handler Certification. This information is maintained in the youth's education record. Youth with employability as one of their goals are to have the opportunity to complete a sample employment application, resumé summarizing education and work experience, and a calendar schedule identifying an appointment with Career Source. A review of three closed youth records validated all three youth had completed an employment application, resumé , and documentation indicating location and business hours of a local Career Source Center. One youth record did not have a State issued identification card, birth certificate, or Social Security card which are essential for obtaining employment. All three youth records documented the youth's parent/guardian and assigned juvenile probation officer were aware of the established vocational plan. An interview with the lead teacher reported career education services and assessments are offered including hospitality, safe staff certificate, and driver's education.

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.	

TrueCore Behavioral Solutions, LLC operates a year round school providing educational services and vocational services. Youth are provided the opportunity to participate in educational and career-related programs for 250 days a year with a minimum of twenty-five hours of instruction weekly. A maximum of ten days may be used for teacher planning and professional development. Documentation provided by the program indicated the program provides 250 days of instruction distributed over twelve months with a minimum of twenty-five hours of instruction weekly. A review of the program's daily activity schedule indicates educational classes are to begin weekdays at 8:00 a.m. and ending at 2:37 p.m. However, observations made during the week of the annual compliance review and review of the program's master control logbooks, indicated the program is not consistently adhering to the schedule. Five youth were interviewed and all five indicated there are a lot of interruptions during educational instruction. The lead teacher was interviewed and stated the youth attend school for 312 minutes a day on a year round schedule.

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

The program maintains a policy and procedures outlining transition, release, and discharge. Youth are required to participate in an education program and career-related program for 250 instruction days each year. A review of three closed youth education records indicated each youth had an established individual education transition plan based upon the youth's post release goals beginning at admission. Each of the three reviewed plans documented key members related to transition activities including the youth, parent/guardian, educational representative, post-release staff, community school counselor, and the home county registrar. Each education transition plan contained specific goals for continuation of education and/or employment, interventions based on the youth's assessed educational needs, recommended post-release placement, and individuals responsible for coordination and support services. A review was conducted of three closed youth records applicable for education transition goals including employability. All three reviewed education transition plans documented provisions for continued education and/or employment. Reviewed records documented three youth had a completed employment application, resumé, and all three records contained documentation indicating the location and business hours of a local Career Source Center. One youth record did not contain a Florida identification card. All three youth records documented the youth's parent/guardian and assigned juvenile probation officer were aware of the established vocational plan, documents, and post-release discharge plans.

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

The program maintains a written policy and procedures regarding transition planning, conferences, and Community Re-entry Team (CRT) meetings. A review of five youth case management records revealed only one youth was in the transitional phase of the program. Two closed youth case management records were also reviewed. Reviewed documentation supported each of the three transition conferences was held at least sixty days prior to the youth's targeted release date. The youth, treatment team leader, facility administrator/designee, and other team members attended the transition conference. Documentation confirmed all treatment team members were invited and encouraged to participate in the transition conference to include the assigned juvenile probation officer (JPO), parent/guardian, education staff, and other pertinent parties. Each youth record documented the treatment team reviewed

the transition activities outlined on each youth's performance plan during the transition conference. One performance plan was applicable for revision. Documentation supported target completion dates and individuals responsible for goal completion were identified at each completed conference. Signatures documented participation of the treatment team leader, youth, facility administration, education staff, and nursing staff for each treatment team. Documentation of each CRT meeting noted the assigned JPO and parent/guardian participated by telephone.

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

Three closed youth case management records were reviewed for an exit portfolio completed prior to each youth's release from the program. All three reviewed records documented the exit portfolio was discussed with the youth at the transition conference as evidenced by dated signatures. Two of the three reviewed exit portfolios supported the youth had a State issued identification card and Social Security card. Each reviewed portfolio contained copies of the vocational certificates earned in the program, school transcripts, resumés, and completed sample job application. One case management record did not include a completed job application; however, the program provided email documentation to evidence the youth applied for a job online. Each youth signed a portfolio acknowledgement form indicating they received a copy of their portfolio containing contents to enable them to be better prepared to return to their home community. The three reviewed records contained a calendar with the dates, times, and locations of upcoming community appointments. Youth are also provided a copy of "A Plan for Success" which includes school contact information, treatment provider contact information, and contact information to Career Source to help the youth obtain employment. "A Plan for Success" is transmitted by electronic mail prior to the Community Re-entry Team meeting to all participants and is addressed at the exit staffing. All three youth case management records reflected the exit portfolio was addressed and verified at the exit conference. Each exit portfolio was completed and provided to each youth upon their release from the program and a copy mailed to each assigned juvenile probation officer.

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.	

Five active youth case management records were reviewed and none were applicable for an exit conference. Three closed records were reviewed for the completion of an exit conference. Each conference was conducted after the program notified the juvenile probation officer (JPO) of the youth's release and at least fourteen days prior to the youth's release date. All three reviewed records documented the date of the completed exit conference as well as the signatures of the participants including the youth, case manager, facility administrator, parent/guardian, JPO, and education representative. All three records also documented a summary of pending transition goals for the youth and finalized plans for the youth's release. A review of the Department's Juvenile Justice Information System (JJIS) confirmed the dates of admission and dates of release recorded in the youth records correlated with the dates entered into JJIS.

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 facility administrator is responsible for the administrative oversight and management of mental health and substance abuse services in the program. The program has a full-time licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is accountable for ensuring appropriate coordination, implementation, and oversight of the mental health and substance abuse services provided by the program in accordance with Rule 63N-1 Florida Administrative Code. A review of the program's clinical supervision log found the DMHCA provides direct weekly clinical supervision to the four non-licensed therapists in a face-to-face setting. In addition to supervision, the DMHCA facilitates groups and counseling sessions, provides some training, assistance with applicable drills, oversees fidelity monitoring, and provides crisis stabilization services as needed. The DMHCA is on-site at least five days a week and on-call twenty-four hours a day, seven days a week for consultation and emergencies. A copy of the DMHCA's license was reviewed and was found to be clear and active in the State of Florida with an expiration date of March 31, 2021. An interview conducted with the DMHCA, verified their role in the coordination and implementation of the mental health and substance abuse provided in the program, to include how often the DMHCA is on-site. The program has an operating capacity of thirty males and does not utilize a clinical coordinator. A review of the youth records and the DMHCA's position description validates the practice. The DMHCA verified the program provides mental health overlay services (MHOS) for all the youth in the program.

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

The program's facility administrator is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors are to ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The program has a full-time licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA), a full-time licensed mental health counselor (LMHC) who serves as the program's director of treatment services, and one LMHC who serves as group facilitator when needed, and a contracted part-time licensed psychiatrist. A review of the mental health

professionals' licenses found all were clear and active in the State of Florida. Staffing was in accordance with the program's contract and Florida Administrative Codes 63E-7, 63 N-1.002(46) and (47). The DMHCA the psychiatrist, and the program's director of treatment are on-call for emergencies and consultation twenty-four hours a day, seven days a week. A review of all licensed mental health professionals and licensed qualified professionals confirmed the practice. The reviewed records found each staff worked within the scope of their licensure, experience, and training. In addition, the program is licensed through the Florida Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment with an expiration of April 7, 2020.

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

The program's facility administrator (FA) is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors are to ensure clinical staff working under their supervisors are performing services they are qualified to provide based on education, training, and experience according to Rule 63N-1 and the contract. The program has four master's-level non-licensed therapists working under direct supervision of the designated mental health clinician authority (DMHCA). A review of the clinical supervision log documentation found the non-licensed therapists received direct clinical supervision by the DMHCA. The reviewed documentation found the clinical supervision log included all required elements as outlined in Chapter 397, Florida Statutes. Direct supervision for mental health clinical staff indicates a licensed mental health professional has at least one hour a week of on-site, face-to-face interaction with a non-licensed mental health staff person individually or in group format, for overseeing and directing the mental health services provided in the program, as permitted by State licensure law. The DMHCA also review and sign each Assessment of Suicide Risk (ASR) and follow-ups, crisis assessment and follow-up, comprehensive evaluations, initial and individualized treatment plans prepared by the non-licensed therapists within ten calendar days. The reviewed documentation found the clinical supervision log included a review of the youth's case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, trends, and/or problem areas. Each reviewed log included all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. In addition, the reviewed forms documented specific clinical focus areas for each clinician. Reviewed training documentation for non-licensed staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, crisis intervention, and emergency mental health services, the training documentation also included the administration of at least five ASRs or crisis assessments conducted on-site in the physical presence of a licensed mental health professional which was documented on the Department's required form. Direct supervision for substance abuse clinical staff means a qualified professional provides at least one-hour a week of on-site, face-to-face interaction with a non-licensed or non-certified substance abuse clinical staff who is an employee of a service provider under Chapter 397, F.S., or an employee in a program licensed under Chapter 397, F.S. individually or in group format, for the purpose of overseeing and directing the substance abuse services they are providing in the program. The program maintained a current license with the

Florida Department of Children and Families (DCF) for the provision of substance abuse services for adolescents.

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 facility administrator (FA) is responsible for developing written facility operating procedures for the implementation of a standardized admission/intake mental health and substance abuse screening process. The program identifies the mental health and substance abuse needs of youth through a comprehensive screening process to ensure referrals are made when youth have mental health and/or substance abuse needs or suicide risk. The program has a written comprehensive plan for mental health and substance abuse services which includes a standard admission/intake mental health and substance abuse screening and the administration of the Massachusetts Youth Screening Inventory – Second Version (MAYSI-2). Reviewed documentation revealed all youth's available information inclusive of the commitment packet, reports, and records of mental health, substance abuse and suicide issues are reviewed by the mental health staff upon intake. A review of five randomly selected active mental health and substance abuse youth records found the program completed a review of the commitment packet documentation, a MAYSI-2, an Assessment of Suicide Risk (ASR), and one Adolescent Psychopathology Scale for each youth upon admission. In addition, consent forms for urine collection and analysis, the Youth Consent for Release of Substance Abuse Treatment Records, Youth Consent for Substance Abuse Services, and the Youth Consent for Substance Abuse Treatment forms are obtained during the admission screening process. The program also completed a Substance Abuse Subtle Screening Inventory for each applicable youth. An interview with the FA, confirmed the program utilized the program's screening process, the Assessment of Suicide Risk (ASR), and the MAYSI-2 at each youth's admission to identify potential risk factors for suicide and to identify prior treatment services, psychotropic medications, emergency interventions, substance abuse issues, level of emotional stability, traumas, and history of family's mental health illness.

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 ensures a comprehensive mental health and substance abuse evaluation is conducted when a youth's mental health and/or substance abuse need is identified during screening. If a comprehensive evaluation was conducted within twelve months of admission to the program, the program may update the evaluation instead of conducting a new evaluation. The update is identified as "Updated Comprehensive Mental Health Evaluation," "Updated Comprehensive Substance Abuse Evaluation," or "Updated Comprehensive Mental Health/Substance Abuse Evaluation" which is attached to the updated evaluation. Updated evaluations must provide any new or additional information applicable to each area based upon current information provided by the youth, the parent/guardian, and the youth's records. A review of five youth mental health and substance abuse records found each youth received a new comprehensive mental health and substance abuse bio-psychosocial evaluation completed

within thirty calendar days of the youth's admission, regardless of length of time previous comprehensive assessment was completed. Each reviewed evaluation contained all required elements including a comprehensive summary of clinical impressions, applicable mental health and substance abuse treatment recommendations, and recommendations of prior assessments. If a non-licensed mental health clinical staff or non-licensed substance abuse clinical staff completes the evaluation, it shall be reviewed and signed by a licensed mental health professional or licensed qualified professional within ten calendar days of the evaluation being conducted. Each reviewed records contained a signed Youth Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records.

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 has a comprehensive plan for mental health and substance abuse services which was reviewed, approved, signed, and dated by the designated mental health clinician authority (DMHCA) and the program's psychiatrist on August 8, 2018. A review of five youth mental health and substance abuse (MHSA) records indicated the program assigned each youth to a multidisciplinary treatment team at the time of the youth admission to the program. Observation of a treatment team during the annual compliance review found the treatment team was comprised of all required parties. A review of five youth MHSA records and documentation confirmed the program provided mental health overlay services (MHOS) and clinical interventions to each youth including individual, group, and family therapy, therapeutic activities, psychiatric services, substance abuse services, and mental health crisis intervention services. Mental health treatment groups for youth with mental health diagnoses are limited to ten or fewer participants. Substance abuse treatment groups are limited to fifteen or fewer youth with substance abuse diagnoses. Psychosocial skills training and substance abuse groups were provided by master's-level therapists who are qualified and received the required training. A review of the five youth (MHSA) records revealed each youth had a properly executed Authority for Evaluation and Treatment form (AET). Each youth record reviewed also contained a Youth Consent for Substance Abuse Treatment form and a Youth Consent for Release of Substance Abuse Treatment Records form. Each youth record reviewed also contained weekly progress notes which documented in detail the types of services and clinical interventions provided by the program. Five youth interviews confirmed each youth's participation in groups and therapy sessions. Interviews completed with five staff members indicated none of the direct care staff facilitate any mental health or substance abuse groups. Four of the five interviewed youth confirmed they participate in daily groups and are receiving specialized therapies including groups related to anger management and teen relationships, monthly family therapy sessions, and life skills groups. One youth indicated they were not receiving group therapy.

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

The program maintains a written policy and procedures and a comprehensive plan for mental health and substance abuse services to address the responsibilities and required elements of mental health and substance abuse treatment services and discharge planning. A review of five active youth mental health and substance abuse (MHSA) records revealed each youth had an initial mental health and substance abuse treatment plan completed on the date of admission to the program, an individualized mental health and substance abuse treatment plan completed within thirty days of admission, and all applicable monthly reviews and treatment notes. None of the reviewed records were for youth admitted with psychotropic medications. All plans and reviews were completed timely, signed, dated, and distributed to the required parties. A review of five closed youth MHSA records found each contained a complete discharge summary which listed the services needed for daily maintenance of the positive behavioral improvements in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the youth's progress in treatment while participating in the program, relevant mental health and substance abuse history, and the reason for recommending on-going treatment. Reviewed documentation confirmed each discharge summary was discussed in the exit staffing and was provided to the youth, the assigned juvenile probation officer, and the parent/guardian, when applicable.

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

A review of the program's contract and clinical program description indicated the program is to provide mental health overlay services (MHOS) to all youth in accordance with Rule 63N-1, Florida Administrative Code. A review of case notes in five active youth mental health and substance abuse (MHSA) records confirmed the program provided MHOS to each youth at the program. MHOS services are provided by the program's licensed staff or by the non-licensed clinical therapist working under the direct supervision of the designated mental health clinician authority (DMHCA). MHOS treatment services provided by the program include mental health and substance abuse evaluation and testing, mental health treatment planning, individual, group and family therapy, therapy/counseling, daily therapeutic activities, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Interviews completed with the facility administrator, DMHCA, and staff confirmed the program specialized clinical services provision.

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

The program maintains a written policy and procedures to address the provision of psychiatric services to the applicable youth at the program. The program maintains an Independent psychiatrist agreement with a licensed, board-certified psychiatrist for the provision of weekly on-site part-time psychiatric screenings, assessment, and evaluation upon youth admission as well as psychiatric consultations and psychopharmacological treatment to all applicable youth in the program. The psychiatrist is also available for psychiatric emergency consultation twenty-four hours a day, seven days a week. A review of five youth mental health and substance abuse records (MHSA) found none of the youth entered the program while on prescribed psychotropic medication. However, all youth in the program receive an initial psychiatric diagnostic interview within fourteen days of admission. Each diagnostic interview documented the youth history, mental health status examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. All other youth admitted to the program not on prescribed psychotropic medication received psychiatric evaluations and services. Four of the five reviewed MHSA records indicated the youth were prescribed psychotropic medication subsequent to their admission and received monthly medication reviews, as required. A psychiatric list is developed by the nurse to identify youth to be evaluated and receive medication management during each visit. Each youth’s psychiatric evaluation was documented timely on the Department’s Clinical Psychotropic Progress Note (CPPN). In addition, the psychiatrist completes an Abnormal Involuntary Movement Scale form, when applicable. Reviewed documentation and an interview with the psychiatrist, confirmed the psychiatrist is on-site two hours a week and provides all the contracted psychiatric services. The psychiatrist reviews all youth MHSA records as well as medical and laboratory reports. The psychiatrist also works with the treatment team regarding the progress and treatment recommendations for each youth, and with the medical and nursing staff with regards to potential medical issues and side effects. The psychiatrist contacts parent/guardians to obtain appropriate consent when any psychotropic medication is being considered. The psychiatrist meets with the designated mental health clinician authority when on-site and is available by telephone twenty-four hours a day, seven days a week for psychiatric emergencies or consultation. The psychiatrist also consults and work with the treatment teams to develop and modify youth treatment plans, as needed. A review of the psychiatric license found it was clear and active in the State of Florida. The program does not utilize an advanced practice registered nurse. Reviewed documentation found another Florida licensed psychiatrist was appointed to cover psychiatric duties when the program psychiatrist is absent or on vacation.

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 procedures to establish a method by which suicide prevention services shall be provided to all youth. The program also maintains a written suicide prevention plan which was reviewed, approved, signed, and dated by the program's director of treatment on August 1, 2018 and reviewed by the licensed clinical social worker who serves as the designated mental health clinician authority on September 10, 2019. The plan details the program's suicide prevention procedures and precautions, and provides a systematic process for the safety assessment and protection of youth with elevated risk of suicide in the least restrictive means possible. The plan covered the identification, referral process, communication, assessment, suicide precautions, levels of supervision, procedures for use of precautionary observation, serious suicide attempt or serious self-inflicted injury review and mortality review, and training as required by the Florida Administrative Code (F.A.C.) Rule 63N-1. In addition, the program has a comprehensive plan for mental health and substance abuse services which covered suicide risk and suicide alerts. Reviewed documentation and an interview with the facility administrator , confirmed the program provides training and quarterly mock drills for each staff's shift which includes emergency response to suicide attempts or self-inflicted injury.

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 has a suicide prevention plan which includes suicide precautions, a process for every serious suicide attempt or serious self-inflicted injury, and a mortality review for a completed suicide. Five youth mental health and substance abuse records (MHSA) were reviewed for suicide prevention services and none were applicable for exhibiting risk factors requiring a suicide assessment. An interview with the program's director of treatment indicated no youth active in the program were currently applicable for exhibiting risk factors requiring a suicide assessment. All direct care staff and non-direct care staff received ongoing on-site training regarding suicide prevention, crisis intervention, and emergency care. Reviewed documentation revealed when applicable, the program utilize color coded forms for youth placed on precautionary observation (PO). A review of five youth active MHSA records and interview completed with the program's director of treatment validated the program completed one Assessment of Suicide Risk (ASR) for each youth regardless of any concerns or intake screening results. All reviewed ASRs and the Department's Juvenile Justice Information System (JJIS) alerts were completed by clinical staff. A review of the program's logbooks and completed ASRs revealed the administrative or supervisory staff provide instructions related to the ASR findings and suicide precautions decisions. An interview with the program's director of treatment

confirmed the program does not utilize secure observation (SO). Observations made during the program tour confirmed the program maintains two suicide response kits with one located in the medical office and the remaining kit is located in the program's dormitory building, number eighty-four. Examination of each kit confirmed each contained a knife-for-life, wire cutters, and needle nose pliers. Interviews with five staff revealed each are aware of the location of the suicide response kits. Five staff interviews indicated direct care staff are responsible for notifying mental health staff when a youth expresses suicidal thoughts. Staff will then search the youth and the youth's assigned sleeping room for sharp objects, place youth on constant sight and sound supervision, and document supervision. The mental health professional is notified of youth referred for an ASR during business hours both verbally and by the Mental Health/Substance Abuse Referral Summary. All staff are trained to immediately place any youth exhibiting suicidality on PO and any staff can initiate precautionary observation. Staff are further trained in the use of the Mental Health/Summary Abuse Referral Summary and the need for notification to licensed mental health staff and the facility administrator, as soon as possible.

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 suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO). Five individual youth mental health and substance abuse (MHSA) records were reviewed for suicide prevention services. One was applicable for completion of a PO log. An interview completed with the program's director of treatment revealed there were no other active youth in the program applicable to suicide prevention services. A review of the one applicable MHSA record indicated the youth was placed on PO once. A review of the related suicide precautions observation logs indicated the logs were maintained for the duration the youth was on suicide precautions. The appropriate level of supervision and observations of the youth's behavior were documented in real time at thirty-minute intervals. The were no warning signs observed, the logs were reviewed, and signed by the applicable supervisor as well as mental health staff. The safe housing areas of the program were clearly identified on each log and each log contained the signatures and dates of the applicable shift supervisors, and the mental health clinical staff.

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

The program maintains a written pre-service training plan approved by the Department's Office of Staff Development and Training and an in-service training plan approved by the Department. A review of five licensed and non-licensed mental health and substance abuse clinical staff training records found all staff received a minimum of six hours annually of suicide prevention training and implementation of suicide precautions. Two of the six hours were completed in the Department's Learning Management System (SkillPro) and four hours were completed by instructor-led training. In addition, all the program's clinical staff participate in the required quarterly mock suicide drills. Each reviewed drill documented a description of the incident, a synopsis of the response, identified deficiencies, corrective action, and staff members involved. A review of the program's mock suicide drills confirmed the drills also included contacting other

facility staff by radio, calling for medical personnel and emergency medical services (9-1-1), and the provision of life savings measures such as cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and the use of the suicide response kit according to established protocol. An interview with the facility administrator (FA) indicated drills are conducted on a monthly basis and staff are knowledgeable of the program's emergency response to suicide attempts or self-inflicted injury, and what to do in event a youth is suicidal.

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 written policy and procedures regarding mental health crisis intervention services and a written crisis intervention plan which was reviewed, approved, signed, and dated by the program's director of treatment on August 1, 2018 and reviewed by the licensed clinical social worker who serves as the designated mental health clinician authority on September 10, 2019. A review of the plan and applicable documentation confirmed the program's plan contained all required elements and detailed crisis intervention procedures including safety and security, notification and alert system, referrals, communication, supervision, documentation, and review. Youth demonstrating acute emotional distress or behavioral issues are referred immediately to the mental health clinical staff for crisis intervention, assessment, and counseling.

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 crisis intervention plan which includes crisis assessments. A review of five active youth mental health and substance abuse records indicated none were applicable for crisis assessments. An interview with the program's director of treatment and reviewed documentation found the program had two instances applicable for crisis assessments, since the last annual compliance review. Examination of the two applicable records found each included the reason for assessment, mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, parent/guardian notifications, and recommendations for follow-up. Each assessment was completed immediately and reviewed by a licensed mental health counselor (LMHC) within twenty-four hours of the referral, as required.

One youth was an alleged victim of a Prison Rape Elimination Act (PREA) event and their Substance Abuse Referral Summary was immediately submitted for crisis assessment. A review of applicable records found the program utilizes the Department's Crisis Assessment form which includes all the required elements. Both youth were determined not to pose a safety or security risk to themselves or others and both were placed on standard supervision.

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 procedures to establish a method in which emergency mental health and substance abuse services will be provided to all youth. The program also maintains an emergency mental health and substance abuse service plan. A review of the program's emergency care plan included a process for emergency identification and immediate staff response, supervision, authorization of transport for emergency services, and transportation for mental health and substance use emergencies. The plan was completed by the program's director of treatment on August 1, 2018 and reviewed by the licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA) on September 10, 2019. The program's DMHCA, the director of treatment, and the psychiatrist are available by telephone for emergency consultation twenty-four hours a day, seven days a week. A tour of the program found all program staff have the right to immediately contact 9-1-1 for emergencies. Reviewed documentation indicated the program utilizes New Horizons of the Treasure Coast in Okeechobee as the crisis stabilization unit.

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

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

Standard 4: Health Services

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

The program maintains a written policy and procedures which require 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) to serve as the designated health authority (DHA) which was signed on September 10, 2019 by the program's chief financial officer. The DO holds an unrestricted, clear and active license in the State of Florida with an expiration date of March 31, 2020. Since the last annual compliance review, the program had three DHAs to provide services. A review of the DHA's license confirmed each license was free and clear in the State of Florida. The program developed an independent contractor agreement with the DHAs. All parties signed their individual agreement except for the licensed physician (MD). The MD was hired and began working at the program on January 21, 2019 and resigned on April 22, 2019. The program hired another DHA to provide services from May through August 2019. The DHA was terminated on August 5, 2019. The program maintains a contractual agreement with a second physician appointed to provide coverage of the duties and responsibilities during the absence of the DHA. The provider's corporate medical doctor provided DHA coverage from August 5through August 28, 2019. The program has a contract with a licensed DO for coverage for scheduled absences, emergency services, and vacations. The backup DO has an active license to practice in the State of Florida which expires on March 31, 2020. The program does not utilize an advance registered nurse practitioner (ARNP), advanced practice registered nurse (APRN), 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. The DHA is scheduled to be on-site weekly for approximately two hours. Reviewed physician logs for the past six months found the DHA was not on-site for a minimum of two hours for the periods of March 4 to May 3, 2019, May 21, 2019, and September 3, 2019. Additionally, a review of the physician logs reflected more than nine days passed between on-site visits for the periods of April 22 to May 3, 2019 and August 5 to August 16, 2019. This information was presented to the program's administration team during the annual compliance review. The program's administration staff indicated the MD was not on-site for a minimum of two hours each week, is no longer with the agency as a result of the ongoing issue. Additionally, the program provided documentation to validate their attempts to obtain an MD to provide services for the period of April 22 to May 3, 2019 and August 5, 2019 to August 16, 2019. An interview with the DHA confirmed the performing of the Comprehensive Physical Assessments, chronic clinics, sick calls, follow-ups, and reviewing/signing healthcare policy 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 policy, procedures, and protocols. Reviewed documentation found two previous DHA's, the back-up osteopathic physician (DO), and current DHA signed all healthcare policy and procedures. One DHA signed on July 8, 2019 and another DHA signed on August

22, 2019. The backup DO and current DHA signed on September 9, 2019. The facility administrator (FA) signed on July 8, 2019 and the psychiatrist documented a review on July 3, 2019 and July 22, 2019. The program did not have a change in nursing staff since the last annual compliance review. However, the program does maintain a training requirement which requires newly employed healthcare personnel to complete a comprehensive clinical orientation to the Department's healthcare policy and procedures. A review of the facility operating procedures cover page documented signatures of all medical staff. The program maintains a nursing protocol manual developed and approved by the previous DHA on August 22, 2019. The current DHA signed all nursing protocols on September 16, 2019.

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

The program maintains a written policy and procedures regarding the Authorization for Evaluation 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 for minor illnesses requiring over-the-counter (OTC) medications which can be treated by healthcare staff. A review of five youth individual healthcare records (IHCRs) found one youth was eighteen years of age or older and signed a program release of information authorization form. Four youth were applicable for an AET. Each AET had a parent/guardian signature along with a witness signature. Each applicable IHCR included a copy of a completed parental notification behind the AET. All four reviewed AETs were copies with the word "COPY" stamped in red. There were no youth in the care of the Department of Children and Families (DCF) at the time of the annual compliance review. Each AET was valid until the youth's eighteenth birthday. Each reviewed record contained a completed parental notification behind each AET in the IHCR. One AET did not include the parent/guardian initials in the designated box consenting or refusing vaccinations. However, the form did include the witness and parent/guardian signatures. The program's health service administrator (HSA) reported the case manager is immediately made aware when an AET is needed. The case manager contacts the youth's juvenile probation officer (JPO) to obtain a new AET or a copy of the 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 maintains 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. Five youth individual healthcare records (IHCRs) found one youth was eighteen years of age or older. The youth's IHCR contained a Release of Information Authorization form for youth eighteen years of age or older. Five IHCRs confirmed the parent/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. There was three applicable youth IHCRs of parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET). Two youth's IHCRs had documentation to support proper consent was obtained. One youth's IHCR did not have documentation to support proper consent obtained. The youth IHCR contained a blanket consent for OTC medications. However, reviewed documentation reflected the youth had an updated parent consent form for each OTC medication prescribed since April 16, 2019. In

addition, an informal interview with the health services administrator (HSA) validated the program's new practice in comparison with the reviewed records. The program's HSA also provided meeting minutes and training records documenting the change. One reviewed youth was applicable for off-site emergency care and reviewed documentation supported the parent/guardians were notified. Reviewed documentation confirmed verbal notifications and witnessed by another staff with a written follow up was sent by mail when applicable. There were no applicable youth receiving services in the care of the Department of Children and Families (DCF). 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. When applicable parent/guardian consents were obtained, 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 five 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 vaccination consent for medical reasons nor any exemptions due to religious beliefs since the last annual compliance review. The health service administrator (HSA) reported parental consent is required before medications can be started, preferably verbal consent. Parental notification along with the CPPN's third page is mailed by certified mail for medication discontinuances or adjustments. The HSA also explained the program's process for documenting parental/guardian exemption from immunizations in its entirety.

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

The program maintains a written policy and procedures 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 change in custody. A review of five youth individual healthcare records (IHCRs) validated each youth received an admission screening utilizing the Department's FEPHS form. All admission screenings were completed by a registered nurse on the date of the youth's admission to the program. An interview with the health services administrator (HSA) confirmed the program's practice. The HSA also reported the nurse notifies the designated health authority immediately by telephone to make them aware of the youth with serious or chronic conditions and obtain consent to continue current medications if indicated. Reviewed documentation confirmed this practice.

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

The program maintains a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. A review of five youth individual healthcare records (IHCRs) 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, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. The orientation also covers what to do in case of a sexual assault and the non-disciplinary role provided by medical staff. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay which is documented in the healthcare record. Each reviewed healthcare record validated this practice.

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

The program maintains 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. Five youth individual healthcare records (IHCRs) were reviewed. Three applicable youth IHCRs reflected telephonic notification of the DHA)of the youth's admission into the program. None of the youth presented with a condition requiring an emergency response. All records reflected notification documented in the youth's chronological progress notes and/or IHCRs. 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 maintains 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 five youth individual healthcare records (IHCRs) found a new HRH form was completed within seven days of the youth's admission. Reviewed documentation supported the HRH form was completed on the day of admission. One youth had a change in physical custody and an updated HRH was completed. All five reviewed HRHs were completed by a registered nurse (RN). The nursing staff provided their electronic signature on the HRH form. A review of the CPA confirmed the designated health authority reviewed the HRH in each record. The program's health service administrator reported the program practice is for the RN to complete the HRH 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 maintains a written policy and procedures ensuring each youth shall receive or have on file a current Comprehensive Physical Assessment (CPA). A review of five youth individual healthcare records (IHCRs) 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" or an "X". All five reviewed CPAs did not complete sections numbers twenty-three, twenty-four, twenty-five, and twenty-six (pelvic and rectum examination). The DHA documented either the examination was not clinically indicated or the youth did not have a diagnostic history. None of the youth refused any portion of the examination. 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 indicated youth will not be placed into the general population until their healthcare needs 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. The health service administrator reported all youth are screened upon arrival on admission. If there is no documentation of the youth's last PPD an order is obtained to place a PPD on admission. If youth is symptomatic, the youth will be rescreened and retested if needed.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STIs). A review of five youth individual healthcare records (IHCRs) 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 IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no youth 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) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of five youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. Three youth consented to HIV testing 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 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 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. Five 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 maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. Youth are informed of the sick call process at the time of their admission to the program during orientation. The program's cottage has sick call forms located on the wall and a deposit box is located outside of the cafeteria accessible to all youth. The program's practice is to check the boxes every two hours. The program conducts sick calls Monday through Friday from 7:50 a.m. until 8:50 a.m. and 3:00 p.m. until 4:00 p.m. Additionally on Saturdays and Sundays, the program has sick call from 7:00 a.m. until 8:30 a.m. and 12:00 p.m. until 12:30 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 manage 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's date of February 28, 2020 and February 28, 2021. A review of five youth individual healthcare records (IHCRs) found three 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. An observation of one sick call encounter indicated the youth are assessed in the medical clinic by the RN. The youth provided verbal consent and initialed consent for the regional monitor to observe the sick call process. The youth was seen in a private area within the medical clinic on an exam table. The direct care staff stood by the door inside the clinic during the assessment. Five interviewed youth indicated they are allowed to see a dentist and doctor when needed and medications are

administered by the nurse. Five interviewed staff indicated nursing staff or the doctor conducts 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 maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. 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 person 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 five youth individual healthcare records (IHCRs) found three youth requiring 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/emergency care incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA) on the log. An interview with the health service administrator (HSA) confirmed this practice. The program maintains an automated external defibrillator (AED), suicide kit, and a knife-for-life located in the supply room in the hallway next to the medical office. The program maintains three first aid kits. Two are located in the medical office and one is located in building eighty-five. The first aid kits, AED, and suicide response kits are checked monthly by nursing staff to ensure they are fully stocked and do not have any issues. The AED provides audio instructions on step-by-step procedures. The HSA demonstrated the AED and validated it was in working order. The AED batteries expire in January 2023 and were last changed on December 13, 2018. The AED pads expire in December 2020. Medical was unable to provide an exact date of when the pads were last changed. Five reviewed in-service and pre-service training records supported all non-healthcare staff having direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. 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 mock 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 last twelve months supported drills were conducted monthly on each shift and included CPR/AED demonstration at least quarterly. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in main master control and the medical clinic inaccessible to youth. Five interviewed staff reported they could call 9-1-1, if needed.

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

The program maintains a written policy and procedures 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 five youth individual healthcare records found one youth requiring off-site care and/or emergency care. Two additional IHCRs were requested and reviewed. Parental notification was documented when applicable. The Summary of Off-Site Care form was completed for each youth and was filed in the healthcare record. Reviewed documentation supported the DHA reviewed each completed off-site care form and applicable discharge paperwork as evidenced by the DHA signature and date. Two youth required follow-up care and both youth were 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 an appointment calendar.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness 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 five youth individual healthcare records (IHCRs) indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening form. All three youth were classified with a medical grade of two. One youth was currently 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 chronological progress notes and treatment orders were clearly written. All three youth IHCRs documented updating of the Department's Problem List as changes occurred. 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 health service administrator (HSA) also confirmed this practice. The HSA 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 maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and indicated. Nursing staff complete the Facility Entry Physical Health Screening 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 five youth individual healthcare records (IHCRs) indicated one youth was admitted into the program on prescribed medication. The program provided one additional youth IHCR. The program reported only having one additional youth admitted into the program on prescribed medication since the last annual compliance review. 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 verbally 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. Reviewed Medication Administration Records (MARs) validated the practice. The program sends a Pharmacy Notification identifying the prescribed medications to 1st Choice Pharmacy. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. 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. Two reviewed youth IHCRs were taking prescribed medications upon admission and an additional record was requested for a sample size of three. The initial MAR for each IHCR matched the medication(s) listed. Observations found the medications are procured through 1st Choice Pharmacy. The medications are maintained in blister packs documenting the number of pills in each prescription order. 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 two registered nurses (RNs). All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated the 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. Observations conducted during the annual compliance review found nursing staff maintain a black locked tackle box mounted on the wall in the medical office with over-the counter (OTC) medications listed on the 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. An observation of one medication administration by nursing staff during the annual compliance review validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. The Six Rights of Medication Delivery/Administration was maintained for the youth. The program maintains one locked refrigerator for medications requiring refrigeration. There were no applicable medications requiring refrigeration during the annual compliance review week. A review of the Department's Central Communications Center

reports validated there were no incidents of missed medications. 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. There were no narcotics on-site during the annual compliance review week. The program had three controlled medications on-site during the annual compliance review week and observations indicated medications were stored behind two locks and inventoried, as required. Five interviewed youth indicated medications are administered by the doctor and nurse. Five interviewed staff indicated medication administration is performed by a RN.

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

The program maintains a written policy and procedures ensuring all chemical products, medicines, 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. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three over-the-counter (OTC) medications were reviewed and the inventories were accurate. Three sharps were reviewed and inventories were accurate. Three youth with prescribed psychotropic medications found the inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. All medications were securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of OTC medications were placed in a black tackle box on the wall of the clinic. There were no narcotics on-site during the annual compliance review week. Controlled medications are securely stored in the medication cart. Oral medications were not stored with injectable or topical medications. The program maintains one locked refrigerator for medications. There were no medications requiring refrigeration during the annual compliance review week. The program securely stored sharps and syringes separate from all medications. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The medications are in blister packs documenting the number of pills in each prescription order. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The program's pharmacy license is issued through the Department of Health, Division of Quality Assurance and expires on February 28, 2021. The consultant pharmacist license expires on 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 confirm all OTC medications are inventoried perpetually and weekly. Shift-to-shift inventories of controlled medications are conducted by two registered nurses. The program also maintains an agreement with Stericycle, Inc. for biomedical waste treatment with an operating permit by the State of Florida, Department of Health expiring on September 30, 2020. Medical waste is picked up on a monthly basis. An interview with the health service administrator confirmed the program's practice.

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

The program maintains a written policy and procedures ensuring there is an approved plan for infection control. The infection control plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases as outlined in the Occupational Safety and Health Administration (OSHA) Federal regulations and guidelines. The plan was reviewed and approved by the facility administrator on July 1, 2019, the previous designated health authority (DHA) on July 8, 2019, and the corporate medical doctor (MD) on August 22, 2019. The infection control procedures include all elements outlined in Florida Administrative Code (F.A.C. 63M-2.050-051). The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth, staff, or six individuals whichever number is less. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator (FA) has a process to establish a separate record containing all documents for youth and staff who have experienced a facility or occupational exposure. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the program's FA explained the program's exposure control plan and infection control plan is located in the medical office and the administration building. A review of five pre-service and five in-service training records found all staff were trained on the program's infection control plan.

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

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

Standard 5: Safety and Security

5.01 Youth Supervision	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. Youth and staff observations were conducted for four days during the annual compliance review week. The observations included youth movement from the dorm to the outdoor recreation area, from school to cafeteria, from classroom to treatment team meeting, leisure time, and from the dorm to school. 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 master control logbooks verified at least six formal youth counts were documented in the log within every twenty-four-hour period. Interviews conducted with staff revealed staff was able to describe the steps to take when there is a discrepancy in youth counts. Observations of youth-to-staff ratios were in compliance with the program's contract during the annual compliance review week. The program's head counts are maintained in the facility logbook which is maintained by the program staff in master control. The master control staff documented all youth and staff movement throughout the day in the facility logbook. Youth counts are consistently conducted during each shift and the master control staff calls for a count from each youth care worker. Observations found the program staff interactions with the youth were positive and followed the program's behavior management system. The program has a daily schedule posted in the dormitory activity area and in the cafeteria. During a random review of three days of the program's video footage, it was observed there was a lack of supervision during morning hygiene and dorm area. The program had one staff conducting morning hygiene, work detail, and supervising the youth in the dorm. Staff were observed leaving the dorm area several times to check the youth in the bathroom. An informal interview with several staff revealed their knowledge of the process for reconciling discrepancies in youth counts. Staff explained what procedures which would be implemented when youth count could not be reconciled to include performing a recount, performing an emergency count, notification to the supervisor and facility administrator, securing youth, conducting a facility 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 violation of the program rules 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 a multi-level system designed to increase desired behaviors using reinforcements and decrease unwanted behaviors through a menu of appropriate violations. The written description is provided to youth in the youth handbook at orientation to allow easy access for youth, including rules governing conduct, and positive and negative consequences for behavior. In five reviewed youth records, documentation of acknowledgement receipts was found confirming each youth received the youth handbook at orientation. The BMS is reviewed with the youth by the staff completing the orientation phase. The youth handbook included a list of behavioral infractions and rewards they can earn for positive behavior. The BMS 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 BMS for all staff. A review of five staff in-service and five staff pre-service training records found staff are being trained on the BMS. Five interviewed youth were able to explain the BMS and the kind of rewards earned with positive behavior. The youth indicated a variety of rewards are provided to them which consist of special snacks, game room, access to the gym, daily and weekly incentives, and a fieldtrip to restaurants. During the annual compliance review week, staff were observed implementing the BMS during interactions with the youth to include lunch time, leisure time, and during groups. Staff acknowledged youth's positive actions and behavior and negative behavior at a four-to-one ratio. Documentation confirmed youth and staff are surveyed quarterly by the program to ensure fairness and consistency with the BMS. Five interviewed youth reported staff give rewards and consequences correctly and on a consistent basis. According to the youth interviews, two youth rated the BMS as very good, two rated the BMS as good, and one youth rated the BMS as fair. An interview with the facility administrator indicated the program utilizes a level system through the BMS. The level system measures progress in the program overall based on positive days, work on performance plan and treatment plan goals, behavior in education, and healthy participation in all other program 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 behavior management system (BMS) is designed to maintain order and security, provide constructive discipline, and positive and negative consequences to encourage youth to meet behavior expectations. The program's BMS requires all staff to be responsible for monitoring and addressing behavior. Case managers are responsible for tracking the youth violations and utilizing the BMS when confronting the youth about their behaviors. The youth handbook informs each youth of the program's responsibility to the youth and the youth's responsibility and expectations to the program. The BMS reminds the youth of their responsibility to follow all program rules, follow staff directives, and exhibit appropriate behavior at all times. An interview with the program's facility administrator indicated the BMS reminds the youth of their responsibility to follow all rules, to provide positive reinforcement for growth and development in the program, and ensure all staff having direct contact with youth are trained. The program's BMS includes a process wherein staff explain to the youth the reason for sanctions being imposed and the youth are allowed an opportunity to explain their behavior. Observations of youth and staff interactions during the annual compliance review week revealed the exchange of open communication between youth and staff in relation to youth actions and behavior. The program does not use room restrictions for major infractions as part of the BMS. Youth length of stay is not increased subsequent to engaging in negative behavior nor are youth denied basic rights or services. Youth grievances and "Let's Talk" forms are mechanisms through which youth may voice their concern regarding the fair and consistent implementation of the BMS. All five interviewed youth stated they are not allowed to punish other youth. Five interviewed staff indicated they receive feedback from supervisors regarding the BMS system.

5.04 Ten-Minute Checks (Critical)	Failed 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 a total of fourteen cameras and all were operational during the annual compliance review week. The digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days. According to the program's policy, staff assigned to each dormitory will conduct ten-minute checks on all youth by utilizing a flashlight to ensure skin or a body part is seen to confirm the youth's presence. Additionally, the shift supervisor is required to complete a minimum of three walkthroughs for each dormitory each night. A random review of ten-minute check logs found staff documented youth checks on the program's approved ten-minute room

check form. A random review of ten-minute room check sheets compared to video footage for all three dormitories for six days and during various times was completed for “A” and “B” shifts from three camera views. During a review of ten-minute check logs and video footage for the Bengal’s dormitory, it was discovered several ten-minute checks did not occur as it was documented. The staff was observed sitting in a chair with a blanket covering their head and appeared to be sleeping. In the same dormitory, another staff documented a ten-minute check was conducted; however, video footage revealed no check was completed. There were no ten-minute checks documented or conducted during the observed time period the youth were in their beds sleeping. Additionally, the ten-minute check log sheets for August 18, 2019 were missing. In the Panther’s dormitory, video footage revealed on August 30, 2019, a ten-minute check was conducted and documented at thirty minutes interval. The next ten-minute check was not completed until forty-five minutes later; however, ten-minute check logs documented the checks were conducted at ten-minute intervals. Observed video footage discovered ten-minute checks did not occur as documented on the ten-minute check logs. The Panther’s dormitory video footage revealed a staff sitting down with a blanket in a chair. In the Jaguar’s dormitory on August 20, 2019, observed ten-minute checks conducted for two hours and twenty minutes did not occur as it was documented. There were no ten-minute checks conducted early morning while youth were in their beds sleeping. The incident was reported and accepted to the Department’s Central Communications Center (CCC). The program provided documentation in which two staff members received a written warning and two staff were terminated in reference to ten-minute checks. The program’s facility administrator stated a training will be conducted on policy and procedures regarding ten-minute checks and during shift changes while the youth are in their beds sleeping. An interview with five staff reported room checks are conducted every ten-minutes when a youth is placed in their room for sleeping reasons.

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

The program maintains a written policy and procedures for tracking counts and maintaining a census. A review of the program’s logbooks from March to September 20, 2019 revealed a daily count of youth in the program. The program has one program logbook which is administered and maintained by the master control staff. The master control staff document head counts at the beginning and ending of each shift and outdoor activities. Master control staff conducted at least six formal head counts within each twenty-four period and random informal head counts throughout each shift. All formal and informal counts in the logbook includes the time of the count, location, and number of youth accounted. Emergency counts were observed in the

logbooks and accounted for the basis of the count, time, location, and number of youth accounted. A review of the logbook indicated the documentation of daily counts, head counts, youth movements, admissions, releases, and youth temporarily away from the program. The staff highlight in yellow head counts of youth and any emergency situations. During the annual compliance review week, the review team observed head counts being called several times during the day on a two-way radio. Observations of youth counts were made and reflected prior to any youth movement, master control was contacted to inform of the number of youth being moved, and to what location. There are two tracking boards in the master control office. The first tracking board in master control documented the daily census for the program which maintains the daily totals, admissions, releases, and youth temporarily off-site/campus. The second tracking board in master control identified each youth by their photo with their name, date of birth, Department identification number (DJJID), assigned cottage, medical alert, mental health alert, and security risk alert. An interview with five staff reflected each are aware of the program's policy and procedures on adequate supervision of youth and discrepancies in youth counts as well as conducting counts during an emergency.

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

The program maintains a program logbook containing a chronological record of events, incidents, and activities. The program logbooks were reviewed from March to September 20, 2019 and revealed the logbooks were bound with no loose or missing pages and all pages were numbered. All logbook entries were brief and legible, written in ink, and included the date and time of the event. The entries consistently included the full name and the signature of the staff making the entry. All entries had consistent color-coded highlighting. Any errors were struck through with a single line and initialed by the person making the correction. The program conducts shift briefings prior to each shift with significant issues identified on the previous shift. The shift briefing information is documented in the shift reports and all staff signed the report at the end of briefing to reflect they have been briefed about its contents. The shift supervisor is assigned to maintain the report and make entries regarding chronological events for their 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 five CCC report numbers were documented in the logbook.

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

The program maintains a written policy and procedures regarding key control. The program's key policy includes procedures for assignment of the keys, usage, restrictions, inventory, tracking, and storage. The policy also includes a procedure for reconciling missing, damaged, and/or lost keys. Documentation of permanent issue keys included the chit identification of keys on the key ring, key identification number, and the names and title of the person permanent keys are issued to.. All program keys are maintained within master control and are housed within a central key cabinet which 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, master control staff is responsible for the inventory, inspection, return, and documentation of active, restricted, and emergency keys. Staff must turn in their personal keys in order to obtain the program keys prior to entering the program grounds. Staff must return the assigned keys upon completion of their shift in order to obtain their personal keys. If a staff did not have personal keys, the staff key tag is placed in the slot of the issued key. Each staff are required to sign-in and out for keys daily. Observations of key exchange confirmed the program practice. Restricted keys are maintained in a separate key box located in master control. Only medical staff has access to the restricted key box. When medical staff report to work, they enter master control, obtain their program keys, and deposit their personal keys in the medical key box. A random check of three staff keys was conducted and each had the appropriate number coded key. A review of the program's daily key logs from March to September 18, 2019, revealed the program's sign-in and sign-out for keys was consistently tracking keys and assigning keys. An informal interview with master control staff and the physical plant assistant indicated the program did not have any incidents of missing or lost keys in the last six months. An interview with five staff confirmed all staff are aware of the program key control protocols regarding lost, missing, damaged keys, and restricted keys.

5.08 Contraband Procedure	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 program's prohibited list includes personal cellular telephones, electronic devices capable of taking pictures, and/or audio/video recordings. 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 and includes a list of items considered as contraband. Youth's parent/guardians are mailed a handbook which outlines a list of items considered as contraband and the program visitation procedures. The program staff stated all searches are conducted unannounced daily. A random review of daily search reports from March to September 2019, documented the following contraband items have been found including color pencils, pens, staples, hair clippers, flat metal, water bottle, and empty hygiene bottle. Documentation of the contraband is found in the contraband binder. 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 master control logbooks and safety perimeter check inspection reports for the past six months, confirmed searches and program checks are conducted daily on each shift. An 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 procedure for conducting searches and full body visual searches to include when and how. Searches are conducted on every youth after all movements by the same gender staff member as the youth. Observations of youth searches from classroom to classroom, classroom to lunch, and common area to recreation verified compliance with youth search procedures. Youth are advised of the

search process and basis for the search. The search was conducted in a positive manner not causing stress or embarrassment to the youth. Also, searches of the youth were conducted according to the Protective Action Response (PAR) requirement. There was no scheduled transport during the week of the annual compliance review; therefore, full body visual searches of a youth were not able to be observed. Observation of incoming staff found all staff received a security check utilizing an electronic metal detector when entering the program. An interview with five staff confirmed all staff had knowledge of how and when to conduct youth searches. An interview with five youth confirmed searches occur when items are missing, after visitation, after meals, after outdoor activities, when returning from off campus, from classroom to classroom, and after work detail.

5.10 Vehicles and Maintenance	Failed 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 campus wide. Both vehicles received an annual safety inspection and required maintenance with documentation of services completed on each of the vehicles. One of the two vehicle used to transport youth was observed to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. First aid kits are maintained inside master control until the vehicles are in use and transport staff brings the designated first aid kits with staff on all transports. A check of the available transport vehicle at the program found the van was unlocked when not in use. The second vehicle was being utilized by another program during the week of the review. A random check of fourteen staff personal vehicles and one transport vehicle at the program found two personal vehicles and the program vehicle were not locked and secured when not in use. One of the two staff personal vehicles had the vehicle keys inside. An informal interview with the transport staff confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt. Five interviewed staff confirmed the program provides staff with a cellular telephone and two-way radio for use during transports in case of an emergency or if there are any issues with the vehicle while in use.

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 campus wide and one of the vans was been utilized by another program during the week of the annual compliance review. There was no scheduled transport during the week of the annual compliance review; therefore, transport was not able to be observed. An informal interview with three youth and two staff reported staff and youth were wearing seat belts, two staff conducting each transport and one of the staff is the same gender as the youth being transported and had a cellular telephone for communicating with the program during the transport. Observation of the

van used for transporting displayed a rear and side doors and the van was equipped with a safety screen separating the driver's compartment from the passenger's compartment. Review of the vehicle inspection sheet dated for the past six months, indicated the program met the Department's requirement for each vehicle used to transport youth and 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. The program administration staff provided documentation to indicate one staff received a written warning and two staff received oral warning due to unlocked and unsecured vehicles when not in use. The program maintains a driver list which includes the staff member's name and title. The list was approved by the program's FA and human resource department. All staff on the driver's list 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 five staff confirmed a cellular telephone is provided during transports and are not allowed to transport youth in their personal vehicles.

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

The program maintains a written policy and procedures regarding weekly safety and security audits. The policy meets all the requirements of Florida Administrative Code 63E-7. The program's facility administrator and unit manager 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 documents confirmed the program is conducting weekly safety and security audits for the past six months, with the exception of third week in May and first week in June 2019. An informal interview with the program's facility administrator indicated there is a clear process to correct and track all deficiencies identified during the weekly safety and security audits. 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 on 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 has a total of five different buildings which house tools and other supplies needed for maintenance and one van used by maintenance to transport and store tools. The maintenance van was found to be locked when it was observed during the review. An informal interview with the program's physical plant manager stated all tools stored in the buildings and the van are Class A tools. The tools are secured in locked cabinets inside the buildings which the physical plant staff are the only workers assigned keys to unlock the buildings. Inventory of the tools and chemicals is completed daily and weekly. Observations of the maintenance building, garage, offices, carpenter warehouse, supply warehouse, and one van used as a maintenance vehicle support the practice of daily and weekly inventories. The physical plant manager maintains a perpetual inventory of all tools and chemicals which is attached to the door of each locked cabinet containing tools and/or

chemicals in the various buildings. 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 in the cottage. Inventory of the Class B tools are maintained by the program's unit manager. The kitchen knives are locked in a shadow box in the main kitchen. These are inventoried daily by the kitchen staff. Youth are trained to use mops and brooms. A review of five staff in-service and five staff pre-service training records found staff are being trained on Class A and Class B tools. Five youth were interviewed regarding what tools they use in the program and all five youth responded mops and brooms. Five interviewed staff reported youth in the program are allowed to use mops and brooms, and scrub brushes.

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. 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 bed time. A review of three random days of video footage of early morning work detail was observed. There was one staff supervising eight youth, conducting hygiene, and early morning work detail in the dorm. The one-to-five ratio involving class B tools activities was not met. Searches were conducted prior to each youth transition to the school area. A review of five youth case management records found risk assessments were completed monthly. Documentation indicated certain youth are qualified to use Class A tools; however, the program does not allow youth to use Class A tools. Five interviewed staff reported youth are permitted to use mops, brooms, and scrub brushes. Five 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 maintains a written policy and procedures regarding outside contractors and requirements the contractor must adhere to while working on-site at the program. An interview with the physical plant assistant and the program's regional compliance manager stated the program's practice is to have all contractors receive and sign an acknowledgment of the program's contraband list and the Prison Rape Elimination Act (PREA) guidelines. Thereafter, the contractor will only sign-in and sign-out the contractors log each time a repairman enters the program grounds to perform a work project. The program's policy states all contractors while on-site, must be in direct supervision of the physical plant worker or authorized staff. A random review of five outside contractor's sign-in and sign-out logs documented the contractor workers were not consistently signing-out when exiting the program. Documentation did not support the contractor's tools were checked upon their arrival and departure from the program for the past five months. Documentation did not support the program practice of searching contractor's tools upon arrival and departure from the program. Florida Administrative Code 63E-7 indicates the program must check tools upon the worker's arrival to and exit from the program. The program administration staff stated the physical plant assistant developed a new form on September 4, 2019 on how to document the contractor's tools when entering and exiting the program. The program has identified the outside contractor's sign-in and sign-out logs problem along with the

contractor's tools were not checked upon their arrival and departure from the program prior to this annual compliance review. The program has implemented a new sign-in and sign-out log which captures contractor's tools and the program employee escorting and/or providing direct supervision. A review of the program's new contractor log process from September 4 through 11, 2019 supported the program practice. There were no reports of missing contractor tools during the annual compliance review period. The program's policy specifies the responsible person for providing approval and/or 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 May 17, 2019. 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 facility administrator (FA) and the program's regional compliance manager stated fire drills are always conducted monthly and unannounced on each shift. Documentation indicated fire drills were conducted for each shift since the last annual compliance review dated on November 2, 2018, with the exception of December 2018 and January 2019. The program's master control logbooks documented fire drills were conducted for both months. However, the program staff were unable to locate the fire drills documentation for December 2018 and January 2019. The program conducted twelve COOP drills relating to safety, evacuation, lightning in the area, disaster, and chemical spill since the last annual compliance review, with the exception of January 2019. Three of the five interviewed youth reported the program conducted fire drills every month and two new youth reported they have not participated in a fire drill. Four of the five youth reported they have been instructed on what to do in case of a fire and one new youth reported they have not. Five interviewed staff indicated they have participated in fire, escape, chemical spill, weather-related drill, medical drill, mental health drill, and bomb threat drills. An interview with the FA stated drills are completed one time a month on each shift.

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 May 17, 2019 by electronic mail. An interview with the facility administrator stated the COOP is available to all program staff and

is located in the master control office and building number eighty-five which is the administration office of the program. A review of five staff in-service and five staff pre-service training records found staff were trained on the COOP. All completed training was documented in the Department's Learning Management System (SkillPro).

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

The program maintains a written policy and procedures regarding the control of hazardous materials. These items are stored in a metal cabinet inside building thirty-two identified as flammables 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 physical plant manager maintains a list of materials and authorized staff list for access to chemicals posted on the outside door, along with a permanent log to present 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 initials of the authorized staff using each chemical. Additionally, all chemicals are inventoried one time a week by the program's physical plant worker. The storage area was well-organized, clearly marked hazardous chemicals, items were numbered by the building number followed by item number, and color-coded to easily identify them.

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 maintains a written policy and procedures which prohibits the handling of flammable, poisonous, and toxic items and materials by youth. The program's physical plant manager maintains strict control over the flammable, poisonous, toxic items, and materials stored in building thirty-two which is not accessible to the youth. The program daily cleaning schedule is set for early morning before school and late at night before bed time. Therefore, three days of random video footages were reviewed. The youth were observed mopping and sweeping the activities area inside their room and cottage. The youth were never observed holding any cleaning products. Five youth were interviewed on what type of chemicals they have handled since being at the program. Three of the five youth reported they do not use any chemicals and/or cleaning products and two reported using cleaning products, but staff sprays the chemical.

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 physical plant manager verified all supplies 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. The program maintained a disposal log to document chemical disposal as needed. The program maintains all chemical materials in building twenty-one inside a locked room. The program policy is to dispose of items in accordance with the Occupational Safety and Health Administration (OSHA) standards 29 CFR 19.10.1030. The program continues to maintain a contract with KRK Enterprises Inc. to dispose of kitchen grease accumulated from cooking on a quarterly basis. An interview with the facility administrator verified the program's practice for the disposal of flammable, poisonous, toxic items, and materials.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Failed 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 holds quarterly family days and the next family day is scheduled on December 6, 2019. Visitation is conducted on each Saturday from 1:00 p.m. to 4:00 p.m. The program provides alternative visitation days for families who are unable to come during scheduled visitation which involve the therapist and case manager. The program utilizes the alternative visitation day as a family session for the youth and the family if youth and their family come to an agreement. A review of visitation sign-in and sign-out logs documented youth visitation with family members or parent/guardian on each Saturday and on a quarterly basis. According to the program staff, youth letters are mailed twice a week Monday to Friday and youth are not limited in the number of letters they can send. However, there was no documentation for six months to indicate youth were given an opportunity to communicate with their family members by mail. There was no documentation of incoming and outgoing mail being monitored and searches of mail. A review of chronological documentation and telephone logs confirmed youth made contact with their family members or parent/guardian one time a week. Five youth interviews confirmed youth have been given the opportunity to communicate with their family members by mail, during visitation, or by telephone.

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

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

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

A review of five youth case management records was conducted in reference to a safety planning process for each youth. Reviewed documentation found the program has developed a program's safety plan form which identifies stimuli which included positive and negative effects on the youth. The program's safety plan form included an initial and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth admission to the program. However, none of the plans meet the fourteen days intake requirement during the review period due to this being implemented at the beginning of July 2019. The safety plans are jointly prepared by the youth, parent/guardian or family member, case manager, and clinical staff. The plans are reviewed and signed by all staff involved and the youth. Thereafter, the youth's safety plan will be updated every thirty-days to include signatures and date of the youth and staff. The program's safety plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences. During the annual compliance review week, the program made changes to include detailed information and incorporating recommendations from previous and current clinical assessments in all five youth's safety plans. Five youth's safety plans were reviewed. Each youth's safety plan was updated every thirty days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. The youth's safety plans were maintained in a centralized binder inside a closet in the cottage and easily accessible to all staff. An interview with five staff indicated they are not aware of the process for reviewing youth's safety plans and four did not know where the youth's safety plans were located. The program administration staff stated they will address youth safety plans with all the direct care staff. None of the five interviewed youth were able to explain if they were involved in the development of their safety plan. The program's facility administrator stated the youth's safety plans are part of the monthly formal treatment team meeting and youth are not yet familiar with their safety plan. Observations of two formal treatment teams meeting confirmed the program practice for each youth's safety plan.