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): October 6-9, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tonya Gittens, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Christina Calvert, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Patrick Morse, Office of Accountability and Program Support, Regional Supervisor (Standard 3 and 4)

Program Name: Okeechobee Intensive Halfway House
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): October 6-9, 2020

MQI Program Code: 1159
Contract Number: 10188
Number of Beds: 30
Lead Reviewer Code: 160

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.07 Treatment and Discharge Planning *	1.16 Youth Input
	1.20 Recreation and Leisure Activities
	2.18 Education Transitions Plan
	3.02 Licensed Mental Health and Substance Abuse Clinical Staff *
	3.13 Suicide Prevention Training *

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	Failed
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Failed

* 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/Guardian 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	Failed
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory
2.22	Safety Planning Process for Youth	Satisfactory

* 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 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 *	Failed
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 *	Limited
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 *	Failed
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

* 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 4: Health Services
Residential Rating Profile

Indicator Ratings

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

* 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 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicles and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Management	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 Supervision of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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

Program Overview

The Okeechobee Intensive Halfway House was a thirty bed, non-secure residential program, for males age thirteen to eighteen years old located in Okeechobee, Florida. The program was operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provided Mental Health Overlay Services (MHOS). In addition, the program fostered each youth by providing Thinking for a Change (T4C), Teen Relationships, and Impact of Crime (IOC) restorative justice programming. Additional treatment services provided included daily group therapy, monthly family and individual therapy, and recreational therapy.

Program administration was comprised of a facility administrator (FA), a unit manager, a clinical director, and a director of case management. Case management services were provided by a lead case manager, a case manager, and the transitional service manager. Mental health staff at the program included the clinical director, one full-time licensed therapist, and two master's-level therapists working under the direct supervision of the clinical director. Medical services were offered seven days a week and were provided by a full-time lead registered nurse and a part-time registered nurse. A health services administrator served this program and two additional programs co-located on the same campus under the same contract number. The program contracted with a licensed medical doctor (MD) to serve as the designated health authority (DHA) who was 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 included screening of youth for medical concerns and assisting youth with medication when the youth were prescribed medication while at the program.

Educational services were provided by TrueCore Behavioral Solutions, LLC staff. The layout of the program included 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.

At the time of the annual compliance review, the program had sixteen operational security cameras providing coverage with a thirty-day recording capacity. At the time of the annual compliance review, the program had no staff or youth present due to program closure. The program's last youth was released on August 28, 2020. Staff who were assigned to the program were transferred to other programs on the main campus under the shared contract number and/or they resigned or were terminated. Due to no staff or youth at the program during the annual compliance review, there were no staff or youth interviews conducted. The review was conducted off-site and three closed youth records as well as the program's Lauris System were used to conduct the review.

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 maintained a written policy and procedures requiring initial background screenings in compliance with the Department's Background Screening (BSU) and Clearinghouse. The program had no applicable new hires based on the program's staff roster at the time of the annual compliance review.

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 maintained a written policy and procedures to address the five-year background re-screening process. A background re-screening is required every five years, which is calculated from the staff's original date of hire with the program. All rescreenings are required to be submitted to the Department's Background Screening Unit (BSU) and Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program's human resource manager tracked the five-year anniversary of hire dates and processed the five-year re-screenings for all staff. The program had no applicable new hires based on the program's staff roster at the time of the annual compliance review.

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

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

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

The program maintained a written policy and procedures to establish an environment in which youth, staff, and others feel safe, secure, and without the threat of any form of abuse or harassment. Upon hire each staff electronically signed the Employee Code of Conduct and Handbook, which was maintained in the agency's electronic system. The program had two abuse allegations reported to the Department's Central Communications Center (CCC) and/or the Florida Abuse Hotline since the last annual compliance review. Both allegations were reported by youth and were investigated and were closed as unsubstantiated. The program's Trauma Responsive and Caring Environment (TRACE) assessment action plan was completed on April 10, 2020.

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 maintained a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice was to initiate an internal investigation regarding the complaint and remove the staff member from youth contact, when necessary. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. A review of all incidents since the last annual compliance review found two incidents which involved a complaint against staff for physical abuse. Reviewed documentation of each report found management took appropriate and immediate action by initiating an internal investigation regarding staff on each allegation of abuse. Documentation confirmed both staff

were removed from youth contact, as required. Both reviewed reports were found to be unsubstantiated for abuse.

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 maintained a policy and procedures regarding the reporting of incidents to the Department's Central Communications Center (CCC). The program was required to notify the CCC within two hours of a reportable incident or within two hours of being notified of the incident. The program had a total of thirteen CCC reports in the past six months. Five CCC reports were reviewed; all five reviewed incidents were reported within the required two-hour time frame. Two of the three incidents were shown to be logged in the program's master control logbook, three were not logged. A review of the program's internal incident reports found there were no incidents which met the requirements for being reported to CCC and were not reported.

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 maintained a written policy and procedures regarding Protective Action Response (PAR) physical intervention techniques in accordance with Florida Administrative Code. A PAR report shall be completed any time a PAR incident occurs. All PAR reports should include statements from every staff member involved and be completed by the end of the staff members workday. A PAR certified instructor or a supervisory staff should review the report along with the review from the program's facility administrator (FA) or designee within seventy-two hours of the incident. The program had a total of seven PARs in the past six months, which was lower than the last annual compliance review. There were no reported instances of excessive force since the last annual compliance review. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. A review of five PAR reports was conducted. Each report showed documentation of the report being completed by the end of the staff member's workday, with each staff involved completing a statement. All five reports contained documentation of a review by a PAR certified instructor, which was completed within seventy-two hours by all required parties. There were no reports which required calls to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth requested or made a report to the Florida Abuse Hotline. The program's PAR rate during the annual compliance review period was 5.15, which is above the statewide residential PAR rate of 2.23.

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 maintained a written policy and procedures regarding pre-service training. The program is required to ensure all newly hired employees are sufficiently prepared to meet the needs of the facility and youth in their care. The program is required to develop a written training plan for all newly hired employees which is reviewed annually, and updated as needed, and submitted to the Department for approval. The program had no applicable new hires or staff applicable for pre-service training based on the program's staff roster at the time of the annual compliance review.

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

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

The program maintained a written policy and procedures regarding the youth grievance process. The program maintained a written pre-service training plan, which indicated all staff will be trained in the program's grievance process. The program's grievance process consisted of the following phases informal, formal, and appeal phase. The program used "Let's Talk" forms before filling out a grievance, which allows youth an opportunity to first voice an objection and informally to resolve a complaint. All informal grievances must be responded to within forty-eight hours. The program maintained a binder of "Let's Talk" and grievance forms for at least twelve months. The program had a total of one grievance and fifteen "Let's Talk" forms in the past year.

A review of one grievance showed the form was filled out completely with the required signatures and responses. The reviewed grievance did not require an appeal.

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

The program maintained a written policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract confirmed the program utilized Impact of Crime (IOC) and Thinking for a Change (T4C) as the delinquency intervention programs. The program had two staff trained to facilitate both T4C and IOC, and three staff trained to facilitate IOC. A review of facilitator training records found trainings in each applicable intervention were completed, and each staff had the appropriate education and experience to facilitate. The program prescribes delinquency interventions to each youth based on identified needs. A review of sign-in sheets since the last annual compliance review showed groups were being delivered. The T4C group started on January 23, 2020 and ended April 16, 2020 with five youth, and IOC started January 23, 2020 and ended April 16, 2020, with five youth. A review of three closed youth records found three youth participated in T4C and IOC. Each youth had goals in their performance plan to address their individualized delinquency needs.

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

The program maintained a written policy and procedures to address life skills training for youth. The program provided life skills training utilizing Skillstreaming the Adolescent, and Teen Relationship Workbook, Thinking-Feeling-Behaving, and Independent Living Skills curricula as outlined in the program's contract. The social skill intervention groups specifically address communication, interpersonal relationships and interactions, anger management, and critical thinking. The program had a policy and procedures which determined how services were provided and how youth were placed in groups. A review of youth progress notes for the past six months verified youth were receiving life skills training.

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

The program maintained a written policy and procedures for the provision of restorative justice awareness. The program's contract indicated Impact of Crime (IOC) is a required service provided to all youth in the program. A review of the program training records showed there were three staff trained to facilitate IOC groups. A review of three closed youth records indicated all three youth completed the IOC group curriculum. A review of six months of IOC progress notes determined the curriculum was delivered as designed. The program completed two cycles

of IOC since the last annual compliance review. The most recent group started on April 20, 2020 and was in progress until the last youth was released from the program on August 28, 2020.

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

The program maintained a written policy and procedures outlining youth participation in gender-specific programming. A review of the provider's contract identified Young Men's Work and 24:7 Dad Fatherhood Handbook for gender-specific programming. The Young Men's Work group is a group for males ages fourteen to nineteen. The group is designed to teach young men to work together to solve problems without violence. 24:7 Dad Fatherhood is a group to help youth with parenting. A review of three closed youth records and progress notes verified youth were receiving groups. A review of staff training records confirmed groups were facilitated by trained facilitators.

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 maintained a written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. The program's last youth was released on August 28, 2020; therefore, the program did not have any alerts within JJIS or any applicable internal alerts.

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 maintained a written policy and procedures ensuring the management of all Individual Healthcare Records, mental health and substance abuse records, and case management records for each youth. The program is required to have the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department's

identification number labeled on each youth record. Each record is required to be marked "confidential" and secured in file cabinet in an assigned office not accessible to youth.
The program's last youth was released on August 28, 2020. The program's policy required the complete official youth case record to include the youth's individual management record, mental health and substance abuse record, and individual healthcare record to be sent to the youth's juvenile probation officer within five business days of a youth's release, discharge, or transfer.

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

The program maintained a written policy and procedures ensuring youth have the opportunity to provide constructive feedback. The program's policy requires a youth participate in an advisory board comprised of youth enrolled in the program, giving the youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. The program was unable to locate any documentation supporting a formal process to promote constructive input by youth.

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 had a community advisory board, which serves all of the Department's residential programs located in Okeechobee County. The advisory boards were combined due to a limited amount of people living in this rural community and the number of boards and local representatives whom participate. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator (FA) mailing a letter, thirty days in advance of the scheduled meeting to increase attendance. Reviewed documentation supported the program's community advisory board met at least quarterly. The meeting minutes were documented with an agenda and sign-in sheets. The program maintained a list of thirty-eight community advisory board members consisting of representatives from local law enforcement officials, school board officials, the judiciary community, community partners, faith-based organizations, a mentoring agency, victim advocacy representatives, business community, and parents/guardians of former residents. Reviewed documentation of the community advisory board's agendas and sign-in sheets reflected the program's community advisory board met on March 3, 2020. The program tentatively scheduled the next quarterly advisory board meeting in June 2020; however, it was cancelled due to the COVID-19 pandemic and the Department canceling all visitation according to the facility administrator (FA). The last quarterly meeting was held virtually on September 29, 2020.

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

The program maintained a written policy and procedures for ensuring the program's planning, adequate staffing, staff appreciation, and recognition. The program conducted daily morning management meetings Monday through Friday, daily shift briefings, and monthly all-staff meetings to discuss issues affecting the program's operation and to keep staff informed of

important corporate information. The program's daily morning management meetings follow a pre-set agenda and included the discussion of Protective Action Response (PAR) incidents, calls to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), grievances, youth behaviors, admissions and discharges, and any upcoming events. The program administration conducted comprehensive quarterly youth and staff surveys. The results of the surveys were discussed in detail at the corporate office and subsequently, the results were reviewed and shared with staff during the all staff monthly meetings. The program had incentives for staff which included tuition reimbursement, staff appreciation, and staff celebrations.

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

The program had a written policy and procedures ensuring the evaluation of staff performance. The program completed ninety-day performance evaluations for newly hired staff and annual evaluations for all staff completed during the fourth quarter October to December each year. A review of three staff performance evaluations was completed. Documentation showed each was completed on time. All three staff performance evaluations documented review by the program's facility administrator (FA). The evaluations rated the staff's quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff's job-specific responsibilities.

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

The program maintained a written policy and procedures ensuring the active participation in a variety of structured recreation and leisure activities. The program is required to provide a range of supervised, structured indoor and outdoor recreation activities for youth. The activities are to be based on the developmental levels and needs of the youth in the program, as well as youth input about their preference and interests in various activities. The program was unable to locate any documentation supporting youth received a variety of recreation and leisure activities since the last annual compliance review. The program's last youth was released on August 28, 2020. Staff who were assigned to the program were transferred to other programs on the main campus, under the shared contract, resigned or were terminated.

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 maintained a written policy and procedures addressing initial contact to parents/guardians and court notification upon each youth's admission. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted. Three closed case management youth records reviewed found each parent/guardian was notified by telephone and in writing of the youth's admission within twenty-four hours of arrival to the program. Each of the three reviewed records confirmed youth were provided a telephone call to the parent/guardian at the time of admission. Each record documented an admission letter and an input questionnaire was sent to the parent/guardian within forty-eight hours of each youth's admission. Each record documented a written notification was sent to the committing court within twenty-four hours of each youth's admission and a copy was sent to each assigned juvenile probation officer. None of the reviewed records documented the youth was assigned to a post-residential counselor at the time of admission.

2.02 Youth Orientation	Satisfactory Compliance
The program shall provide each youth an orientation to the program's 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 maintained a written policy and procedures addressing youth orientation. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted. Each reviewed record documented the youth was provided an orientation within twenty-four hours of admission. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet, youth handbook, and information regarding the program's daily schedule, expectations, youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers, contraband, dress code and hygiene procedures, community access, grievance procedures, emergency procedures, services provided, and assigned living units. The program's standardized orientation packet included a map of the program and designated areas which were not accessible to youth and a youth handbook. The program's handbook outlined the program's rules governing conduct and positive/negative consequences for behavior.

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 maintained a written policy and procedures which addressed obtaining written consent of youth who are eighteen years of age or older. The program's last youth completed the program on August 28, 2020. A review of six closed case management records reflected only one youth was applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. The reviewed record contained the required signed consent of the youth who turned eighteen years old while attending the program.

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 maintained a written policy and procedures addressing the classification process. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted. Each of the three reviewed records documented an admission classification completed for the purposes of assigning youth to a living/sleeping area and staff advisor. Each reviewed admission classification form was completed on the date of admission. Each reviewed classification reflected the youth was applicable for having an alert entered into the Department's Juvenile Justice Information System (JJIS). Documentation confirmed the appropriate alerts were entered for each of the youth. Each reviewed case management record indicated the youth was applicable for reassessment prior to participation in activities, work projects, consideration for an increase in privileges, or freedom of movement. Each reviewed record documented the completion of a reassessment which included review of the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. It was the program's practice to complete a reassessment each month for each youth and documentation supported this was completed in each of the three youth case management records reviewed.

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

The program maintained a written policy and procedures addressing gang identification which included notification to law enforcement. The program's last youth completed the program on August 28, 2020. A review of three closed case management records reflected no youth were

applicable for being identified as a gang member or gang associate. A review of three additional closed youth records reflected no youth were applicable. An interview with the campus-wide assistant superintendent identified each case manager served as a gang liaison.

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

The program maintained a written policy and procedures regarding gang prevention and intervention activities, which included procedures to ensure the youth had the opportunity, if they desired, to disaffiliate from a street gang. The program's last youth completed the program on August 28, 2020. A review of three closed case management records reflected no youth were applicable for being identified as a gang member or gang associate. A review of three additional closed youth records found no youth were applicable. An interview with the campus-wide assistant superintendent reported the program utilized the Gang Resistance and Drug Education (GRADE) and Gangs: 50+ Stories of Fractured Lives curricula. Each curriculum included individual lessons and a final essay.

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 maintained a written policy and procedures regarding the completion of an initial Residential Assessment for Youth (RAY) within thirty days of admission and RAY Reassessments to be completed at ninety-day intervals thereafter. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted. Each of the three reviewed records documented a RAY was completed within thirty days of admission to the program. Each RAY was completed in the Department's Juvenile Justice Information System and was used to identify criminogenic risk and protective factors and prioritized the youth's criminogenic needs. Each of the three reviewed case management records were applicable for a RAY Reassessment. Documentation supported two of the three RAY Reassessments were completed within ninety-days of the initial RAY. One RAY Reassessment was completed four days late.

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 maintained a written policy and procedures regarding the completion of the Youth Needs Assessment Summary (YNAS) upon admission. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted. Each reviewed record contained a YNAS completed within thirty days of the youth's admission to the program. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS), as required.

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 maintained a written policy and procedures addressing performance plan development. The program practice was for the treatment team, including the youth, to meet and develop the individualized performance plan (IPP), based on the findings of the initial assessment of each youth within thirty days of the youth's admission. The program's last youth completed the program on August 28, 2020.

A review of three closed case management records was conducted. Two reviewed records documented the IPP was developed within thirty days of the youth's admission and was completed two days late. Two of the three records chronological notes documented treatment team members who participated in the development of the IPP included the case management representative, youth, administration representative, living unit representative, mental health treatment staff, and education staff. One record did not have a corresponding chronological note for IPP development. Team member signatures could not be verified due to the original IPP being sent to the youth's assigned juvenile probation officer in accordance with the program's discharge policy. Each IPP was documented within the Department's Juvenile Justice Information System as required. Three youth IPPs were reviewed and each included individualized goals based on prioritization needs. All goals included specific interventions which were measurable, included youth and staff responsibilities to complete the goals, and included projected target dates for completion. Two reviewed IPPs contained a recreation goal and one did not. The record with no recreation goal on the initial IPP did contain a recreation goal on subsequent performance plan revisions. A review of three youth disposition court orders indicated two were applicable for additional court-ordered sanctions besides court fees. The additional targeted court-ordered sanctions were included in the youth's IPP as required.

All three reviewed records indicated each youth was enrolled in educational programing. Each of the three reviewed IPPs addressed the youth's top three criminogenic needs and transition activities. The program practice was to send a transmittal letter, and a copy of the IPP to the youth's committing court, juvenile probation officer (JPO), and each parent/guardian within ten working days of completion of the IPP; however, only one of the reviewed IPPs clearly documented this practice within the chronological record. Due to the original IPP and corresponding cover letters being sent to each youth's assigned JPO, mailings could not be verified.

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 maintained a written policy and procedures addressing performance plan revisions. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted and each was applicable for a revision to the individualized performance plan (IPP). Documentation supported each IPP was revised based on the Residential Assessment for Youth (RAY) reassessment results, newly acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and completing a goal. Documentation found each IPP was updated with recommendations from the treatment team. In addition, each closed youth case management record documented each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

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

The program maintained a written policy and procedures addressing performance plan summaries and transmittals. The program's last youth completed the program on August 28, 2020. A review of three closed case management records was conducted and each was applicable for requiring a performance summary. Each youth record supported the individualized performance plan (IPP) was updated every ninety days, as required. All performance summaries included the youth's overall progress on the IPP, academic status, behavior, level of readiness to change, interactions with peers and staff, the status of each goal, and significant positive or negative events. Each reviewed performance summary was signed and included comments by each youth. Each reviewed case management record contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and the parent/guardian. Each of the three closed youth case management records were reviewed for completion of a release summary. Documentation supported a release summary was completed

and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least forty-five days prior to each youth's planned release. Each of the three applicable closed case management records contained a signed PRN. There were no youth applicable for the Sexually Violent Predator Program (SVPP) or a victim notification.

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 maintained a written policy and procedures which addressed the encouragement of parent/guardian involvement in case management services. Each parent/guardian was to be contacted by telephone by the case manager upon each youth's admission to the program, and a welcome letter was mailed within forty-eight hours of admission. The program's last youth completed the program on August 28, 2020. A review of three closed case management records confirmed a welcome letter and a calendar of all treatment team meetings was mailed upon the youth's admission. The letter encouraged parent(s)/guardian(s) to participate in person or by telephone.

A review of Youth Needs Assessment Summaries, individualized performance plans, and performance summaries verified parent(s)/guardian(s) were involved in the assessment process, the development of the youth's performance plan, and progress reviews. The program hosted family days and weekly visitations; however, in compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, visitation and family days were suspended as of March 2020. The program was providing alternative measures such as allowing youth to make video calls to parents/guardians according to the campus-wide assistant superintendent.

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 maintained a written policy and procedures addressing treatment team and its members. The program's last youth completed the program on August 28, 2020. A review of three closed case management records confirmed each contained a copy of performance summaries signed by all required members of treatment team, inclusive of each youth's case manager, a representative from administration, a living unit representative, educational staff, mental health staff, the assigned juvenile probation officer. Each reviewed performance summary documented the participation of the youth's parent/guardian by telephone and/or attempted parent/guardian contact.

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 maintained a written policy and procedures regarding performance plan requirements inclusive of referencing or incorporating the youth's treatment or care plan. The program's last youth completed the program on August 28, 2020. A review of three closed case

management records reflected each had separate academic, mental health, substance abuse, and/or wellness plans which were incorporated into the individual performance plans for all three youth. The incorporated goals included the responsibility of the program staff in assisting the youth to successfully complete the goal(s). The Florida Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD) behavior support plan was not applicable for any of the three youth records reviewed.

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 maintained a written policy and procedures addressing formal and informal treatment team meetings. The program's last youth completed the program on August 28, 2020. A review of three closed case management records supported formal treatment team reviews were conducted at least once every thirty days for two of the three youth. One youth was missing formal treatment team reviews for February and June 2020. Three case management records were reviewed for informal treatment team reviews, and documentation supported informal treatment team reviews were conducted at least once within thirty-days for two of the three youth. One youth was missing an informal treatment team review for February 2020. The program utilized a performance plan review form which included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions. Documentation supported treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and Residential Assessment for Youth (RAY) Reassessment results. Reviewed documentation supported all participating staff provided relevant input on the youth and agreed on how to proceed during formal treatment teams.

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

The program maintained a written policy and procedures to address career education. The program provides instruction in career education which was supervised and supported by the Okeechobee County School District, the program's education component. The program offered Type 3 career education services. This identified career education programming type combines instruction of personal accountabilities while providing program content directly related to the prerequisites for entry into a specific occupation. This offering teaches interpersonal communication skills, decision-making skills, and behaviors which are appropriate for youth in all age groups, and ability levels. The curriculum incorporated activities which contributed to learning positive work habits which support and maintain positive employment and living standards. Youth were instructed how to create résumés, learn how to correctly fill-out an employment application, and participated in mock interviews.

A review of three closed youth case management records found each contained a sample of completed employment applications, a résumé, earned vocational certificates, and a post-release calendar of appointments. Each discharge packet contained contact information of a

Career Source Center in the community where the youth will reside post-release. Three reviewed youth records contained appropriate documentation to gain employment inclusive of a birth certificate and social security card. A State of Florida Identification card was not present in any of the reviewed records. Documentation reflected each youth was scheduled to obtain a State of Florida Identification card; however, the appointment was cancelled due to the COVID-19 pandemic. Each reviewed closed record contained documentation verifying the youth's parent/guardian, the youth's assigned juvenile probation officer (JPO), case manager, and other participating parties were aware of the youth's vocational plan and discharge plan.

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

The program's educational programming was directly supervised and managed by the Okeechobee County School District. Reviewed documentation indicated each youth was provided a minimum of 250 days of instruction during the calendar year, with a minimum of twenty-five hours of instruction weekly. A review of the program's daily academic schedule reflected the hours of instruction were from 8:00 a.m. to 2:37 p.m. with a thirty-minute lunch and a fifty-minute teacher planning period Monday through Friday. Additionally, ten days were incorporated into the annual education calendar to provide for teacher planning and professional development. A review of three closed youth case management records supported educational staff attend and/or submit written input during formal treatment team meetings, transition conferences, and the exit conference for each youth.

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

The program maintained a policy and procedures regarding educational transition plans. The program shall complete an educational transition plan for each youth which included provisions for either continuation of education or employment after release. Three closed youth case management records were reviewed, and two contained a completed educational transition plan. The two reviewed plans were based upon each youth's specific individualized post-release goals which were created and integrated into the individualized performance plan (IPP) upon admission and revised during the youth's stay at the program. Two of three records contained evidence of services and interventions based upon the youth's assessed education needs. Documentation supported all required parties involved in the youth's transition provided input into the completed IPP and the creation of the Department's Electronic Educational Exit Plan. Documented participants included the youth, the youth's parent/guardian, the youth's assigned juvenile probation officer (JPO), a representative of the program's instructional team, a representative from the post-release school district, and a representative from the program's treatment team. One of the three reviewed closed youth case management records included school transcripts indicating the youth was receiving special education services and on track for a standard diploma; however, the youth's IPP and subsequent revisions indicated the youth was not receiving special education services and was seeking to obtain a General Education Diploma. A review of the Department's Juvenile Justice Information System (JJIS) reflected an Electronic Educational Exit Plan was not created for the youth. The youth was admitted to the program on October 29, 2019 and discharged on August 2, 2020. The program was unable to

provide any documentation to support an individual education transition plan and/or the required elements were initiated upon admission and moving through commitment to post release for the reviewed record.

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 maintained a policy and procedures regarding transition planning conferences and Community Re-Entry Team (CRT) meetings. Three closed youth case management records were reviewed. Reviewed documentation validated each transition conference was conducted at least sixty days prior to the youth's release date. Reviewed documentation supported the youth, case manager (who acted as the treatment team leader), the facility administrator or designee, educational staff, mental health staff, and medical staff participated in person, and the youth's parent/guardian, and assigned juvenile probation officer (JPO) participated by telephone. The transition activities and target dates were reviewed, and all required signatures were obtained. A copy of the transition plan and conference was electronically sent to the JPO for all three youth and each closed record contained an electronically signed copy of the form. A chronological note reflected a copy of the transition plan and conference documentation were mailed to each parent/guardian for each youth. Documentation supported each transition conference included a discussion of all transition activities including persons responsible for completing the activities and targeted completion dates. Each of the three reviewed closed records contained documentation supporting a CRT meeting was conducted and documented the youth and case manager's participation in the CRT meetings.

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

The program maintained a policy and procedures regarding the assembly of an exit portfolio for each youth to assist the youth upon release back into the community. A review of three closed case management records found the exit portfolios were discussed and signed by each youth during the transition conferences. Each youth's exit portfolio included a copy of the transition plan, calendar with dates, times, and locations of follow-up appointments in the community, social security card, birth certificate, vocational certificates, school transcripts, résumé, and a sample job application. No closed records contained a State of Florida Identification card. Documentation reflected each youth was scheduled to obtain a State of Florida Identification

card; however, the appointment was cancelled due to the COVID-19 pandemic. No reviewed exit portfolios contained the Department's Electronic Educational Exit Plan; however, the plan was available in the Department's Juvenile Justice Information System for two of the records. Reviewed documentation confirmed case management staff sent a copy of the exit portfolio to the juvenile probation officer for all three youth in addition to providing a copy to the youth upon release. Youth were provided with completed forms and clear instructions on how to obtain relevant information, when applicable. All responsible staff were identified during the transition conference to assist the youth in obtaining the required information to successfully complete their goals.

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

The program maintained a written policy and procedures regarding the completion of the exit conference at least fourteen days prior to each youth's release. A review of three closed case management records found each exit conference was conducted at least fourteen days prior to the youth's release. Reviewed documentation supported the youth, case manager (who acted as the treatment team leader), the facility administrator or designee, educational staff, mental health staff, and medical staff participated in person, and the parent/guardian and the assigned juvenile probation officer (JPO) participated by telephone. Each exit plan documented the review of transition activities and target dates, and all required signatures. Chronological notes supported a copy of the exit conference was mailed to each parent/guardian; however, none were returned with a signature. Additionally, a copy of the exit conference was electronically sent to the JPO for all three youth and each closed record contained an electronically signed copy of the form. The date of admission and release validated the dates entered in the Department's Juvenile Justice Information System for each reviewed record.

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

The program maintained a written policy and procedures addressing the safety planning process for youth. The program's last youth completed the program on August 28, 2020. The program does not retain copies of youth safety plans within the closed youth case management record. The program practice was to maintain safety planning documentation within the mental health and substance abuse record which is returned to the Department, in accordance with program's policy. An interview with the campus-wide assistant superintendent reported safety plans were maintained within the mental health/substance abuse record as well as maintained in a centralized binder located within the facility administrator's office. The assistant campus-wide superintendent reported the program's practice was to update and review safety plans during the program's monthly formal treatment team meetings.

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 had a full-time State of Florida licensed clinical social worker (LCSW) who serves as the designated mental health clinician authority (DMHCA) and as the clinical director. The DMHCA was supervised by the campus-wide director of treatment services. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA was scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:00 p.m. The program did not maintain a sign-in log for the DMHCA since they are a full-time staff. The program's contract outlines the position requirements of the DMHCA to be accountable for ensuring appropriate coordination, implementation and oversight of mental health and substance abuse services in the program.

The DMHCA supervised three non-licensed master's-level therapists; however, at the time of the annual compliance review, all three therapist positions were transferred to Okeechobee Youth Development Center. In addition, the DMHCA supervised one recreational therapist; however, the individual was terminated for not showing up to work for two weeks. The DMHCA was responsible for providing weekly face-to-face clinical supervision to the program's non-licensed therapists. The DMHCA did not show up to work from August 17-20, 2020 and the individual was terminated on August 20, 2020. The DMHCA served as the mental health and substance abuse authority and was responsible for ensuring compliance with the Mental Health Overlay Services (MHOS), behavior modification, cognitive behavioral therapy, individual and group services, assessments, and diagnostic services. The DMHCA role is responsible for ensuring youth receive evidenced-based group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required primary Standardized Program Evaluation Protocol (SPEP) services, and supplemental specialty services addressing each youth's unique clinical needs. The DMHCA position requires the availability for consultation twenty-four hours a day, seven days a week. Since the program's DMHCA position was vacant as of August 20, 2020, the campus-wide director of treatment services stepped in as the interim until the last youth left the program on August 28, 2020.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Failed 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 is contracted to have one full-time designated mental health clinician authority (DMHCA) who serves as the clinical director. The program maintained an agreement for professional services with a State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist who is scheduled to be on-site weekly. A review of the license reflected the psychiatrist's license was clear and active in the State of Florida with an expiration date of January 31, 2021. The psychiatrist and DMHCA are on-call for emergencies and consultation twenty-four hours a day, seven days a week. The program maintained an independent contractor agreement with a State of Florida licensed psychologist to provide services and be on-site weekly. A review of the license reflected the psychologist's license was clear and active in the State of Florida with an expiration date of May 31, 2022.

Reviewed documentation supported the psychologist is required to complete assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the director of treatment services. The psychologist is required to meet weekly with the DMHCA to discuss youth tested and the results, participate in weekly group supervision to provide input into case reviews and/or provide training, provide guidance on treatment planning needs for youth who have been tested to have borderline or low IQ, and be available for consultation on youth who may be experiencing a crisis-related situation. The program administration indicated the psychologist has not been on-site or provided services since the signing of the independent contractor agreement on September 30, 2018. According to the program's contract, the psychologist is on-site on an as needed basis.

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

The program's contract required three master's-level non-licensed therapists; however, at the time of the annual compliance review, the program was no longer serving youth as the last youth left on August 28, 2020 and the three non-licensed therapists transferred to Okeechobee Youth Development Center. The program has a contracted board-certified behavior analyst (CBA). The program utilized a part-time CBA providing services to youth in the program and is on-site on Mondays and Wednesdays each week. Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The program's therapists provide mental health and substance abuse treatment under the direct supervision of designated mental health clinician authority (DMHCA). The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was

active and expires April 7, 2021. The program's DMHCA position is responsible for providing clinical supervision to the non-licensed clinical staff. Weekly supervision was not available for review at the time of the annual compliance review.

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.	

Mental health and substance abuse treatment was provided on-site through the provision of Mental Health Overlay Services (MHOS). The program ensured each youth's mental health and substance abuse needs are identified through a comprehensive screening process. Upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team staff to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. As a key component of the initial intake process, following the completion of the Facility Entry Physical Health Screening form conducted by nursing staff, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) is administered by a trained staff member in the Department's Juvenile Justice Information System (JJIS).

A review of three mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for all three youth. Each reviewed MAYSI-2 reflected the screening was completed in full in the Department's JJIS. All three MAYSI-2 assessments resulted in the youth requiring a referral for further evaluation; however, the program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results. Therefore, no additional referrals were generated during the intake process. There were two youth who had an elevated suicide risk based on the MAYSI-2 and the Department's Assessment of Suicide Risk (ASR) was completed. The ASR results indicated both youth were not at risk for suicide and were placed on standard supervision. Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an ASR regardless of MAYSI-2 screening results.

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 maintained a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlined the process by which all youth, regardless of identified needs, are referred for the completion of a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. The program's licensed clinical staff is responsible for reviewing each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and indicating a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review.

A review of three mental health and substance abuse records supported the practice. Reviewed practice supported the program assessed each youth utilizing the Department's Screening for

Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Trauma Symptom Children's Checklist (TSCC), Reynolds Adolescent Depression Scale, Second Edition (RADS-2), and the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2). All three reviewed Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluations were completed within thirty days of admission by the licensed mental health counselor (LMHC).

Each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, recommendations, and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2021.

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 maintained a written policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. Each youth's mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. Each assigned primary therapist develops the youth's individualized treatment plan based on identified needs, and treatment is provided by staff trained to perform the services provided. A review of three closed youth records documented each youth was assigned to a treatment team upon arrival to the program.

A review of the Department's Juvenile Justice Information System (JJIS) Electronic Commitment Package validated each youth had a properly executed Authority for Evaluation and Treatment form. A review of weekly progress notes for each youth documented participation in group therapy, individual therapy, and family therapy sessions. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021. Reviewed progress notes supported the licensed staff and the non-licensed staff were providing substance abuse groups.

3.07 Treatment and Discharge Planning (Critical)	Limited 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.*	

All mental health and substance abuse (MHSA) treatment services are provided through the provision of Mental Health Overlay Services (MHOS). Treatment services conducted at the program were provided by or under the direct supervision of the licensed clinical social worker (LCSW) who served as the program's designated mental health clinician authority (DMHCA). The DMHCA did not show up to work from August 17-20, 2020 and the individual was terminated. Since the program's DMHCA position was vacant as of August 20, 2020, the campus-wide director of treatment services, who is a licensed mental health counselor (LMHC), stepped in as the interim until the last youth left the program on August 28, 2020.

A review of three initial treatment plans found each was documented on the Department's Initial Mental Health/Substance Abuse (MHSA) Treatment Plan form documenting development on the day of admission. Each reviewed initial plan included signatures of the treatment team members; however, two were missing the living unit representative. The program concurred with the identified exceptions. All three reviewed plans were developed by the LMHC. Two of the three reviewed youth initial plans were applicable for the youth being admitted on prescribed psychotropic medication and the initial plan included the youth's psychiatric needs. All three reviewed youth mental health and substance abuse records contained a completed Individualized Mental Health and Substance Abuse Treatment Plan. All three individualized plans were developed within thirty days of each youth's admission. Each completed individualized plan was documented on the program's form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy.

Two of the three reviewed plans were signed by the treatment team members with the exception of the parent/guardian. One plan was missing the case manager, living unit representative, program director, education, and parent/guardian signatures. The program concurred with the exceptions noted. Two applicable plan included provisions for psychiatric services. Each plan documented prescribed services to include individual therapy one time each month, group therapy one time daily, and family therapy one time each month for two youth and seven times a month for one youth. Reviewed weekly progress notes validated each youth received the prescribed services as outlined on the individualized plan. Treatment plan review documentation was not available for review.

Three closed records were reviewed for the completion of a mental health and substance abuse discharge summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth being released on suicide precautions. Each reviewed discharge summary documented

services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail.

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 provided on-site mental health and substance abuse (MHSA) services through the provision of Mental Health Overlay Services (MHOS). Youth with co-occurring substance abuse disorders receive both mental health and substance abuse services. Treatment services is guided by an individualized mental health and substance abuse treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment was provided by the licensed clinical social worker (LCSW) who served as the program's designated mental health clinician authority (DMHCA) or provided by one of the four non-licensed therapists working under the direct supervision of the DMHCA.

When the LCSW as terminated on August 20, 2020, the campus-wide director of clinical services served as the DMHCA until the last youth was discharged from the program on August 28, 2020. Each youth is assessed upon admission utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). A review of youth progress notes supported each youth received individual therapy at least one time bi-weekly, group therapy seven days a week, and family therapy was conducted or attempted to conduct at least one time each month. The program's contract outlines MHOS services provided include 24:7 Fathering Handbook, Young Men's Work, Thinking, Feeling, Behaving MHOS Group, Teen Relationship Workbook, The Passport Program, Skillstreaming the Adolescent, Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Living in Balance, and Towards No Drugs. Reviewed progress notes for each youth supported the program conducted all required groups with the exception of 24:7 Fathering Handbook, The Passport Program, and Towards No Drugs. The program reported there were no applicable youth in the last twelve months requiring 24:7 Fathering Handbook. The Passport Program was last concluded on November 30, 2019 and Toward No Drugs was last concluded on November 24, 2019.

The program's contract required the utilization of a certified behavior analyst (CBA). The program utilized a contracted part-time board-certified behavior analyst (CBA). Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The youth are referred through program staff and the schoolteachers. According to the program, the CBA provided services to one applicable youth in June 2020.

The program's contract requires the program to have a licensed psychologist available to provide services, as needed. The program maintained an independent contractor agreement

with a State of Florida licensed psychologist to provide services and be on-site weekly. A review of the license reflected the psychologist's license was free and clear in the State of Florida with an expiration date of May 31, 2022. Reviewed agreement supported the psychologist is required to complete assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the director of treatment services. The psychologist is required to meet weekly with the DMHCA to discuss youth tested and their results, participate in weekly group supervision to provide input into case reviews and/or provide training, provide guidance on treatment planning needs for youth who have been tested to have borderline or low IQ, and be available for consultation on youth who may be experiencing a crisis-related situation. The program indicated the contracted psychologist has not been on-site or provided services for the last twelve months.

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 maintained a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's procedures outlined the role of a contracted psychiatrist for the management and oversight of psychiatric care. The program's psychiatrist supervises the treatment team and provides psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical and psychiatric follow-up visits are conducted on an individualized basis. The program maintained an independent contractor agreement with a State of Florida, licensed psychiatrist, board certified in psychiatry, as well as child and adolescent psychiatry, to provide services to the youth at the program. A review of the license showed the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program did not utilize an advanced registered nurse practitioner (ARNP).

A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. Reviewed documentation supported the program maintained an independent contractor agreement with an additional psychiatrist to serve as back-up in the event the primary psychiatrist is not able to be on-site or is on scheduled leave. The program's policy and practice are to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission. A review of three mental health and substance abuse records indicated one youth was admitted on prescribed psychotropic medications. However, program's practice is to complete a psychiatric initial diagnostic interview completed within seven days of admission on all youth. Subsequent to admission, the other two youth were prescribed psychotropic medications.

Each diagnostic interview documented youth history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. Each reviewed record documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN. All three

applicable youth were assessed by the psychiatrist at least every thirty days. The review was documented on the program's Medication Management form and page three of the Department's CPPN was attached to each form completed in full. There were no documented lapses in psychiatrist services for the records reviewed. Reviewed documentation and interview with the assistant facility administrator supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications.

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

The program maintained a written suicide prevention plan. The suicide prevention plan was last updated and approved by the campus-wide director of treatment services on August 20, 2020. The plan outlined the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process.

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

The program maintained a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. The program's suicide prevention plan outlines an established review process for every suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

The program maintained two suicide response kits with one located in the medical office and the other kit located in the dormitory. Staff interviews indicated each kit contains a knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct the Department's Assessment of Suicide Risk (ASR) on each during the admission screening process. A review of three ASRs found each youth was screened upon admission utilizing the Department's ASR form. Two of the three reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. One youth was placed on precautionary observation (PO) and a Follow-Up ASR was completed twice before the youth was determined to be eligible for stepdown to close supervision, and then subsequently on standard supervision.

A review of the applicable ASRs found the forms were completed by the licensed mental health counselor (LMHC). The transition to a lower supervision level documented a discussion between the LMHC and the facility administrator. In addition, there was telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. A review of the Department's Juvenile Justice Information System (JJIS) documented an alert was initiated and removed as required for the applicable youth. A review of the program's shift reports and logbooks documented clear updates regarding youth on PO status. Reviewed of the program's policy and procedures and an interview with the AFA indicated the program did not utilize secure observation. The program utilized New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Raulerson Hospital in Okeechobee, Florida for Marchman Act.

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 indicated the completed Suicide Precaution Observation Logs were sent to the assigned juvenile probation officer with the original healthcare record and did not maintain copies.

3.13 Suicide Prevention Training (Critical)	**Failed 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 maintained a written policy and procedures outlining staff training in suicide prevention. The policy outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, in addition to participation in mock suicide and emergency drills. A review of three staff in-service training records supported each staff received a minimum of six hours annual training on suicide prevention and implementation of suicide precautions. Each staff received two hours of training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training.

A review of the program's staff roster indicated twelve staff remained in the program as of August 28, 2020 when the last youth left the program and there were twenty-two vacant positions. The program indicated they did not maintain copies of the mental health mock suicide drills; therefore, staff participation in drills could not be determined for the last twelve months. A review of the mock emergency medical drills conducted in the last twelve months supported they were conducted on each shift at least quarterly and included the demonstration of cardiopulmonary resuscitation (CPR) and least one time annually.

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 maintained a written crisis intervention plan. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process. The program maintained a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The program maintained a written crisis intervention plan. The plan was reviewed, approved, signed, and dated by the campus-wide director of treatment services on August 11, 2020. The program's crisis intervention plan included a process for notification and alert system, means of referral, communication, supervision, documentation, and review ensuring the safety and security of youth and staff.

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 maintained a written crisis intervention plan, which included provisions for the completion of Crisis Assessments. The program indicated there were no applicable youth requiring a Crisis Assessment in the last twelve months.

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 maintained a written emergency mental health and substance use services plan, which was last revised and approved by the campus-wide director of treatment services on August 20, 2020. The plan included procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act to New Horizons of the

Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilized the emergency services through Raulerson Medical Center in Okeechobee, Florida for substance abuse Marchman Act. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. The program indicated there were no youth applicable for emergency mental health and/or substance abuse services in the last twelve months.

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

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

Standard 4: Health Services

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

The program had an independent contract with a State of Florida board-certified licensed osteopathic physician (DO) who has a specialty training in family practice to serve as the designated health authority (DHA). The DHA holds an unrestricted clear and active license with an expiration date of March 31, 2022. The DHA is contracted to be on-site at a minimum of two hours weekly with no more than nine days passed between site visits. The program had a contract with a licensed medical doctor (MD) for coverage in place for scheduled absences, emergency services, and vacations. The backup MD has a clear and active license to practice in the State of Florida with an expiring on January 31, 2021. The program did not utilize an advanced practice registered nurse (APRN) or physician's assistant. The DHA was available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The DHA was responsible for completing comprehensive physical assessments (CPA) on all newly admitted youth within seven days of each youth's admission, assessment and renewal of medication for chronic conditions and health complaints which need to be address by a physician. The DHA reviews labs, progress notes, acute complaints, referrals to specialists as needed, review of all specialty visits and recommendations, and reviewing and signing healthcare policies and procedures and nursing protocols.

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

The program had a written policy and procedures for all health-related procedures and protocols utilized at the program. The program's designated health authority (DHA) conducted an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA and FA conducted an annual review of the healthcare policies, procedures, and protocols on June 16, 2020 and June 17, 2020. The program maintained an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2021. The psychiatrist signed the healthcare polices on June 22, 2020.

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 had a written policy and procedures regarding the Authority for Evaluation and Treatment (AET) for all youth admitted into the program. The Department's Juvenile Justice Information System (JJIS) Electronic Commitment Record and three copies youth AETs supplied by the program verified each youth had a current AET. The program utilized a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. No reviewed

documentation or practice was applicable for a court order filing in the record due to the youth being in the care of the Florida Department of Children and Families.

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 had a written policy and procedures ensuring the parent/guardian was informed of significant changes in the youth's condition and obtains consent of new medications or treatment prescribed. A review of documentation provided by the program supported the program completed the Department's Parental Notification of Health-Related Care: General form to notify the youth's parent/guardian of significant changes in care, new medications, discontinuation of medication, and assessments from the designated health authority and/or psychiatrist. In addition, Nursing Chronological/Nursing Progress Notes validated the practice. No youth was applicable for vaccinations/immunizations.

Two youth were applicable for significant changes to existing medication and discontinuation of prescribed medication. Reviewed documentation supported each youth's parent/guardian was notified when the youth were tested for COVID-19. One youth required off-site X-ray for back pain and shoulder pain and parent/guardian notification was made by telephone and, subsequently, in writing. Two applicable records contained documentation of the program obtaining consent prior to administering psychotropic medications. Telephone consent conducted by the psychiatrist and witnessed by the nurse was documented when applicable. The parent/guardian 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.

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 had a written policy and procedures in place ensuring every youth receives a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. The program provided copies of the healthcare admission screening for three youth. Reviewed documentation supported an admission screening was conducted on the day of admission by the registered nursing staff utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. There were no applicable youth who had a change in custody and required a new FEPHS re-screening completed by the registered nurse upon the youth's return to the program.

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 had a written policy and procedures to ensure all youth are oriented on the general process of healthcare delivery services at the program. The programs practice was to have the nurse or a medical staff knowledgeable with the healthcare delivery system provide healthcare

orientation upon each youth's admission. Reviewed documentation of orientation for three youth demonstrated each youth received a healthcare services orientation on the day of admission. Reviewed documentation supported the healthcare topics included access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempted sexual assault, non-disciplinary role of healthcare staff, a review of healthcare contacts, and the role of the healthcare providers. All orientation was documented on the Department's Health Education Record form. The program provided signed and dated copies of healthcare services orientation indicating the youth and the registered nursing staff discussed the required healthcare topics.

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 had a written policy and procedures to ensure the designated health authority (DHA) is notified when youth admitted to the program requires emergency care or routine notification. The program's practice was to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. The DHA is notified by telephone, text message, or verbally, if on-site, of all admissions. The program provided three copies of the notification to the DHA documented on the DHA Notification of Admission form. All three reviewed forms reflected telephonic notification to the DHA of the youth's admission and current allergies, medications, and applicable chronic condition(s).

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 had a written policy and procedures ensuring each youth admitted shall receive or shall have a completed Health-Related History (HRH) prior to the completion of the Comprehensive Physical Assessment (CPA) and prior to any participation in sports, exercise, or any other strenuous activity. The program provided copies of three youth HRH forms completed by a registered nurse (RN) on the day of admission for each youth. The nursing staff provided their electronic signature on the HRH form. Documentation further reflected the designated health authority (DHA) reviewed the HRH for each of the three youth. All three HRHs were completed prior to the CPA.

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 had a written policy and procedures ensuring each youth admitted shall receive and/or shall have on record a current Comprehensive Physical Assessment (CPA) and Health-Related History (HRH) no later than seven calendar days of admission into the program. The program provided copies of the completed CPA for three youth for review. All CPAs were completed by the DHA within seven days of the youth's admission. All sections of the CPA were completed in full utilizing "O" with no applicable "X" markings. The youth did not refuse any portion of the examination. Each reviewed CPA documented the last tuberculosis skin test (TST) on the CPA and each was conducted within the last year to determine exposure to

tuberculosis (TB). As part of the admission healthcare screening, nursing staff utilized 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 all three youth. Reviewed documentation found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form.

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

The program had a written policy and procedures in place ensuring all youth entering the program are clinically screened, evaluated, and treated (if necessary) for sexually transmitted infections (STI) and human immunodeficiency virus (HIV). The designated health authority (DHA) shall then decide, based on the screening tool and medical evaluation, to order testing for STIs. The program provided copies of the Department's Sexually Transmitted Infections Screening Form for three youth for review. One of the three youth were identified as sexually active and was clinically screened and evaluated for STIs. The applicable youth was then referred to the designated health authority for further evaluation. Since the original healthcare record was returned to the Department, there was no testing documentation available for review. According to the program, there were no applicable youth who had been out of the Department's physical custody and/or exhibited symptoms who required a rescreening. The program had a written policy and procedures ensuring all youth at risk for HIV infection are offered counseling, testing, referral for medical treatment as indicated, education, and prevention counseling. The program utilized a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. The program provided three youth's Health Education Record supported two of the three youth received HIV pre-test and post-test counseling conducted by the DHA during their stay. The other youth did not consent to a HIV test.

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

The program has a written policy and procedures regarding Sick Call requests. There are approved treatment protocols appropriate to the level of the provider conducting sick call. Sick Call care was provided by licensed medical staff, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). Youth are informed of the Sick Call process at the time of their admission to the program during orientation. The program's practice was to have youth complete a Sick Call Request utilizing the Sick Call Request form and submitting them in the wall-mounted locked boxes located in designated areas in the program. The program's practice was to check the boxes randomly throughout the day. Sick Call was provided Monday through Friday from 7:00 a.m. to 7:30 a.m. and 5:30 p.m. to 6:00 p.m. Saturday and Sunday's Sick Call was scheduled from 7:30 a.m. to 8:30 a.m. and 12:00 p.m. to 12:50 p.m. The program provides a Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site. While

conducting an on-site tour of the program the sick call hours were observed posted throughout the program. The DHA was on-call seven days a week, twenty-four hours a day for consultation. The program provides a Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site.

The program maintained 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 expirations date of February 28, 2022 and February 28, 2021, respectively. Emergency dental care services shall be provided by the contracted/licensed dentist and/or the youth will be transported to the emergency room. The program provided supporting documentation to validate two of the three youth records submitted a Sick Call Request at least one time during their stay. Reviewed documentation found 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. Reviewed Sick Call Request forms and the Sick Call Referral Log supported the practice.

There was one applicable youth who presented a similar sick call complaint three or more times within a two-week period for back and shoulder pain and was assessed and evaluated by the DHA and received off-site care and follow-up care for the complaint. Due to the program not having any youth at the time of the annual compliance review, no observations of a sick call encounter could be observed. The program did not utilize restricted housing. When a licensed healthcare staff was not on-site, all Sick Call Request forms are turned into the on-duty supervisor for review. The on-duty supervisor was 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 are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions.

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 maintained 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, in response to unexpected illnesses, accidents, or conditions requiring immediate attention or an immediate professional assessment to determine the severity. Episodic care was provided by the nurse and documented in the progress chronological notes and tracked on the Episodic Care Log. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if off-site care is needed. 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 documents the follow-up evaluation on a nursing chronological note.

The program provided the Episodic First Aid/Emergency Care Log for review. Three youth episodic encounters were reviewed and found 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. The program maintained three first aid kits located with two in the medical clinic and one in the school/cafeteria building.

The program had one AED located in the medical clinic which provides audio instructions on step-by-step instructions and procedures. The program had access to the AEDs located in the gymnasium, maintenance building, and in the administration building. The batteries for the AED in the medical clinic expire in April 2021 and were last changed in April 2017. The AED pads expire on December 31, 2021 and according to review documentation, the date the pads were last changed could not be determine. The batteries for the AED in the gymnasium expire in April 2021 and were last changed on April 13, 2020. The AED pads expire in October 2021 and were last changed April 13, 2020. The batteries for the AED in the maintenance building expire in March 2021 and were last changed on April 13, 2020. The AED pads expire on December 31, 2021 and were last changed in October 2020. The batteries for the AED located in the administration building batteries expire in April 2021 and were last changed in April 2017. The AED pads expire on December 31, 2021 and according to review documentation, the date the pads were last changed could not be determine.

A review of the mock emergency medical drills conducted in the last twelve months supported they were conducted on each shift at least quarterly and included the demonstration of cardiopulmonary resuscitation (CPR) and least one time annually. A review of three staff training records supported each maintained a current certification in first aid and CPR. Training records supported supervisory staff were trained in assisting youth in self-administration of the epinephrine auto-injector. The registered nurses each maintained current certifications in CPR/AED and basic first aid.

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 had a written policy and procedures for the provisions of off-site emergency and non-emergency referrals for medical care and treatment. 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. 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. The program provided four examples of one youth requiring off-site care for an injured back and shoulder during their stay. Reviewed documentation supported the parent/guardian was notified as required. The Department's Summary of Off-Site Care form was completed for each off-site appointment. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care form and discharge paperwork as evidenced by signature and date. The applicable youth required follow-up care and there was evidence the referrals were tracked, and the youth received the appropriate care as needed.

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 had 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. The program provided documentation to support two youth were identified with a chronic condition and/or required period evaluations due to being prescribed on-going medications as documented on the Facility Entry Physical Health Screening form. Each of the youth were classified with a medical grade of five and were taking prescribed medication on an ongoing basis. 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. The reviewed youth sample and three additional closed records supported there were no youth taking anti-TB medication.

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 had a written policy and procedures which outlines the process of how medications are to be received, stored, inventoried, and administered in a safe and effective manner. 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 (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) form serves as the authority to continue the present medication(s) and administer the medication(s) as ordered.

The program provided supporting documentation for review of medication management. The reviewed three FEPHS forms supported two youth were admitted on prescribed psychotropic medications. A review of nursing Chronological/Notification Progress Note confirmed the designated health authority (DHA) and the psychiatrist were notified by telephone of the youth's admission providing a history, obtaining admission orders, and to continue the prescribed medications. In addition, the registered nurse (RN) completed the DHA Notification of Admission form documenting current medications, applicable chronic conditions, allergies, and medical grade. The program stopped providing on-site services to youth as of August 28, 2020 when the last youth was released and according to their policy and procedures, the youth's healthcare record was returned to the Department's assigned juvenile probation officer within five days of the youth's release. The program did not maintain copies of the Medication Administration Records (MAR). The program was able to provide supporting documentation in their Lauris System to validate both applicable youth received on-going care and received their medications. When the youth refused their medication, the program completed a Refusal of Treatment form identifying the medication name and dosage. The registered nursing staff electronically signed the form and placed it in the applicable youth's healthcare record. Reviewed psychiatric evaluations, Medication Management forms, and Physician Order forms validated the prescribed medication(s) was continued, discontinued, changed, or a new medication was

ordered. In each instance, the practitioner's order clearly documented the medication and dosage.

The program procured medications through 1st Choice Pharmacy and the medications were delivered to the program in in blister packs documenting the number of pills in each prescription order. Procured medications were administered by nursing staff. The program maintained a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program's procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore; storage of controlled substances and other medication could not be observed. The program maintained one refrigerator in the medical clinic for the storage of medication and nursing staff documented the temperature daily.

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 had a written policy and procedures ensuring medical equipment classified as medications/sharps are secured and inventoried by using a routine perpetual inventory. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Medications such as injectables, topicals, drops, and liquids are stored separately. The program's practice was for over-the-counter (OTC) medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances were maintained on all controlled substance with a shift-to-shift inventory conducted by two registered nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly.

The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The consultant picks up all expired medication, unused medication, disposal of narcotics, and other controlled substances at the end of the month for proper disposal. The consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. All disposed medications were documented on the Consultant Pharmacist Monthly Inspection form and on the applicable Controlled Medication Inventory Record in the disposition of remaining doses box. The program's process for the disposal of medication was for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. The program maintained a contract with Stericycle, Inc. for biomedical waste treatment with a certificate of exemption issued on October 19, 2019 with the State of Florida, Department of Health. Since the program no longer had any youth as of August 28, 2020, observations of medication management inventories and sharps inventories could not be conducted during the annual compliance review week.

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 had a written policy and procedures ensuring there is an approved plan for infection control and exposure control to ensure staff, youth, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan included prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan included common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. The plan was reviewed and approved by the designated health authority (DHA) on October 21, 2019 and the facility administrator (FA) on September 17, 2018.

The program maintained procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program maintained a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintained monthly receipts of medical waste pick-up through Stericycle, Inc. The program's Exposure Control Plan/Infection Control Plan was written in accordance with the OSHA standards. The program's plan had a comprehensive process for needle stick post-exposure evaluation. The plan included risk assessment and methods of compliance. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. The FA reported a copy of the program's exposure control and infection control plans are maintained in the medical clinic and master control. The program reported applicable incidents to the Department's Central Communications Center (CCC) involving all COVID-19 related incidents during the annual compliance review period.

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.

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

The program had a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. Daily clinical care was performed by licensed registered nursing (RN) staff in accordance to developed authorized protocols. Reviewed contract supported the program is required to have two registered nurses scheduled to provide on-site services seven days a week. As of August 28, 2020, the program had one full-time RN and one part-time RN. The full-time nurse served as the lead nurse and scheduled to work Monday through Friday, 7:30 a.m. to 4:30 p.m. The part-time RN was scheduled to work Wednesdays from 11:00 a.m. to 7:00 p.m. and Saturdays and Sundays from 6:00 a.m. to 7:00 p.m. Reviewed documentation confirmed both licensed nursing staff holds an unrestricted clear and active license in the State of Florida. Both nursing staff maintained a current cardiopulmonary resuscitation (CPR) certification.

Standard 5: Safety and Security

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

The program no longer has youth or staff on-site. The last youth left the program on August 28, 2020. Observations of youth supervision could not be conducted during the annual compliance review week. A tour of the program was conducted. The facility was observed clean both inside and outside. The grounds were landscaped and maintained.

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 maintained a written policy and procedures which indicated all consequences and sanctions for violation of the program's 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) was a multi-level system designed to increase desired behaviors using reinforcements and decrease negative behaviors through a menu of appropriate violations. The written description was 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.

A review of three closed youth records and documentation showed each youth received the youth handbook at orientation. The BMS was 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 was a level system and rewards which are generated through a point system which youth earn daily. A review of training documentation verified the educational staff were trained in the implementation of the BMS by the program's clinical director.

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

The program maintained a written policy and procedures regarding the implementation of the behavior management system (BMS) and to ensure staff were provided feedback on their implementation of the BMS system. A review of the BMS indicated it was not intended to increase a youth's length of stay, deny basic rights, or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program had a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth were given an opportunity during this process to explain their behavior. A special treatment team meeting was held when a youth's behavior required immediate intervention. The program did not utilize room restriction for major infractions.

A review of three staff position descriptions indicated BMS implementation is addressed as a part of the staff daily functions. The program's policy states staff with direct-youth contact were to be trained in the implementation of the positive performance system annually. Three staff training records were reviewed, and each staff successfully completed BMS training. A review of training documentation verified the educational staff were trained in the implementation of the BMS by the program's clinical director.

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

The program no longer has youth or staff on-site. The last youth left the program on August 28, 2020. Observations of youth ten-minute checks could not be conducted during the annual review week. An informal interview with the chief of security verified the program has eight cameras in the school area and eight cameras in the dormitory area. All cameras at the program were working and recordings were stored for thirty days.

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 maintained a written policy and procedures to ensure youth are always accounted for through a system of physically counting youth at various times throughout each day. The program conducted formal head counts each hour and master control called for informal head counts. The program's policy indicated counts were conducted during power outages, escapes, program disturbances or any other disruptions which may have occurred. A review of randomly selected dates and times in the facility logbooks for the previous six months validated head counts and movements were conducted at the beginning of each shift, after outdoor activities, during emergency situations such as program disturbances and during actual and simulated drills. In addition, the program logbooks included documentation of new admissions, releases, transfers and youth temporarily away from the program. All formal and informal counts documented in the logbook included the time of the count and number of youth at each location.

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 maintained a written policy and procedures to ensure the maintenance of a chronological record of events, incidents, and activities in a central logbook. The program maintained a bound logbook with numbered pages for each month. A review of logbooks for the previous six months found logbook entries were documented in ink with no erasures or white-out areas. Errors were typically struck through with a single line, dated, and initialed by the person correcting the error. Reviewed documentation of randomly selected days within the logbooks reflected each entry included the date and time of the event, the name of the staff and youth involved, as well as a brief description, the name, and signature of the staff making the entry. Logbooks included entries for emergency situations, population counts, perimeter checks, and emergency situations. In addition, admissions and releases were documented as well as transports away from the program. Reviewed logbooks reflected three out of five calls to the Department's Central Communications Center (CCC) were not documented in the logbooks.

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 maintained a written policy and procedures for the assignment, inventory, tracking, storage, and accountability of all keys used in the program. The program utilized a Daily Key Log to track keys. The log indicates the name of staff and what type of key they are assigned according to their position. Program keys are maintained in the master control office within a locked key box which has limited access. Keys are bound on tamper-resistant color-coded rings which include a brass colored tag with a tracking number and the initials of staff positions. Medical staff keys were maintained in a separate locked key box to ensure only appropriate staff are issued medical keys. Upon arrival at the program, staff gained access to the program by way of master control. Staff submitted personal keys in exchange for a program key. Staff signed the key log, acknowledging receipt of the keys. Personal keys were placed in the key box next to the corresponding staff's name. The policy for damaged keys indicates the keys are to be turned over to maintenance staff to have the key replaced. The program has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff sign an acknowledgment form indicating receipt of the key identification number and the number of keys issued. Master control staff complete a daily inventory of program keys.

A review of key inventory documentation for the previous six months confirmed the program's practice. The program's policy indicated if keys are reported lost, all program movement is stopped, and a search is conducted. If the keys are not found within two hours, a call to the Department's Central Communications Center (CCC) is made. A review of CCC incident reports since the last annual compliance review verified there were no incidents were program keys were lost and not recovered.

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 maintained a written policy and procedures to identify materials considered to be contraband, to prevent contraband from entering the program and consequences when found in the possession of youth in the program. The program's youth handbook included a list of contraband items and informed youth of the consequences if found with contraband. Each youth was provided with a written copy of the youth handbook upon admission into the program and each were oriented to the program's rules including the list of items considered to be contraband. The program's policy and youth handbook included all items considered contraband as outlined in Florida Administrative Code. The list of contraband items included personal cellular telephones and/or equipment or electronic devices capable of taking pictures or video recordings, as well as smart watches, which are prohibited. The program's policy specifies the manner in which any unauthorized or contraband item is to be disposed, to include return to the sender, mailed to the youth's home, returned to the youth upon release, or illegal contraband is turned over to law enforcement. A review of the master control logbook for the last six months validated the program's practice of consistently monitoring areas of the program, grounds, and youth rooms for contraband. An informal interview with the campus-wide assistant superintendent verified all incoming and outgoing mail was checked for contraband.

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 no longer has youth or staff on-site. The last youth left the program on August 28, 2020. Observations of youth searches could not be conducted during the annual compliance review week.

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

The program maintained a written policy and procedures to ensure vehicles used for youth transportation are properly maintained. The program had two operable vans to transport youth; however, one vehicle was sold at auction on June 12, 2020. The other van is currently used by Okeechobee Youth Correctional Center. Inspection of the vehicle confirmed it had an installed safety screen and doors which could not be opened from inside the passenger area. The observed vehicle was equipped with a fully-charged fire extinguisher, a seatbelt cutter, window punch, and operable seatbelts for each passenger. The vehicle first aid kit was stored in master control to be checked out when using the vehicle. Annual vehicle inspections are conducted by the program's in-house mechanic, who is automotive service excellence (ASE) certified until June 30, 2022 to conduct auto maintenance, breaks, and light repairs. The vehicle documentation verified the van's annual inspection was conducted on August 21, 2020. The program's practice was to secure all program vehicles and personal vehicles when not occupied. Observations of five vehicles parked in the staff parking lot outside of the secure fenced perimeter validated each was locked and secured.

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 maintained a written policy and procedures to ensure the safety and security of youth and the community when youth are transported outside of the program. Documentation for the last six months verified the program completed a driver's license check on a monthly basis for all approved drivers. The program assigned a ratio of one staff to five youth during transport, not including the driver. Observations of a transport could not be conducted as there were no youth remaining at the program during the annual compliance review. An informal interview with the campus-wide assistant superintendent verified transport staff were issued a company cellular telephone during transportation of youth and there was at least one staff of the same gender of the youth.

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

The program maintained a written policy and procedures requiring a safe and secure physical plant, grounds, and perimeter to be maintained and for weekly safety and security audits to be conducted. The program's facility administrator (FA), unit manager, and the physical plant manager were responsible for conducting weekly safety and security audits and submitting them to the Department. Identified deficiencies were documented on the reports including the status and due date of any needed corrective action and were added to the program's tracker. A review of facility security audit and safety inspections for the prior six months indicated the FA or

designee completed the weekly safety and security audits as required. The reviewed audits documented any corrective action needed for repairs and the date to be completed.

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 maintained a written policy and procedures addressing the proper control and management of tools used within the program. The policy encompasses the storage and inventory of tools, as well as class type. The Class A tools are maintained in the carpenter's shop and the mechanic shop which are located outside of the program's secured fenced perimeter and inaccessible to youth. Class A tools are stored on shadow boards, in locked cabinets, with a list of the contained tools posted on the outside of each cabinet. Additional tools are maintained in the maintenance truck's bed-mounted tool chests organized with wooden tool cut-outs for each stored tool. All tools are classified as Class A list tools by the program and each is labeled and inventoried daily. An informal interview with maintenance staff indicated there were no occurrences of any lost or missing tools since the last annual compliance review. A review of the inventory lists for the prior six months for carpentry and mechanical tools validated there were no missing tools. Observations of the carpentry and mechanical tools areas confirmed the areas were neat and clean. Class B tools, including brooms and mops, were stored in the dormitory in a designated locked closet.

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 maintained a written policy and procedures to ensure youth use tools safely and are supervised appropriately to prevent injuries. A review of the program's procedures verified staff were required to complete a sign-out and sign-in log when Class B tools are taken and are returned to the designated storage room. The program's practice was to complete a youth risk assessment monthly in order for youth to use Class B tools. The program's policy stated staff-to-youth ratio during a work project is no less than one staff to five youth and youth were to be searched after using Class B tools.

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 maintained a written policy and procedures specific to outside contractors entering the program areas with tools and equipment. The program restricted tools to those necessary, checked tools upon the worker's arrival and departure, restricted youth access to the work area, ensured immediate reporting of any tool the worker cannot locate, and followed up if any tool was missing. When a contractor arrived on campus, the workers signed the contractor log, were provided a visitor's contraband list outlining unauthorized items, signed a Prison Rape Elimination Act (PREA) acknowledgement and reviewed the contractor guidelines. A list of tools the contractor required to complete the project was inventoried. If any unauthorized items were needed by the contractor while in the program, approval was obtained by the facility administrator (FA) or designee. A maintenance staff was assigned to the work area to ensure

the work was completed, all tools were accounted for, and ensured no items which were identified as contraband were present. A review of three invoices for contractor services rendered at the program revealed the contracted workers did sign-in and sign-out of the program when services were performed.

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 maintained a written Continuity of Operations Plan (COOP) which was approved by the Department on March 4, 2020, and a written policy and procedures to ensure drills were consistent with the program's COOP. The COOP required the program to conduct unannounced fire drills once every month for each shift. Reviewed documentation for the prior six months validated fire drills were conducted each month. The program additionally conducted monthly emergency drills on each shift ensuring fire, severe weather, program disturbances, hostage situations, and bomb threats were covered on a rotating basis. Drill documentation included the type of drill, date and time, participants, a brief scenario description, deficiencies identified during the drill, and applicable corrective actions. All fire extinguishers were inspected on August 2020 and inspected annually, as required.

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 maintained a written Emergency Disaster Preparedness and Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a varied range of potential emergency situations. A review of the COOP validated the plan was submitted and approved by the Department on March 4, 2020. Further review of the COOP indicated alternative housing plans were included should the program be required to vacate due to an emergency or disaster. The program maintained the required critical identifying information for each youth in administrative hard-copy records which were accessible and mobile in the event of an emergency. An interview with the campus-wide assistant superintendent indicated copies of the program's COOP were maintained in master control, the program's administration office, and the medical office.

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 maintained a written policy and procedures to address the control of hazardous materials. These items were stored in locked metal cabinets within a secure building outside the secure fenced perimeter of the program and are inaccessible to the youth in the program. A binder of Safety Data Sheets (SDS) were located with the chemical items and included a photograph of each item. The program's physical plant manager maintained a list of materials, an authorized staff list for access to chemicals posted on the outside of the door, and a permanent log to display the signing in/out of chemicals. The program recorded the daily use of chemicals on a daily chemical usage log including the initials of the authorized staff using each chemical. A review of six months inventory forms verified all of the chemicals are inventoried once a week by the program's physical plant worker. The storage area was observed neat and well-organized. Chemicals used to clean the dormitories were stored in a secured area with limited access. There were no chemicals stored at the program during the annual compliance review.

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

The program maintained a written policy and procedures prohibiting youth from handling poisonous, flammable, and toxic items and materials. The program's policy stipulated the facility administrator (FA), unit manager, physical plant manager, dietary manager, and shift supervisors may draw and utilize chemicals. Youth care workers, nursing staff, case management staff, clinical staff, and administrative staff are authorized to use chemicals but may not draw chemicals from the inventory. Authorized staff-maintained control over all flammable, poisonous, toxic items off-site and was secured when not in immediate hands of staff. When needed, authorized staff obtained a supply of chemicals used to clean the dormitories from the supply closet. Youth were not allowed to possess flammable, poisonous, toxic, or caustic items. The program's policy dictated staff were to spray the chemical for youth to clean up. Youth were not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waste.

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 maintained a written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials were kept in the locked storage shed located off campus and are disposed of according to the Safety Data Sheet (SDS). The program had a list of staff who are authorized to dispose of unused flammable, poisonous, and toxic materials. An interview with the campus-wide assistant superintendent indicated the program disposed of unused chemicals during the county's Amnesty Day which is a day set bi-annually by Okeechobee County Waste Management for the disposal of hazardous materials. According to the campus-wide assistant superintendent, the program had no chemicals disposed of since the last annual compliance review.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable
Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity. *Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:* • *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;* • *Type of water, such as pool or open water;* • *Water conditions, such as clarity, turbulence, and bottom conditions;* • *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.* • *Lifeguard-to-youth ratio and positioning of lifeguards;* • *Other staff supervision; and* • *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.* *Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.* *Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.*	

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

5.22 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program maintained a written policy and procedures to ensure youth are provided the opportunity to receive visitation and communication with approved family members. During admission, each youth was provided with the program's visitation, telephone and mail policies and guidelines. The program's visitation policy indicated consideration for requests of alternative visitation arrangements with parents/guardians, if needed. The program conducted visitation for all youth on Saturdays and Sundays; however, due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control and Prevention (CDC) on-site visitation was suspended at the Department's direction on March 13, 2020. The program was providing alternative measures such as allowing youth to make video calls to parents/guardians according to the campus-wide assistant superintendent. In addition, youth were able to write letters or call by telephone at least once a week to approved family members.

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

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

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

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

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

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