STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Youth Correctional Center

TrueCore Behavioral Solutions, LLC.
(Contract Provider)
7200 Highway 441 North
Okeechobee, Florida 34972

Review Date(s): October 1-4, 2019

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Yvrose Sylvain, Office of Program Accountability, Lead Reviewer (Standard 1 and Interviews)
Keith Bennis, Office of Program Accountability, Regional Monitor (Standard 5)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 4)
Gabriel Medina, Office of Program Accountability, Regional Monitor (Standard 3)
Maggie Starr, Department of Juvenile Justice, Commitment Manager (Standard 2)

Program Name: Okeechobee Youth Correction Center | MQI Program Code: 1288
Provider Name: TrueCore Behavioral Solutions, LLC | Contract Number: 10188
Location: Okeechobee County / Circuit 19 | Number of Beds: 16
Review Date(s): October 1-4, 2019 | Lead Reviewer Code: 125

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.12 Restorative Justice Awareness for Youth	2.17 Educational Access
2.19 Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	4.01 Designated Health Authority/Designee *

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	Limited
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Satisfactory
5.24	Controlled Observation	Satisfactory
5.25	Controlled Observation Safety Checks and Release Procedures	Satisfactory
5.26	Safety Planning Process for Youth	Satisfactory

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Program Overview

The Okeechobee Youth Correctional Center (OYCC) is a sixteen-bed program, for thirteen to twenty-one-year-old males, located in Okeechobee, Florida. The program is co-located with Okeechobee Youth Development Center. There is one program facility administrator (FA) responsible for both programs and the entire management team. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides mental health overlay services (MHOS), life skills, on-site educational classes, and vocational programming services. In addition, the program fosters each youth by providing Thinking for a Change (T4C), Skillstreaming the Adolescent, and Impact of Crime (IOC). The three effective intervention groups are taught by specifically trained staff to assist youth in the program. The program also provides Living in Balance, Young Men's Work, Passport Program, Towards No Drugs, Strategies for Anger Management, Anger Management for Mental Health, Thinking Feeling Behaving, and The Teen Relationship. Additional treatment services provided includes group therapy seven days a week, and individual and family therapy once a month. Program administration is comprised of a superintendent, assistant superintendent, facility administrator, unit manager, shift supervisors, health services administrator, food service director, compliance managers, and a human resource manager. Case management services are provided by the director of case management, transitional services manager, and one case manager. Mental health staff at the program includes a designated mental health clinician authority (DMHCA), director of clinical services, one recreational therapist, one therapist, and an independent psychiatrist agreement with a licensed psychiatrist. Medical services are offered twenty-four hours a day, seven days a week. Sick call is offered seven days a week for youth who have health concerns and are provided by the registered nurses (RNs), a health services administrator, and an independent contractor agreement with a licensed medical doctor who serves as the designated health authority (DHA). Educational services were previously provided by Washington County School Board until Okeechobee County School District started providing services on August 13, 2019. The youth receive academic credits and have the opportunity to work towards the General Educational Development (GED) test. At the time of the annual compliance review, the program had ten vacant positions which included eight youth care workers, one master control technician, and one therapist. The layout of the program includes the cottage, medical area, one administration building, a cafeteria, school areas, and a master control building. The program has thirty-two operating security cameras providing coverage. Two of the cameras were not operational during the annual compliance review week. The digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days.

Standard 1: Management Accountability

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

The program maintains a written policy and procedures requiring compliance with the Department's background screening requirements. The program had twenty-two staff members, one contracted employee, and two volunteers who were applicable for an initial background screening during this annual compliance review period. A review of initial background screenings for the twenty-two newly hired staff, one contracted staff, and two volunteers found the program received background screenings from the Department's Background Screening Unit/(BSU) Clearinghouse prior to each staff and volunteer having access to youth and confidential records. Documentation revealed the program added all employees and volunteers to the program's roster lists in the Clearinghouse employment roster. The program utilizes an ergometric pre-employment assessment tool for all direct care applicants. Documentation indicated applicants must have a minimum score of sixty-five percent to pass the human relations video portion of the assessment and a minimum score of sixty percent on the reading portion of the assessment. A review of twelve applicable direct care employee records revealed each employee passed both portions of the pre-employment assessment tool. There was documentation in all reviewed staff and volunteers' records indicating the hiring specialist reviewed the Department's Central Communications Center (CCC) system, Staff Verification System (SVS), and the Florida Department of Law Enforcement's Automatic Training Management System (ATMS) as part of the pre-employment background screening process. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the BSU on December 10, 2018, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was completed and submitted to the BSU on December 11, 2018, meeting the annual requirement.

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

The program maintains a written policy and procedures requiring compliance with the Department's five-year background re-screening requirements. The program's human resource manager tracks the five-year anniversary of hire dates and processes the five-year re-screenings for all staff. A review of the program's staff roster and volunteer list indicated

there were ten staff and four contracted staff applicable for a five-year rescreening during this annual compliance review period. Each staff's re-screening was completed and submitted to the Department's Background Screening Unit/Clearinghouse prior to their anniversary date. There were no volunteers who required a five-year re-screening since the last annual compliance review.

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

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

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

The program maintains a written policy and procedures outlining an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Observations made during a tour of the program found signs posted throughout the program listing the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC). There is a telephone in the living area of the dormitory for direct connection to the Florida Abuse Hotline; however, it was not operational at the time of the annual compliance review due to internet issues. Documentation supported the service company was contacted and is in the process of restoring the Florida Abuse Hotline direct connect telephone. The program's facility administrator (FA) reported youth are escorted to a case manager or therapist office upon requesting an abuse call. The youth will pick up the telephone and place the call. The program's normal practice once a youth wants to contact the Florida Abuse Hotline, the youth will pick up the telephone in the dormitory which is a direct connection to the Florida Abuse Hotline to place the call. If the youth is not in the dormitory area, the youth care worker will use the radio to call the shift supervisor in which the shift supervisor will escort the youth to the telephone in the dormitory area for the youth to pick up the telephone which is a direct connection to the Florida Abuse Hotline to place the call. Youth eighteen years of age or older may request a call to the Department's CCC through the youth care worker, on-duty shift supervisor, unit manager, and/or the program's FA. The youth care worker will use the radio to call the shift supervisor and the shift supervisor will escort the youth to place the call. The program's policy states allegations of child abuse or suspected child

abuse are immediately reported to the Florida Abuse Hotline and the Department's CCC. The program's FA, unit manager, or the facility investigator will immediately begin a review of all documents, statements, and video as part of their internal review. Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. A review of three staff personnel records documented the staff signed a form acknowledging their understanding of the code of conduct. The youth orientation handbook is provided to each youth upon admission. The youth's handbook includes the youth's rights, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and the Department's CCC. A review of one abuse allegation was reported to the Florida Abuse Hotline and the Department's CCC during the annual compliance review period was still pending investigation. Three interviewed youth reported never being denied from reporting abuse to the Florida Abuse Hotline or the Department's CCC. One of the three youth reported staff are respectful when speaking with them, one reported most of the staff talk to the youth with respect, and one reported sometimes. One of the three youth reported never hearing staff use profanity when speaking to youth, one reported once, and one reported occasionally. All three interviewed youth reported feeling safe in the program. None of the three interviewed staff reported ever witnessing a co-worker deny a youth an abuse call. All three staff were able to explain the process of allowing a youth to call the Florida Abuse Hotline or the Department's CCC, in accordance with the Florida Administrative Code. Two of the three interviewed staff reported they never observed a co-worker use profanity when speaking to youth. One staff reported not exactly profanity but ignores youth with attitude. An interview with the FA reported all staff receive training on the Florida Abuse Hotline and the Department's CCC prior to having contact with the youth in the program. The program's FA reported youth and staff are allowed to call the Florida Abuse Hotline and/or CCC when they request and all allegations are discussed during management meetings.

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

A review of the program's policy outlined procedures regarding abuse reporting in compliance with the Department's criteria for reporting abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff from contact with youth, when necessary. The program had one allegation of abuse involving an unknown staff within the last six months. The Department's Central Communication's Center's report indicated allegations of possible abuse involving an unnamed staff. Reviewed documentation found management took immediate action regarding the incident by initiating an internal investigation regarding the allegation of abuse. Documentation indicated the abuse allegation was under investigation and ongoing at the time of the annual review.

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

The program maintains a written policy and procedures regarding response to incidents in accordance with Florida Administrative Code. The program had two reportable incidents during

the annual compliance review period. A review of the two incidents found both were reported to the Department's Central Communications Center (CCC) within two hours of the incident or staff becoming aware of the incident. The two incidents were documented in the program's facility logbook. A review of the the program's internal incident reports and Let's Talk forms, found there were no incidents which should have been reported to the Department's CCC. The program has experienced a decrease in the number of reportable incidents to the Department's CCC compared to the last annual compliance review period. An informal interview with the program's facility administrator confirmed the program has a policy in reference to the Department's CCC and ensures all matters which require reporting is verbally reported within two hours when the program became aware of the incident.

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

The program maintains a written policy and procedures regarding the utilization of physical intervention techniques in accordance with Florida Administrative Code. The program had one Protective Action Response (PAR) incident in the past six months. There was documentation to support a monthly summary of PAR reports were submitted to the Department. A review of the PAR report found all involved staff completed appropriate statements prior to the end of their shift. The PAR report was reviewed and processed within seventy-two hours by all required parties. The PAR report documented a Post-PAR interview was conducted with the youth by the facility administrator (FA) within thirty minutes after the incident. The program's PAR plan was approved by the Department's Office of Staff Development and Training on December 20, 2018. The program has not experienced an increase in the number of PAR reports compared to the last annual compliance review period. The program's PAR rate during the annual compliance review period was 2.19, which is above the statewide Residential PAR rate of 1.59. An interview with the FA reported staff were instructed to complete a PAR report at the end of their shift if a PAR occurred; signatures and any corrective action taken after the PAR must be documented.

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

The program maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training plan was approved by the Department's Office of Staff Development and Training on January 16, 2019. Pre-service training is provided through a combination of instructor-led and web-based courses. Three staff training records were reviewed for pre-service certification training. All three reviewed training records documented each staff completed the certification process within 180 days of hire. The staff completed the required trainings related to Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All completed training was documented in the Department's Learning Management System (SkillPro) and was delivered by qualified trainers.

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

The program maintains a written policy and procedures regarding in-service training for all staff. Three staff training records were reviewed for in-service training. All three reviewed staff training records documented each staff exceeded the twenty-four hours of annual in-service training requirements; however, one staff did not complete two of the mandatory training topics which are professionalism and ethics and blood-borne pathogens. An interview with the program's training instructor reported the staff was scheduled for the required trainings; however, did not attend. All three staff had current certifications in Protective Action Response (PAR). Each staff had certification in first aid, automated external defibrillator (AED), cardiopulmonary resuscitation (CPR), and six hours of suicide prevention training. The one applicable staff exceeded the eight hours of management/supervisory training. The program has a training calendar which is updated as necessary. All trainings were delivered by qualified trainers and were documented in the Department's Learning Management System (SkillPro). The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 16, 2019.

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

The program has a written policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. According to the program's policy, procedures are in place to confirm each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's grievance procedures include informal, formal, and appeal phases with time frames of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are also provided with the opportunity to file an alternative informal request by utilizing a "Let's Talk" form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and "Let's Talk" forms were available to youth as observed during the program tour. Reviewed documentation found there were no grievances and four "Let's Talk" forms submitted by youth since the last annual compliance review. A review of the four "Let's Talk" forms revealed each youth's complaint was addressed and resolved as an informal grievance within the required seventy-two hours. Three staff training records were reviewed for pre-service trainings. All three training records documented each staff received the required training on the program's grievance process and procedures. During the annual compliance review, three youth and three staff were interviewed. The three youth were able to explain the grievance process to include submission of a completed grievance form into the secured grievance box. All three interviewed youth reported being able to request assistance in completing a grievance form, if needed. All three

interviewed staff were able to explain the grievance process. An interview with the facility administrator (FA) reported grievance forms are available to the youth on the dorm and the sealed grievance box located at the cafeteria entrance. The program's FA checks the grievance box and "Let's Talk" form daily and addressed each youth's complaint within seventy-two hours.

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

The program has a policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract of required services identified "Thinking for a Change" (T4C) as a promising practice intervention curriculum. The program currently had four staff trained to facilitate T4C. Two facilitators had a bachelor's-level degree and over three years of experience working with youth. One facilitator had a master's-level degree and three years of experience working with youth. The remaining facilitator had a high school diploma and over ten years of experience working with youth. An interview with the facility administrator reported the program provides T4C as a promising practice intervention. The program completes a Residential Assessment for Youth (RAY) on each youth to determine criminogenic needs of the youth and based on the outcome, the decision is made on which group the youth is placed. A review of the program's activity schedule confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. The T4C groups are held twice a week, for one hour each. A review of three youth records confirmed two youth were currently in T4C group, one youth had completed the T4C group, and each youth had goals in their performance plan to address the delinquency needs.

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

The program maintains a written policy and procedures to address life skills training for youth. The program provides life skills training through Teen Relationships groups and Skillstreaming the Adolescent. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. A review of the program's activity schedule confirmed a one-hour life skills training group is provided to the youth once a week by the therapist. All staff conducting groups received formal training and on-the-job training by a certified trainer to deliver the curriculum. A review of three youth case management records and group sign-in sheets indicated services were delivered, as required. Reviewed documentation found all three youth were actively participating in Skillstreaming the Adolescent groups. Three interviewed youth were able to explain the new skills or behavior they were taught in life skills group such as coping skills, how to improve their behavior, and how to stay positive. All three interviewed youth also reported they were able to demonstrate the skills doing role play activities in groups. An interview with the clinical director stated youth can practice skills in group role-play activities and interactions with staff and youth while at the program.

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

The program has a policy and procedures for the provision of restorative justice awareness to the youth. A review of the program's contract indicated Impact of Crime (IOC) curriculum is a required service to be provided to all youth in the program. The program currently had six staff trained to facilitate IOC group. During the six months review period from April to October 4, 2019, the program provided IOC groups for restorative justice from April to July 30, 2019. The restorative justice groups conducted from April to July 30, 2019, did not provide opportunities for youth to plan and participate in reparation activities such as restitution activities, expose youth to victims' perspectives through victim speakers, and community service projects. Documentation found group schedules were not followed for IOC groups and there was no restorative justice service delivery from July 31, 2019 to October 4, 2019. A review of three youth records confirmed the youth were participating in an IOC group and had completed the group without participation in reparation activities.

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

A review of the program's contract of required services for gender-specific programming identified "Young Men's Work" (YMW) as the gender-specific curriculum provided to the youth. All youth in the program are provided YMW which is a gender-specific curriculum and includes exercises specifically for males regarding issues of violence, bullying, substance abuse, and issues related to teen fatherhood. A review of three youth case management records confirmed youth were currently in or had completed this gender-specific group. YMW groups are included on the program's activity schedule once a week for one hour. An interview with the facility administrator (FA) reported gender needs are addressed through YMW group and youth engagement in activities such as competitive football, basketball, and other sporting tournaments during weekend and recreation time. Three interviewed youth reported they participated in substance abuse, life skills such as teen relationships, and mental health groups.

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

The program has a policy and procedures addressing youth alerts. The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert which may not have been previously entered prior to the youth's admission. The program has an alert board in master control which identifies each youth's special alerts, escape risk, and/or gang affiliation. The alert board also identifies youth placed on any type of mental health alert. The alert board has each youth's picture, arranged by cottage, and the alert associated with the youth. Reviewed documentation indicated the program's internal alert report is reviewed daily during shift briefings by the program's shift supervisory staff. An extra copy of the program's internal alert report is located in master control near the door on a clip board and is accessible to all staff. Three youth records were reviewed for case management, medical, and mental health and substance abuse and all applicable alerts were accurately entered into JJIS. All internal and JJIS alerts were downgraded or discontinued by a medical staff, case manager, and/or licensed mental health staff. Three staff were interviewed to include one supervisor. Each reported they are informed of youth alerts during shift meetings, review the program's alert board for youth alerts in master control, and alerts sheets are available in master control. An interview with the one applicable supervisory staff stated there is an internal electronic mail alert sent to all supervisor daily. An interview with the facility administrator (FA) reported all internal alerts are entered into JJIS by their specific departments and medical alerts are updated and forward to the shift supervisor daily. The alerts information is also reported to master control where the controller will update the alert board for the program.

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

The program maintains individual healthcare, mental health and substance abuse, and case management records for each youth. All three reviewed case management, healthcare, mental health and substance abuse records were marked "confidential" and each record contained the required documents. One of the three closed records reviewed was not marked confidential. The youth case management records contained all required documentation on the spine and front of the binder including each youth's name, Department's identification number, date of birth, county of residence, date of admission, and committing offense. The documents were organized into the required sections. All youth case management records, mental health and substance abuse records, and healthcare records were secured behind a locked office door when not in use. The office door and file shelves were marked "confidential."

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

The program has a written policy and procedures to allow for youth feedback outlined in the grievance procedures. The program has a resident advisory council where elected youth represent their respective dormitories. Youth are allowed to discuss issues and ideas on behalf of other youth in the program during a meeting with the facility administrator (FA) or unit manager in an effort to come to a resolution. A review of the resident advisory council meeting binder reflected an agenda, sign-in sheets, and meeting minutes summarizing the subject areas which were discussed. The meetings provide youth opportunities to identify issues impacting their residential community and recommendations to improve conditions enhancing the quality

of life for both the youth and staff in the program. Further, program administration conducts quarterly surveys with randomly selected youth. The results of the surveys are forwarded to the corporate office and formally reviewed and discussed whereby possible changes are made, accordingly. Three youth were interviewed and each reported the program does provide a process allowing youth to provide input regarding what happens at the program. In addition, each youth reported daily youth meetings are conducted for youth to express their concerns and needs. An interview with the FA indicated the youth completes and signs the "Let's Talk" form as a first attempt where youth will voice issues and concerns in the program. The youth meet once a month to discuss youth issues in their particular living cottage and present these findings to administration. The program's FA stated cottage meetings are conducted Monday through Friday allowing youth to provide feedback directly five days a week.

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

The program has a community advisory board which serves six programs located in Okeechobee County. The advisory board meets quarterly and were combined due to a limited amount of people living in this rural community. Reviewed documentation supported the program's community advisory board meets at least quarterly. The reviewed meeting minutes, sign-in sheets, and agendas documented meetings occurred in March, June , and September 2019. The next community advisory board meeting is scheduled for December 2019. The advisory board members currently consist of a member from law enforcement, interested community partners, a community business member, school board member, victim advocate/victim services member, a parent/guardian whose child was previously involved in the juvenile justice system, a member from the judiciary, and a faith-based community member. A review of community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and community service activities. The board rotates meeting locations between Okeechobee Juvenile Offender Correctional Center, Okeechobee Youth Development Center, and Okeechobee Girls Academy each quarter and serves as the board for Okeechobee Youth Treatment Center and Okeechobee Intensive Halfway House, as well. A telephone call was made during the annual compliance review to the local sheriff who serves as a board member and indicated they send an officer to participate in the scheduled meetings and also confirmed the program's regular invitations to events and meetings.

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

The program maintains a written policy and procedures identifying service, employment recognition, and tuition reimbursement. The program administration conducts comprehensive quarterly youth and staff surveys. The results of the surveys are discussed in detail at the corporate office and subsequently, the results are reviewed and shared with staff during the all staff monthly meetings. The program conducts daily management meetings, shift briefings, and monthly meetings for all staff to discuss relevant issues affecting the program's operation and to keep staff informed of corporate objectives. The program's daily management meetings follow a pre-set agenda and includes the discussion of Protective Action Response (PAR) incidents, calls to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), grievances, youth behaviors, admissions and discharges, and any upcoming events.

The program has recognitions for staff such as tuition, registration certification, employee appreciation, staff celebration, and continuing education (CEU) reimbursement. The program also utilizes a system called the “TrueCore Way”, which allows supervisory staff to recognize employees for exemplifying the “TrueCore Way” which is a positive culture, team work, and going above and beyond. Three interviewed staff reported staff meetings are held monthly and shift briefings daily. Two interviewed staff reported the communication amongst the staff at the program is very good and one staff reported fair. According to the interviewed staff, the topics discussed during the monthly meetings at the program includes staff positions during sight and sound supervision, Protective Action Response (PAR) incidents, employee of the month, youth supervision, searches, youth alerts, staff attendance, and any upcoming events. An interview with the facility administrator (FA) reported a morale committee meets monthly to focus on activities which identifies different ideas to build staff morale and events to reduce staff turnover in the program.

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

The program conducts ninety-day performance evaluations for newly hired staff and annual evaluations for all staff. Three personnel records were reviewed of which two contained an annual performance evaluation and one contained a ninety-day performance evaluation. The performance evaluations were specific to the applicable staff’s job description. All three reviewed performance evaluations found each staff’s evaluation was based on the performance standards for their position. The one applicable staff performance evaluation did not include the effective delivery of the evidence-based curriculum delivered by the staff. The evaluations rated the staff’s quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff’s job-specific responsibilities. Two of the three interviewed staff reported receiving an annual evaluation and one reported receiving a ninety-day evaluation. An interview with the facility administrator (FA) reported staff are given a ninety-day performance evaluation and an annual performance evaluation by their cottage manager. The program’s FA reported each staff annual evaluation is to determine how the staff performed throughout the year and is used as a tool to identify staff who qualify for different incentives from the company.

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

The program has a written policy and procedures regarding recreation and leisure activities. According to the contract, the program is required to have a recreational therapist position. The educational requirements listed state the candidate should preferably have a bachelor’s-level degree of science in recreation and sports management with a track in recreational therapy. Reviewed documentation reflected the recreational therapist is a Bachelor’s-level with education in sports management in recreation and meets the educational requirements. The program provides a variety of recreation and leisure activities for the youth in the program. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. The recreational and leisure activities are provided during the weekdays and on weekends. Youth are provided at least one hour daily of large muscle activity promoting or

creating teamwork, healthy competition, and mental stimulation. The program provides activities such as flag football, basketball, chess games, card games, and board games. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth targeted to promote team building and leadership skills. The weekday activity schedule includes recreation each afternoon for one hour. When the heat index is above the approved temperature or when there is inclement weather, the youth are afforded one hour of recreation time inside the facility. A review of three youth records documented recreational therapy activities are provided and are incorporated into goals on each youth's individualized treatment plan. Randomly selected dates and times were reviewed in the program's master control logbooks and confirmed the youth have allotted time each day for recreation. Observations made during the annual compliance review of recreational activities found youth are participating in teamwork, healthy competition, and physical fitness. Three interviewed youth reported they are provided at least one hour of large muscle activity daily and the program provides activities promoting or creating teamwork, healthy competition, mental stimulation, and physical fitness. Three staff were interviewed and indicated the type of recreation and leisure activities are provided to youth are basketball, flag football, television, chess, video games, and board games.

Standard 2: Assessment and Performance Plan

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

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

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

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

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Three youth case management records were reviewed and none were applicable for written consent of youth over the age of eighteen years of age before providing or discussing information with the parent/guardian. An additional three youth

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

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

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

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

The program has a policy and procedures addressing gang identification which includes notification to law enforcement. Each youth is assessed at intake for suspected gang involvement. Three youth case management records were reviewed and none were applicable for youth gang involvement or association. Three additional records were requested and reviewed. Documentation supported the program notified the law enforcement gang liaison by electronic mail of the suspected gang members residing at the program for each youth. The program informed the educational provider and post-residential provider of the suspected gang youth. A review of the Department's Juvenile Justice Information System (JJIS) system indicated each youth's juvenile probation officer (JPO) was also notified by the program of the youth's suspected gang member classification and the alert was entered into the Department's JJIS.

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

The program maintains a gang binder which contains information on youth who have been documented as gang members or associated with a gang. Three youth case management records were reviewed and none were applicable for youth gang involvement or association. Three additional records were requested and reviewed. The three additional youth records documented each youth was identified as a gang member or affiliated gang member. Each youth's performance plan included gang prevention and intervention strategies. The program utilizes Gang Resistance and Drug Education (GRADE) curriculum. The GRADE curriculum includes seven lessons and a final essay. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities. The program's practice if youth are identified as gang members during the classification meeting, the youth are assigned gang intervention goals and attend gang prevention groups.

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

The program maintains a written policy and procedures outlining each youth's individualized needs shall be identified and prioritized through a comprehensive needs assessment process completed by a multidisciplinary intervention and treatment team staff. The youth's intervention and treatment team shall identify the youth's criminogenic risk and protective factors, and prioritize the youth's criminogenic needs. The Residential Assessment for Youth (RAY) assessment shall be completed within thirty days of the youth's admission to the program.

Three youth case management records were reviewed and the program assessed each youth utilizing the RAY to identify criminogenic risk and protective factors and to prioritize the youth's criminogenic needs. Each reviewed RAY was completed in the Department's Juvenile Justice Information System (JJIS) within thirty days of each youth's admission date into the program. Reviewed documentation supported the program completed a RAY re-assessment within ninety-days after the completion of the initial RAY assessment in two of the three reviewed records. One youth record reflected the youth was attending the program for less than four months. Reviewed records documented updates or re-assessments were completed when deemed necessary by the multidisciplinary treatment team to effectively manage each youth's progress. All re-assessment documentation was maintained in each youth's case management record.

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

The program has a policy and procedures addressing Youth Needs Assessment Summary (YNAS) process which is completed within thirty days of the youth's admission. Three youth case management records were reviewed and two documented a YNAS were completed within thirty days of the youth's admission to the program. One was completed forty-nine days late. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in each youth's case management record.

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

The program maintains a policy and procedures outlining the multidisciplinary treatment team including the youth shall meet and develop the performance plan with individualized delinquency intervention goals to be achieved before the youth is released from the program. Each youth's performance plan is based on the initial findings of the assessment of the youth and shall be completed within thirty days of the youth's admission. The developed performance plan facilitates the youth's successful reintegration into the community upon release from the program and to also facilitate the youth's rehabilitation. Three youth case management records were reviewed and two documented the individualized performance plans were developed within thirty days of the youth's admission and after the initial assessment. One was completed seventy-two days late. Each reviewed performance plan was developed and signed by the

treatment leader, youth, treatment staff, and education staff. The administrative representative participated and signed all three performance plans and two living unit representatives documented their participation and signature on the reviewed performance plans. None of the youth were under the supervision of the Department Children and Families (DCF) requiring DCF participation. Each reviewed performance plan clearly documented the top three criminogenic needs and individualized goals based upon the prioritized needs reflecting the risk and protective factors identified in the Youth Needs Assessment Summary (YNAS) and RAY assessment. Reviewed documentation demonstrated the performance plans were completed with specific delinquency interventions with measurable outcomes which will decrease criminogenic risk factors and promote strengths, skills, and support reducing the likelihood of the youth reoffending. The start date, projected completion date, status, frequency, youth's responsibilities to accomplish the intervention, and the program's responsibilities to enable the youth to complete the goal. In one applicable record, court-ordered sanctions which can be reasonably initiated and/or completed while the youth is in the program was documented mainly completing community service hours. Each performance plan identified the youth's responsibilities and timelines to accomplish the goals and the responsibilities of staff to enable the youth to complete the goals. Reviewed documentation supported within ten working days of the performance plan being completed, a transmittal letter and a copy of the plan was sent to the committing court, juvenile probation officer, and each youth's parent/guardian. There were no signature pages returned to the program and filed with the original performance plan. Three interviewed youth found each was able to verbalize their current goals they are working towards completing. Each validated they were provided a copy of their performance plan.

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

The program maintains a policy and procedures ensuring each youth's performance plan will be revised as needed for completion. A review of three youth case management records documented each performance plan had revisions either based on the Residential Assessment for Youth (RAY) re-assessment results or newly acquired information which warranted a change. Reviewed practice indicated the multidisciplinary treatment team met formally approximately every thirty days to discuss each youth's performance plan and documented the youth's demonstrated progress toward completing each goal. In the event a youth demonstrated lack of progress toward completing a goal, this would be discussed by the team during special treatment team meeting and modifications would be made to the youth's performance plan. None of the three reviewed records were applicable of youth in transition; therefore, three closed youth records were reviewed. Each of the three closed records documented during the last sixty days of the youth's stay in the program, revisions were made to each individualized performance plan to ensure the youth's successful completion of the identified goals for release.

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

The program maintains a policy and procedures ensuring a formal performance review requiring a meeting of the multidisciplinary treatment team shall be conducted at least every thirty days. The treatment team assesses each youth's progress on their performance plan goals and overall behavior in the program and documents a summary which is maintained in the program's Lauris case note system. The treatment team will also develop a performance summary within ninety calendar days following the completion and signing of the performance plan. Each summary includes the youth's status on each performance plan goal, youth's overall treatment progress based on their treatment plan, and the youth's academic status including performance and behaviors in school. In addition, the youth's behavior including the level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment, and the youth's adjustment to the program. Three reviewed youth case management records indicated each had a performance summary completed within the required ninety-day time frame. Reviewed performance transmittals supported each youth was provided the opportunity to review and add comments prior to signing the completed performance summary. Three interviewed youth supported each was provided a copy of their performance plan and a copy of their performance summary. All three interviewed youth indicated they received a copy of the performance summary sent to the court. Reviewed practice supported each completed performance summary was signed by the treatment team leader, staff member(s) participating in the preparation of the summary, facility administrator or designee, and the youth. Transmittal documentation supported each performance summary was sent to the applicable committing court, assigned juvenile probation officer (JPO), parent/guardian, and the Department of Children and Families (DCF) case worker, if applicable within ten working days of completion. Reviewed documentation supported the original completed performance summary was filed in each applicable youth case management record. A review of three closed youth case management records supported the original release summary along with justification for release and Pre-Release Notification (PRN) was sent to the assigned JPO. All three summaries and PRNs were sent at least forty-five days prior to the planned release date. No youth were applicable for the sexually violent predator program (SVPP) and victim notification. Transmittal documentation validated when the youth was released from the program, the assigned JPO received the final performance summary. There were no applicable youth with charges requiring 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 has a policy and procedures which addresses the encouragement of parent/guardian involvement in case management assessment, performance planning and

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

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

The program has a policy and procedures addressing treatment team and its members. The program assigns each youth to a treatment team upon admission into the program. The treatment teams are comprised of the youth, case manager, a representative from education, a mental health therapist, the youth's parent/guardian, assigned juvenile probation officer (JPO), medical staff, a representative from the living unit, and a representative from the program's administration. Three youth case management records were reviewed to verify composition of the treatment team. Each reviewed record contained documentation indicating all required parties were in attendance during formal and informal treatment team meetings or using the feedback form prior to the treatment team meetings. Reviewed documentation validated each assigned youth's JPO and parent/guardian were invited to participate in the treatment team.

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

The program maintains a policy and procedures indicating when a youth has been identified with a mental health, substance abuse, or physical health need. The care treatment plan shall be coordinated with the youth's performance plan through the multi-disciplinary intervention and treatment team process to ensure compatibility of goals, services, and service delivery. The youth's performance plan shall reference or incorporate the youth's treatment or care plan. When a youth has a current behavior support plan or case plan through the Department of Children and Families (DCF) and/or Agency for Persons with Disabilities (APD), the program shall coordinate the youth's performance plan with the youth's DCF/APD care plan for related issues. A review of three youth case management records revealed each youth's performance plan contained goals or information from the mental health and substance abuse treatment

plans, wellness plans, and medical plans. Each youth had separate academic plans which were incorporated into the individual performance plan. There were no applicable youth receiving services from APD or in the custody of DCF requiring performance plan incorporation. Reviewed documentation supported each performance plan was discussed during formal treatment team meetings and the progress or lack of was documented on the overall adjustment and behavior section of the performance plan review form.

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

The program has a policy and procedures in place regarding formal and informal treatment team meeting reviews. The program conducts formal treatment team meetings monthly, on a bi-weekly basis. Informal treatment team meetings are scheduled to be conducted on a bi-weekly basis. Special treatment team meetings are also held for youth having difficulty in the program which allows the treatment team to make necessary revisions to the individual performance plan. The annual compliance review team was unable to observe a formal and an informal treatment team meeting as none were scheduled during the annual compliance review week. Three youth case management records were reviewed for formal and informal treatment team meetings. Formal treatment team meeting documentation included the youth's signature, review date, attendees, comments by treatment team members, and a brief synopsis of the youth's progress in the program. Reviewed documentation supported the youth's performance plan goals were discussed. All three youth records contained documentation of the youth's input during treatment team meetings. Each reviewed record confirmed the treatment team leader invited and encouraged participation of the youth's juvenile probation officer (JPO) and parent/guardian. Each record found informal treatment team meetings were conducted at least once a month and special treatment team meetings were held for youth having difficulty in the program, when necessary. Three interviewed youth reported they are provided the opportunity to demonstrate skills they have learned in the program during their treatment team meetings.

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

The program has a written policy and procedures in place addressing career education. The program offers Type 2 career education services. Career education services were previously provided by Washington County School Board until Okeechobee County School District started providing services on August 13, 2019. The program's career education addresses communication, interpersonal, and decision-making skills. The program offers Type 2 educational programming which teaches personal accountability skills and behaviors appropriate for students in all age groups and ability levels leading to work habits which will help maintain employment and living standards. In addition, youth are given an orientation to the broad scope of career choices based upon personal abilities, aptitudes, interests, and exploring and gaining knowledge of occupation options and the level of effort required to achieve them. Youth may also obtain their high school diploma or General Education Development (GED) credentials. The program provides opportunities for youth to earn certifications in vocational skills while at the program. Students may also earn SafeStaff ® food handler certification. Youth

complete résumé writing to summarize individual education and past work experiences, and completion of job applications and college applications for youth looking to further their education. Three closed youth case management records were reviewed. Each closed record included a sample application, a résumé, and referral to a Career Source Center. Each record contained documentation supporting notification to youth's parent/guardian and juvenile probation officer (JPO) of the youth's vocational plan. The facility administrator (FA) reported youth in the program attend a vocational learning class during their school day which consists of a building trade in construction. The GED preparation is also offered during school and assessments are taken by the youth to prepare for the GED test once they are released. An interview with the lead teacher found youth in the program can participate in résumé building, Florida Food Handler's Certification, Florida Ready to Work, Internet Communication (ICT), Internet Business Associates (IBA), Armed Services Vocational Aptitude Battery (ASVAB) testing, and GED testing.

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

The program operates on a year-round basis providing educational services. Students are required to participate in educational and career-related programs for 250-days of instruction distributed over twelve months, for a minimum of twenty-five hours of instruction weekly. A review of the program's daily schedule documented educational instruction hours are 8:00 a.m. to 11:26 a.m. and 12:55 p.m. through 2:37 p.m. The school schedule documents school hours are 8:00 a.m. until 2:37 p.m. The school calendar documents youth are receiving 240 days of instructional time and teachers work 244 days each year. Youth enrolled in educational programming will receive course credit for the completion of the education and training experience. Observations during the week of the annual compliance review found youth in the dormitory areas playing cards and watching television during school hours. On October 1, 2019, school was offered for a half day by the school principal due to one teacher being in court and another on medical leave. On October 2, 2019, classes were cancelled. An informal interview with the school principal reported the daily schedule indicated minimal interruption to the youth's educational program; however, there is an interruption of delivery of five hours of instructional time when teachers are on approved leave. An interview with the school principal stated there is no plan in place when two of the three teachers are on approved leave. Reviewed video camera footage, an interview with the facility administrator, and a review of the facility logbook reflected the youth consistently did not receive the five hours daily instruction as scheduled from the school district. Based on the information provided during an interview with the school principal; when the program conducts family day on a Friday all school teachers are unable to teach the youth which interferes with the delivery of five hours of instructional time. Informal interviews with the youth reported, when classes are conducted in the dormitory it is usually in the afternoon and teachers will bring the youth assignments to complete and return to collect them. An interview with three youth reported the educational instruction are not really teaching them, sometime there was no school in the afternoon, and classes are taking place in the dorm area. The annual compliance review team discussed the education access concerns with the program's administration staff and the program administration staff stated they will address the education access with the school principal.

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

The program has a policy and procedures in place regarding educational transition plans. A review of three youth case management records revealed none of the youth were applicable for the education transition phase of the program. Each youth had an educational transition plan. Three youth closed records were also reviewed. All three applicable reviewed records indicated the individual transition plans were initiated during the youths' admission process and contained all requirements. Each youth's record contained documentation indicating the youth were involved in the development of their transition plan. The plan addressed different services and interventions based on the youth's assessed educational needs and post-release education plans. Documentation confirmed services were provided during the youth's stay at the program and services were implemented once the youth was released. Two of the three youth records included a copy of their State issued identification card, a continuation of education or employment, résumé, employment application, and information pertaining to the Career Source Center located near the area in which the youth would be seeking employment. One record was missing a State issued identification card and information pertaining to the Career Source Center located near the youth's area. The education staff also provides recommended educational placement post-release and also specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

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

The program has a policy and procedures in place regarding transition planning, releases, transfers, and Community Re-entry Team (CRT) meetings. A review of three youth case management records revealed no youth were in the transitional phase of the program; therefore, three closed youth case management records were reviewed. Documentation indicated all treatment team members were invited and encouraged to participate in the transition conference. Documentation supported each youth's transition conference was held at least sixty days prior to the youth's targeted release date and the youth, treatment team leader, and other team members participated on each transition conference. In all three closed youth records, documentation did not support the facility administrator or designee participating in the transition conference. Florida Administrative Code indicates the program director or designee, the intervention and treatment team leader, and the youth shall attend the transition conference.

All three reviewed closed youth records documented the exit conference was conducted and documented on the exit conference form. During the transition conference, participants reviewed the transition activities outlined on each youth's performance plan during the transition conference. There were no applicable revisions to the performance plans reviewed. Documentation supported target completion dates and persons responsible for goal completion were identified at each completed conference. There was documentation in all three reviewed records to support the program received an invitation to the CRT meetings. The Department's Juvenile Justice Information System (JJIS) was reviewed to determine the knowledge of the meeting and participation by the program, youth, parent/guardian, and assigned juvenile probation officer (JPO). Reviewed documentation of the three closed records indicated the program, youth, and the parent/guardian participated in 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 maintains a policy and procedures ensuring the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program. Transition and release planning is an ongoing planning process which begins at the time of the youth's admission to the program. The transition process is continuously re-evaluated throughout the youth's stay and fully considers the youth's risks, protective factors, as well as identification of ongoing follow-up needs to be addressed upon the youth's release from the program. The multidisciplinary treatment team complies assembled documents to assist the youth after release. Exit portfolios includes identification card, Social Security card, birth certificate, all educational documentation, school transcripts, résumé, sample employment applications, and educational/vocational certificates earned in the program, along with a calendar of upcoming appointments. A review of three closed youth case management records found the exit portfolios were discussed and signed by each youth during the transition conferences. Two of the three reviewed closed youth records found each youth had a completed exit portfolio with all required elements as outlined in their policy. One record was missing a State issued identification card, social security card, and birth certificate. In addition, each youth had a Plan for Success which contained identified goals, contact person, location, and appointment dates. Documentation indicated upon release from the program each youth was provided a copy of their exit portfolio.

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

The program maintains a written policy and procedures pertaining to exit conference. The program conducts a conference at least fourteen days prior to the youth's targeted release date, wherein the youth, residential program staff, the youth's juvenile probation officer, parent/guardian, and other pertinent parties review the status of the youth's transitional activities and finalize plans for the youth's release and reentry into their home community. A review of three closed youth case management records documented a completed exit conference form outlining youth identifying information to include travel arrangements, residence address, post-residential supervision plans, the status of the transition plan, and a summary of youth progress and identification of ongoing strengths, abilities, needs, preferences, and goals to be completed upon return to the community. The multidisciplinary treatment team documented court ordered

sanctions completed and yet to be completed, education plans, mental health and/or substance abuse follow-up plans, and any applicable healthcare needs. Additional information including societal and community-based needs were addressed. All three youth had a plan for continuation of education and/or employment and instructions for their post-release supervision. The date of admission and the date of termination documentation in the record correlated with the information in the Department's Juvenile Justice Information System (JJIS). Each reviewed record also contained documentation to the parent/guardian and juvenile probation officer (JPO) which confirmed the youth's release date and transportation arrangements for the youth's return to the community.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a licensed clinical social worker (LCSW) who is also the designated mental health clinician authority (DMHCA). A review of the DMHCA license found the license was clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA reported being on site at least forty hours a week Monday through Friday and on-call twenty-four hours a day, seven days a week for consultation and emergencies. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. The program's DMHCA also ensures compliance with the requirements of the mental health overlay services (MHOS) and all other mental health and substance abuse services provided by the program. In addition, the DMHCA ensures proper completion of documentation and integration of the program's mental health and substance abuse system with the State of Florida and the federal guidelines. The DMHCA also participates in the overall programming and administration of youth treatment, emergency consultation services, weekly face-to-face clinical supervision on non-licensed clinicians, management meetings attendance, provision of training, and support services as needed within the program. The DMHCA's job description and facility operating procedures also outline the DMHCA's responsibility of reviewing and signing all comprehensive mental health evaluations, Assessment of Suicide Risk (ASRs), initial treatment plans, individualized treatment plans, and treatment plan reviews. An interview with the DMHCA also verified their role in the coordination and implementation of mental health and substance abuse services at the program. Interviews with the program's facility administrator (FA) and DMHCA reported the program provides MHOS and specialized substance abuse services.

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

The program has one full-time licensed clinical social worker (LCSW) serving as the designated mental health clinician authority (DMHCA) and one licensed mental health counselor (LMHC) serving as the director of treatment services. The program also utilizes the services of another LMHC who provides services to the other programs at the campus, as needed. The second LMHC focuses in the comprehensive mental health and substance abuse evaluations and treatment plans. In addition, the program maintains an agreement for professional services with a State of Florida American Board of Psychiatry and Neurology certified licensed psychiatrist

who is scheduled to be on-site weekly. Reviewed documentation found each licensed clinician maintains a clear and active license in the State of Florida. The reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license confirmed it was active. An interview the program's DMHCA verified the DMHCA, the director of treatment services, and the psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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

The program has one full-time non-licensed master's-level therapist and one non-licensed part-time master's-level therapists providing services to youth at the program. A review of clinical supervision logs confirmed the two non-licensed therapists complete weekly on-site face to face clinical supervision lead by either the licensed DMHCA or the director of treatment services, since the last annual compliance review. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. The reviewed clinical supervision logs included a review of case notes, history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. Each reviewed direct supervision log was documented on the program's form and included all elements outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. A review of each therapist caseload assignment documented each was within the contractual limit of sixteen youth. A review of the training records for the two non-licensed staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation also included the administration of five Assessments of Suicide Risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form.

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

The program maintains a written plan and facility operating procedures for mental health and substance abuse services to establish the method in which mental health services and substance abuse services are provided to all youth. The program's mental health and substance abuse facility operating procedures documented review and signature by the psychiatrist, designated mental health clinician authority (DMHCA), and facility administrator (FA) on March 1, 2019. The policy outlines the pre-screen process by which a youth's individualized history is reviewed and an admission screening is completed. A review of three youth individualized

mental health and substance abuse records indicated the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening on the day of admission. Each reviewed record documented the review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems on the program's document review form. A review of three youth records confirmed each of the three records contained screenings administered by a trained mental health staff working under the direct supervision of the licensed DMHCA. An interview completed with the facility administrator (FA) indicated when a youth is admitted to the program, the youth is immediately given a MAYSI-2 within one hour. This screens any risks the youth might have for suicide and drug use, if there is a hit for suicide the youth immediately is placed on suicide alert. The youth is immediately given an Assessment of Suicide Risk (ASR) to determine if the youth should stay on suicide alert or suicide precautions, or if the youth can be removed and placed on standard observation in the program. An interview completed with the director of treatment found results from the MAYSI-2 screening at intake triggers which additional screenings are administered to the youth. The results of the initial and/or subsequent screenings, thorough review of records provided by Department interviews and behavioral observations of the youth, and one or more interviews with the parent/guardian and assigned juvenile probation officer (JPO) are compiled by the mental health therapist to develop the comprehensive assessment.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	**Satisfactory Compliance**
Youth identified by screening, staff observation, or behavior after admission as in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

The program maintains a written plan and facility operating 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 mental health and substance abuse facility operating procedures documented review and signature by the psychiatrist, designated mental health clinician authority (DMHCA), and facility administrator (FA) on March 1, 2019. The policy outlines the process by which all youth are referred to a licensed mental health service provider for the completion of a mental health and substance abuse evaluation. The program's policy is to complete a new compressive mental health and substance abuse evaluation regardless of identified needs for each new admission. A review of three youth individualized mental health and substance abuse records indicated each was referred for evaluation the day of admission and each evaluation was completed within thirty days of admission as required. All three reviewed comprehensive evaluations were completed by a master's-level clinician working under the direct supervision of the DMHCA. Each of the three evaluations completed by a non-licensed staff were signed within ten calendar days by a licensed staff, as required. Each reviewed new evaluation contained identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. Each of the three reviewed records were applicable for a substance abuse diagnosis and contained a substance abuse assessment. Each record documented a consent for substance abuse services and urinalysis. Each substance abuse evaluation was completed within thirty days. Each reviewed substance abuse assessment contained reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impressions, recommendations, and the original referral reason. An interview with the

program's DMHCA reported during the first two weeks of a youth's admission to the program, the primary therapist completes an Adolescent Psychopathology Scale™ short form, Trauma Symptom Checklist for Young Children™, Substance Abuse Subtle Screening Inventory (SASSI), and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessments upon admission and throughout treatment as indicated by the therapist. Reviewed training documentation confirmed program staff received training in mental health and substance abuse issues and administration of the Massachusetts Youth Screening Inventory – Second Version (MAYSI-2). The DMHCA further explained the initial assessments as well as the follow up assessments are included within the comprehensive mental health and substance abuse assessment in addition to all pertinent information from the initial screening, parent/guardian interviews, the youth's juvenile probation (JPO) officer interviews, and youth behaviors exhibited during the first few weeks at the program.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program maintains a written plan and facility operating 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 mental health and substance abuse plan documented review and signature by the psychiatrist and the current designated mental health clinician authority (DMHCA) on March 1, 2019. The plan states mental health and substance abuse treatment services are available to all youth at the program who are determined to meet clinical criteria. Additionally, mental health and substance abuse treatment is provided on-site through the provision of Mental Health Overlay Services (MHOS). All licensed and non-licensed therapists provide substance abuse groups. All therapists received face-to-face training to provide substance abuse education and the program conducted regular fidelity checks.. The program's MHOS services include mental health and substance abuse evaluation and testing, mental health treatment planning, individual group and family therapy, therapy/counseling at least five days of the week, daily therapeutic activities, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. The program's plan for mental health and substance abuse services indicated all youth are prescribed treatment based on their identified individualized need and at a minimum all youth shall receive weekly individual therapy sessions, monthly family sessions, daily clinical group services, and supportive counseling as needed. A review of three youth individualized mental health and substance abuse records documented each youth was assigned to a treatment team on the day of admission. Each of the three reviewed records contained an active Authority for Evaluation and Treatment (AET), substance abuse treatment consent, and urinalysis consent within the record. The program is licensed under Florida Statute, Chapter 397 and is certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. Each of the three reviewed mental health and substance abuse treatment records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Progress notes were completed weekly and each reviewed progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum,

clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and primary counselor's signature. Two of the three interviewed youth responded if they are participating in groups. None of the three interviewed direct care staff facilitated mental health or substance abuse groups. An interview completed with the director of treatment indicated the treatment team meets with the psychiatrist weekly and with the youth monthly in formal treatment team meetings. Behavioral observations, medication responses, and progress in treatment are discussed with the psychiatrist and are conveyed in the monthly formal treatment team meeting. All goals and objectives on the treatment plan are reviewed in the formal monthly meeting and revisions are made to the treatment plan as indicated.

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

The program maintains a written policy and procedures and a comprehensive plan for mental health and substance abuse services in place. The plan outlines the responsibilities and required elements of mental health and substance abuse treatment services and discharge planning. The program's mental health and substance abuse plan documented a review and signature by the psychiatrist, the designated mental health clinician authority (DMHCA), and the director of treatment on August 20, 2019. The plan states treatment planning at the program includes an initial mental health and substance abuse treatment plan and individualized mental health and substance abuse treatment plan, monthly treatment plan reviews, and discharge planning. A review of three youth individualized mental health and substance abuse records indicated an initial treatment plan was developed on the day of admission. Each was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse Treatment Plan form. All three plans were completed by a master's-level mental health staff working under the direct supervision of the licensed DMHCA. The licensed staff signed the three initial plans completed by non-licensed staff within ten calendar days, as required. A review of three youth individualized mental health and substance abuse records contained signatures of all treatment team members participating in the development of the plan. Each of the three reviewed initial treatment plans documented the youth's psychiatric needs to include prescribed medication and medication monitoring frequency. A review of three youth mental health and substance abuse records found each contained an individualized treatment plan documented on the program's form containing all elements in the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. The program's individualized treatment plan form includes youth identification information, youth Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, and ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and signatures of

treatment team members. A review of each individualized plan was developed within thirty days of admission and signed by the non-licensed clinical staff person completing the plan working under the direct supervision of the licensed DMHCA. Each reviewed plan was signed by the clinical staff person creating the plan within ten days. Three records were reviewed for individualized treatment plan reviews. Each reviewed treatment plan review form contained identifying youth information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and services to be provided. Each reviewed treatment plan review was documented on the program's form containing all the information in the Department's Individualized Mental Health/Substance Abuse Treatment Plan Review form. Three closed youth individualized mental health and substance abuse records were reviewed for the completion of mental health and substance abuse discharge plans. Each record contained a discharge plan documented on the program's form and included all elements outlined on the Department's Mental Health/Substance Abuse Treatment Discharge Plan form. Each of the three reviewed discharge plans were completed by the individualized treatment team on the same day of each youth's exit staffing. None of the records were applicable for notification of suicide risk upon discharge. Each youth's discharge summary listed the services needed for daily maintenance of the positive improvements in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the youth's progress in treatment while participating in the program, relevant health and substance abuse history, reason for recommending on-going treatment, and the youth and parent/guardian participation. The program's practice is to obtain the parent/guardian signature on the discharge plan upon admission and then provide the parent/guardian a copy of the plan. The discharge summaries were discussed with the youth, parent/guardian, and assigned juvenile probation officer (JPO) at the exit conference. The program also sends the mental health and substance abuse discharge plans to the youth's parent/guardian for signature and the JPO by mail upon release. An interview with the DMHCA reported within thirty days of the development of the individualized treatment plan, each youth receives a treatment plan review in which their goals and objectives are reviewed and updated. An interview with the director of treatment indicated the mental health therapist utilizes the comprehensive assessment as a guide in developing the youth's individualized treatment plan.

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

The review of the program's contract and clinical program description found the program provides mental health overlay services (MHOS) to all youth in accordance with Florida Statute, Administrative Rule. In addition, the program maintains a written comprehensive plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines specific MHOS provided at the program to include individual, family, psychoeducational, supportive, and group counseling. The program provides evidence-based or promising treatment practices with a basis on restorative justice philosophies, principles, and practices. The program's contract, written plan for mental health and substance abuse services, and schedule support the youth are provided group therapy services to include the following curricula Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT), Thinking for A Change (T4C), Impact of Crime (IOC), Young Men's Work, Thinking, Feeling and Behaving, Pathways to Self-Discovery and Change,

Teen Relationship, Skill Streaming the Adolescent, Anger Management, Living in Balance, The Passport Program, and Towards No Drug Abuse. The program also maintains written policies and procedures for substance abuse services to establish a method in which substance abuse treatment services shall be provided to youth. The substance abuse services facility operating procedure documented review and signature by the psychiatrist and the designated mental health clinician authority (DMHCA) on March 1, 2019 and included procedures for screening, assessment, special needs, residential placement criteria, primary counselor assignment, treatment planning, treatment plan reviews, progress notes, ancillary services, record of disciplinary problems, control of aggression, discharge and transfer summaries, provisions of services for outpatient treatment, record keeping, and drug testing. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes to provide substance abuse services for outpatient treatment. The program maintains an independent contractor agreement with a part time board-certified behavior analyst (CBA) to supplement mental health services. A review of the CBA's credential verified the CBA is a board-certified behavior analyst. A review of three youth individualized mental health and substance abuse records indicated each contained an initial urine drug screen, at least one random urine drug screen, and a detoxification assessment form completed by the program's medical staff. A review of three youth individualized mental health and substance abuse records weekly progress notes supported the groups are provided to youth as scheduled. An interview with the facility administrator indicated the program provide MHOS services to all youth. An interview with the director of treatment revealed all mental health staff are assigned groups with a list of youth names there are responsible for providing groups to. Master control is notified of the daily groups along with the number of youth in each group. Master control ensures the correct number of youth are provided with group. Observation of a group session by a member of the review team found the facilitator agenda for the group included each youth greetings and feelings expression, a work-up exercise, explanation of the group objectives, group topic discussion; provision of work sheets for each youth for individual answers, role play and rehearsal, summarization of the session, youth individual feed-back, and a review of the Prison Rape Elimination Act (PREA) protocol. The therapist is responsible for assuring to provide groups to all youth assigned to them and scanning completed sign in sheets to the director of treatment. An interview completed with the director of treatment indicated attendance at group therapy sessions are verified by sign-in-sheets prior to being placed on the grid. Only the services signed for by the youth are indicated on the grid unless a supportive or individual or family service was provided which is verified by the progress note.

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

The program maintains an independent psychiatrist agreement with a board-certified licensed psychiatrist for the provision of weekly on-site part time psychiatric screenings, assessments and evaluation, upon youth admission, as well as psychiatric consultation and 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. Each youth prescribed psychotropic medications received medication reviews at least every thirty days. Reviewed documentation supported there were no standing

orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the psychiatrist's license confirmed it was clear and active in the State of Florida with an expiration date of January 31, 2020. The psychiatrist is a licensed medical doctor with a specialty in psychiatry and neurology. A review of psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly as required. Additional reviewed documentation supported the psychiatrist participates in bi-weekly treatment team meetings with the program's mental health staff. Treatment team meeting minutes included a review of referred youth, diagnosis, and discussion and meeting outcomes. A review of three youth individualized mental health and substance abuse records documented each contained a psychiatric initial diagnostic interview completed within fourteen days of admission. 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. All reviewed records documented the initial diagnostic psychiatric interview, parent/guardian's verbal consent for psychotropic medications on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained a page number three of the CPPN completed within the required time frame as outlined in policy. A review of documentation revealed other Florida licensed psychiatrist was appointed to cover psychiatric duties when the program psychiatrist is absent or on vacation. An interview with the psychiatrist validated they are on-site weekly and provides evaluations and medication management. The psychiatrist indicated there were no concerns with the healthcare provided at the program.

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

The program maintains a written policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program maintains a written suicide prevention plan. The program's suicide prevention plan was reviewed and signed by the designated mental health clinician authority (DMHCA) on August 20, 2019. A review of the program's suicide prevention plan included identification, assessment, suicide precautions, procedures for use of precautionary observation, serious suicide attempt or serious self-inflicted injury review and mortality review, and training. An interview with the program's facility administrator (FA) indicated the program provides suicide prevention training during the mandatory pre-service and in-service trainings. The FA also reported the program conducts emergency mental health drills to include emergency response to suicide attempts or self-inflicted injury, at least quarterly on each shift.

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

The program maintains a written suicide prevention plan and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. Suicide prevention is provided at the program through the implementation of the suicide prevention plan. The plan included suicide precautions, a process for every serious suicide attempt or serious self-inflicted injury, and a mortality review for a completed suicide. An interview with the program's director of treatment and a review of three youth mental health and substance abuse records indicated none of the sampled youth or any other youth in the program was applicable to suicide prevention services. All direct care staff and non-direct care staff received ongoing on-site training regarding suicide prevention, crisis intervention, and emergency care. The review of three youth mental health and substance abuse records validated the program completed one Assessment of Suicide Risk (ASR) for each youth at admission regardless of concerns or intake results. Each of the three records documented an ASR was completed using the Department's ASR form within twenty-four hours, as required. All ASRs were reviewed and placed in the Department's Juvenile Justice Information System (JJIS) and alerts were documented by clinical staff, when applicable. There was evidence in the program's logbooks reviewed and on the ASRs completed, the administrative and supervisory staff provide instructions related to the ASR findings and suicide precautions decisions. An interview with the program's director of treatment revealed the program does not utilize secure observation (SO). Interviews completed with three direct care staff members indicated if a youth expresses suicide thoughts, they are responsible to notify mental health, search the youth and room, place youth in constant sight and sound, and document supervision. The staff also indicated the program has a knife for life, wire cutters, and needle nose pliers in master control and in the sub-controls. An interview completed with the director of treatment indicated youth were referred for an Assessment of Suicide Risk (ASR) or mental health crisis assessment during business hours. The mental health professional is notified of the referral verbally and via the referral form. After hours, the on-call licensed mental health staff is notified of the referral and any placement on precautionary observation or mental health crisis alert initiated by the therapist or non-mental health therapist. The referral for youth updates psychiatric evaluation is provided to medical staff. If the referral indicates a non-emergency situation, the youth is scheduled to see the psychiatrist at the next visit. If the situation is an emergency and the psychiatrist is not on site, the psychiatrist is notified via telephone. Both a licensed mental health professional and the psychiatrist can be notified twenty-four hours per day. The director of treatment also indicated staff with the first indication of the youth's potentially suicidal ideation/gesture should contact the shift supervisor. The shift supervisor is responsible for supervisory oversight of the process and associated documentation. Master control notifies the facility administrator (FA) and license mental health professional.

3.12 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth shall provide the appropriate level of supervision and record observations of the youth's behavior at intervals of thirty minutes, at a minimum.	

The program maintains a written suicide prevention plan in place outlining staff supervision and documentation requirements during precautionary observation and facility operating procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines requirements for youth maintained on precautionary observation. Three individualized youth mental health and substance abuse records were reviewed for suicide prevention services and none was applicable for completion of a precautionary observation log. Interviews completed with the designated mental health clinician authority (DMHCA) and the director of treatment confirmed none of the youth in the program were placed on suicide precautions during the scope of this annual review.

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

The program maintains a written pre-service training plan and an in-service training plan which were both approved by the Department's Office of Staff Development and Training (SDT). Both plans outlined suicide training requirement for all program staff. A review of six direct care staff training records supported three staff received six hours of pre-service annual suicide training and three staff received six hours of in-service annual suicide training, as required. Training was conducted face-to-face by the program's staff as well as completed in the Department's Learning Management System (SkillPro). The review of the program's mock suicide drills found all completed drills included the use of life saving measures including the use of cardiopulmonary resuscitation (CPR) or an automated external defibrillator (AED). A review of the completed drills and the program staff roster confirmed applicable staff participated in mock drills semi-annually. A review of the program's mock suicide drills and mental health drills since the last annual compliance review supported drills are conducted on each shift quarterly, as required. Each reviewed drill documented a description of the incident, a synopsis of the response, identified deficiencies, corrective action, and staff members involved. An interview with the facility administrator (FA) revealed fire drills are completed once on each shift every month.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program maintains a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The program maintains a written crisis intervention plan which was reviewed and signed by the designated mental health clinician

authority (DMHCA) on August 20, 2019. A review of the program's crisis intervention plan includes a process for ensuring safety and security, notification and alert system, referral, communication, supervision, documentation, and review as required.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.	

The program maintains a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's mental health and substance abuse plan documented review and signature by the psychiatrist on July 9, 2018 and the current designated mental health clinician authority (DMHCA) on July 23, 2019. The plan outlines crisis intervention, suicide prevention, and emergency services provided at the program. The plan states crisis intervention will be provided as needed in a one-to-one setting for youth who require immediate processing relating to the specific incident. The program's crisis intervention services include anger control issues, depressive symptoms, maladaptive coping mechanisms, and impaired impulse control. In the event a youth exhibits out of control behaviors, the program's direct care staff place the youth on mental health alert and refer to a qualified mental health professional for a crisis assessment. A review of three youth individualized mental health and substance abuse records and an interview with the program's director of treatment revealed the program only had one youth applicable to crisis assessment during the scope of this annual compliance review. The review of the applicable record indicated the program completed the crisis assessment at the date and time the youth was determined to be in crisis. The assessment completed includes the reason for assessment, mental health status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, parent/guardian notification, and recommendations for follow-up. All the required elements was conducted within the required time frame by a non-licensed mental health counselor and timely reviewed by a licensed mental health counselor (LMHC). The youth remained on alert until the status examination was completed and crisis interventions were provided. There were no youth requiring off-site crisis assessment and no youth had Prison Rape Elimination Act (PREA) allegations requiring a crisis assessment since the last annual compliance review.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health and substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1 Florida Administrative Code and the facility's emergency care plan.	

The program maintains a written policy and procedures to establish a method in which emergency mental health and substance abuse services will be provided to all youth. The program maintains a written emergency care plan. The program's emergency care plan was reviewed and signed by designated mental health clinician authority (DMHCA) on August 20, 2019. A review of the program's emergency care plan confirmed it included emergency identification and immediate staff response, supervision, authorization of transport for emergency services and transportation for mental health and substance abuse emergencies, mortality review, and staff training as required by Florida Administrative Code. All staff have the right to immediately contact 9-1-1 and have access to the suicide response kits and rescue tools in case of an emergency. The program utilizes New Horizons of the Treasure Coast and Okeechobee located in Fort Pierce, Florida for the crisis stabilization unit.

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

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

Standard 4: Health Services

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

The program maintains a written policy and procedures regarding the authority responsible for the provision of health services at the facility. The program is required to designate a health authority to have responsibility for the overall administrative and clinical healthcare services provided to the youth in the program. The program's policy and procedures outline specific duties of the designated health authority (DHA) to include conducting on-site gender-specific medical evaluations and treatment through comprehensive physical assessments, conducting sick call and/or conduct medical evaluations, and treatment based on referrals either through the program's sick call process or episodic care. The DHA is to conduct periodic evaluations for youth with acute or chronic illnesses as clinically indicated and minimally every two months and review currently prescribed medication(s) and order new prescription medication(s).

During the six month review period, the program had five different DHAs or back-up DHAs, providing service at the program. Prior to the start of the review period in April 2019, the program had engaged a healthcare consultant agency for the locum tenens services of a licensed medical doctor (MD) whose specialty training was in internal medicine as the DHA. An interview with the provider's regional compliance manager indicated the program developed an independent contractor agreement for the DHA services; however, the MD did not sign the agreement but did provide on-site DHA services beginning in January 2019. Services were last provided by this physician on April 22, 2019, after which he resigned. The program was unable to provide documentation to support the DHA was on-site during the week of April 1, 2019. Additionally, reviewed documentation revealed this DHA was on-site less than two hours, as required on April 10 and 22, 2019.

Following the MD's resignation, DHA services were not provided for a period of eleven days; however, a licensed osteopathic physician (DO) who had previously been under contract through November 2, 2017 to provide DHA services at Okeechobee Youth Correctional Center (OYCC) came on-site on May 3, 2019. An interview with the regional compliance manager indicated, although the DO was under contract with TrueCore as the DHA at two other TrueCore programs in Polk County, the DO provided one hour of DHA coverage service at the program on May 3, 2019. This physician whose specialty training was in internal medicine, holds a clear and active license in the State of Florida.

On May 6, 2019 a licensed DO with a completed residency in family medicine was contracted to provide DHA services at the program. This third DHA was on-site weekly on Mondays without exception through August 5, 2019 at which time the DHA was terminated. A review of documentation indicated two on-site visits conducted by this DHA on May 27 and July 1, 2019 were for less than the required two hours.

The program's health services administrator reported an MD was hired as the fourth DHA to replace the terminated DHA and was scheduled to begin on-site services on August 12, 2019. However, the hired MD did not call or arrive to the program. Attempts were made to contact the MD with no success. For seventeen days, from August 6 through August 21, 2019, there was no DHA coverage at the program which was more than nine days between services. An interview with the program's health service administrator and the regional compliance manager indicated

their agency's corporate medical doctor who holds a clear and active license in the State of Florida was unable to provide back-up DHA coverage at the program until August 22, 2019.

The program executed a one year automatic renewing written contract with the program's designated health authority (DHA) effective August 30, 2019 who was in place on the date of the annual compliance review. The current DHA is a licensed osteopathic physician (DO) whose clear and active license expires on March 31, 2020. The current physician serves as the program's designated health authority (DHA) and according to the reviewed agreement letter is required to be on-site a minimum of two hours each week. A review of documentation validated the new DHA began consistent once a week on-site visits on August 28, 2019 with each visit lasting a minimum of two-hours. An interview with the health services administrator indicated the DHA performs all Comprehensive Physical Assessments, chronic clinics, and sick call referrals and follow-up appointments. On September 16, 2019, the new DHA executed a written appointment of the TrueCore corporate medical doctor to cover administrative and clinic duties in the event of needed coverage at the program.

A review of the sign-in logs for the prior six months indicated a DHA, corporate MD, or back-up physician was on-site weekly except for the weeks of April 1 and August 12, 2019. During the same period, there were three instances of more than nine days passing between weekly on-site DHA visit respectively concluding on April 10 after a nine day lapse, May 3 after an eleven day lapse, and August 22 after a seventeen day lapse. Reviewed DHA sign-in logs for April through September 2019 revealed there were five separate weeks whereby a DHA visits were conducted for less than the contractually required minimum of two hours on April 10, April 22, May 3, May 27, and July 1, 2019.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) is to conduct an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported one previous DHA and the current DHA signed all healthcare policies and procedures on July 8, 2019 and September 23, 2019, respectively. Additionally, the corporate medical doctor (MD) signed to acknowledge the annual policy and procedures review on August 22, 2019, the facility administrator signed on March 1, 2019, and the corporate officer signed on July 10, 2017. Signatures were obtained to acknowledge an annual review of unchanged DHA treatment protocols including those for admission and standing orders, non-licensed medical and emergency protocol guides, body mass index protocol, and first aid kits by a previous DHA on July 8, 2019, the corporate medical doctor on August 22, 2019, the current DHA on September 23, 2019, and the facility administrator on July 1, 2019. The program has one full-time and one-part time registered nurse (RN) positions. Additionally, the program shares five additional RNs and a health services administrator (HSA) working a campus-wide rotating coverage schedule with four co-located programs which are included under the same contract. All licensed healthcare documented their annual review of continued and updated facility operating procedures and healthcare protocols through their signature on a specific cover page at least annually and when changes occurred. There were no new nursing staff since the last annual compliance review. The new DHA completed a comprehensive clinical orientation to the Department's healthcare policy and procedures on August 28, September 9, September 16, and September 23, 2019 with each were provided by the licensed HSA.

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

The program maintains a written policy and procedures to ensure parent/guardians authorize or withhold consent with regard to the healthcare provided to their child. Three youth individual healthcare records (IHCRs) were reviewed and each contained a current legible copy of the Department's Authority for Evaluation and Treatment (AET) form stamped with the word "Copy". There were no reviewed records applicable for a youth in the care of the Florida Department of Children and Families. Each reviewed record contained a completed parental notifications located behind the AET in the IHCR. An interview with the program's health service administrator reported the case manager is made aware when an AET is needed immediately. The case manager will contact the youth's assigned juvenile probation officer for assistance in obtaining a valid AET for the youth. An interview with the health services administrator reported upon any youth's eighteenth birthday, the existing AET becomes invalid and the program's practice for the youth must sign a Release of Information Authorization Form for youth eighteen years of age or older.

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

The program maintains a policy and procedures requiring notification to the parent/guardian of any significant changes in the youth condition and obtaining consent when new medications and treatments are prescribed. A review of three youth individual healthcare records (IHCRs) revealed all three documented parental notification for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET) form. The three reviewed records included parental notification for eight instances requiring parental notification including a change in medication for a chronic condition or whenever a youth was taken for off-site medical or dental care. When notification is required, the healthcare staff will contact the parent/guardian by telephone and written notification is also mailed out to the parent/guardian as well. Two of the three reviewed records were applicable for verbal notification made to the parent/guardian and each verbal notification with a staff member witness was clearly documented within the record and written notification was sent as well in each instance. An interview with the program's health services administrator (HSA) revealed the program previously utilized blanket consents for OTC medications. However, the program was notified in April 2019 of the prohibition against the use of blanket consents at which time the program's practice was immediately changed. None of the reviewed records included blanket OTC consents. All three reviewed IHCRs were applicable for requiring parent/guardian consent for OTC medications beyond those covered by the AET and each was documented in the respective section within the records. None of the three reviewed records were applicable for parental consent for vaccinations, discontinuation of medications prescribed prior to the youth's program admission, hospitalizations, or invasive surgeries. None of the reviewed records were for youth in the care of the Florida Department of Children and Families (DCF). The program also maintains a written policy and procedures for obtaining consent specific to any discontinuation, significant changes to, or newly prescribed psychotropic medication. None of the three reviewed records were applicable for a youth prescribed psychotropic medication; therefore, one additional record was reviewed for the single active youth in the program with prescribed psychotropic medication. An interview with the health services administrator and

reviewed documentation validated the program utilizes the third page of the Department's Clinical Psychotropic Progress Note (CPPN) form for such notification, as required. It is the program's practice for all youth admitted to the program to receive a comprehensive psychiatric evaluation within fourteen days of admission and to complete page three of the CPPN regardless of prescribed medications. Each of the four reviewed records (three active and once closed record) contained documentation of a completed psychiatric evaluation and page three of the CPPN sent to the parent/guardian with a request for the return of the written consent. None of the reviewed records were for youth in the care of the DCF. The program also maintains a policy and procedures requiring the program to obtain information regarding a youth's immunization history and for youth to receive proper immunizations. All three reviewed IHCRs documented the immunization histories for each youth were verified within thirty days of admission. Each record documented receipt of the youth's vaccination history on the day of admission and none required any immunizations; therefore, none were applicable for refusing consent for immunization for religious or medical reasons.

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

The program maintains a policy and procedures requiring each youth to receive healthcare screenings upon their admission. An interview with the program's health services administrator (HSA) reported each newly admitted youth is seen immediately upon arrival at the program. The program's registered nurse (RN) documents the screening on the Department's Facility Entry Physical Health Screening (FEPHS) form. The nurse then notifies the designated health authority (DHA) by telephone of the youth's admission and any identified chronic condition(s) and documents the notification in the nursing admission chronological notes. A review of three youth individual healthcare records validated each youth was screened by a program RN upon admission to the program with the screening documented upon the Department's FEPHS form. None of the three reviewed healthcare records were applicable for a change in custody. An interview with the program's health services administrator (HSA) revealed there were no youth who experienced a change in custody during the review period, but the HSA reported the program is required to rescreen each youth and complete a new Facility Entry Physical Health Screening (FEPHS) form anytime a youth is returned to the program after any physical custody change.

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

The program maintains a policy and procedures to ensure all youth admitted to the program are oriented to the program's healthcare services at the time of admission. A review of three youth case management records confirmed documentation of orientation being conducted with each youth within twenty-four hours of admission into the program. The orientation included information on how to access medical and mental health services. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet including a copy of the youth handbook. A review of three youth individual healthcare records (IHCRs) validated each youth received a healthcare services orientation on their day of admission which was acknowledged by the signatures of both the youth and nursing staff on the program's healthcare services orientation forms. Youth are also to receive health education

throughout their stay which is documented on the Department's Health Education Record form and maintained in the IHCR along with a health education packet specifically designed for adolescent males. Each reviewed healthcare record validated this practice. A review of the posted healthcare contacts revealed the list was out-of-date; however, the program updated the list during the annual compliance review to include current information for the healthcare contacts. Three interviewed youth confirmed they received an orientation to the program within twenty-four hours of their admission.

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

The program maintains a written policy and procedures establishing a system whereby upon completion of the youth's healthcare screening and admission process, the designated health authority (DHA) is notified telephonically or verbally of all each new admission regardless of any identified medical conditions to provide a comprehensive overview and obtain initial admission orders, applicable initial medication orders, diet orders, and activity release or restrictions. The DHA will also provide specific treatment orders and instructions for youth identified with a health-related condition identified through the health screening process utilizing the Department's Facility Entry Health Screening (FEPHS) form. The program's practice is for the DHA to be notified by telephone of all admissions. When a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. Nursing staff documents the DHA notification on the Nursing Chronological/Notification Progress Note which is filed in the nursing chronological notes section of the IHCR. None of the reviewed records reflected the youth had a chronic condition or needed an emergency response. An interview with the program's HSA reported the admitting nurse notifies the DHA immediately by telephone to inform them of the youth's health condition and to obtain orders to continue medications if indicated.

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

The program maintains a policy and procedures outlining the completion and/or update of the Department's Health-Related History (HRH) Form upon admission. A review of three youth individual healthcare records (IHCR) documented each youth received a completed HRH within seven days of admission and prior to the Comprehensive Physical Assessment (CPA). Each CPA was completed on the day of admission. All three reviewed HRHs were completed by a registered nurse (RN). The documentation also confirmed the designated health authority (DHA) reviewed the HRH in each record. Each reviewed IHCR indicated the nursing staff and the DHA documented their review of the HRH form either by signing the form or by a documented DHA review on the completed CPA. An interview with the program nurse reported the program's practice is for the RN to complete the HRH at the time of admission for all youth.

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

The program maintains a policy and procedures to ensure all admitted youth receive a current Comprehensive Physical Assessment (CPA) prior to any participation in sports, exercise, or other strenuous activity. A review of three youth individual healthcare records (IHCRs) documented the program utilized the Department's standardized CPA form. Each reviewed CPA confirmed it was completed by the designated health authority (DHA) and/or designee within the required time frame. Each of the three reviewed CPAs had documentation of an "O" for each completed portion with no applicable "X"s to indicate an abnormality. Comments were clearly noted on each CPA justifying the deferment reason in each instance. There were no instances where any of the youth refused part of the examination. The three reviewed youth IHCRs were applicable for having the Department's Problem List updated and each documented an update, as required. An interview with the health services administrator indicated the CPA is completed within seven days of admission to the program and annually for all youth. The program written policy and procedures require the screening of infectious diseases including tuberculosis (TB) prior to any youth being placed into the general population. As part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening which is conducted on the day of admission for each youth. The three reviewed youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) within the last year documented on the CPA and on the Department's Infectious and Communicable Disease form to determine exposure to TB. There were no current youth admitted to the program during the review period with symptoms suggestive of active TB.

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

The program maintains a policy and procedures outlining admission screening and medical evaluations for sexually transmitted infections (STIs). The policy further outlines the role of the designated health authority (DHA) and/or designee to review the admission screening tool and evaluation and to order testing for STIs when indicated. A review of three youth individual healthcare records (IHCRs) found each youth were identified as sexually active and were clinically screened and evaluated for STIs. All three youth were referred to the DHA for further evaluation and the referrals were documented in the IHCR progress notes. Testing was ordered and performed for each youth on the day of admission. Test results were filed in the lab section of the IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days or required a rescreening due to presenting symptoms. An interview with the program nurse reported youth are screened for STIs at the time of admission and all youth are tested at the time of admission according to standing orders. Youth who test positive are then referred to the DHA. The program also maintains a separate written policy and procedures to ensure youth receive a confidential human immunodeficiency virus (HIV) test when testing is recommended on a clinician's assessment, based on risk assessment, or when the youth requests testing. A review of three youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV. The three reviewed youth IHCRs indicated two youth consented to testing and one declined testing on the

Department's HIV Antibody Test Youth Consent form. The program's DHA and back-up DHA both carry a medical doctor license and are authorized to provide pre-counseling, testing, and post-counseling. Each of the three applicable IHCRs for HIV testing included results contained in a sealed envelope which was marked personal and "confidential" along with the youth's name, Department identification number, date of birth, and date of testing. An interview with the program's HSA reported if a youth consents to HIV testing they are pre-counseled by the DHA. An HIV blood draw is then completed by the registered nurse and sent to an off-site laboratory. Post-HIV counseling is then completed by the DHA. Signed HIV consent forms are maintained on the Department's Infectious and Communicable Disease (ICD) form section of each IHCR. Pre-counseling and post-counseling is documented on the youth's Health Education Record. All three interviewed youth indicated they can request HIV testing at the program.

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

The program maintains a written policy and procedures to ensure all youth are able to request and receive sick call care, even if a youth is placed in restricted housing. The policy outlines sick call care to be provided by licensed healthcare professionals pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program offers youth the opportunity to submit written sick call requests seven days a week. Sick calls are scheduled to take place twice daily on Monday through Friday from 12:00 p.m. until 12:40 p.m. and from 6:00 p.m. until 7:00 p.m. On Saturdays and Sundays, sick call is to be conducted from 8:50 a.m. until 9:50 p.m. and from 5:30 until 6:30 p.m. All scheduled sick calls are conducted by the registered nurse (RN). Sick call forms and a wall-mounted deposit box for the forms are accessible to all youth in the hallway adjacent to the dormitory. An interview with the health services administrator indicated the program checks the sick call box every two hours. Completed Sick Call Request forms are filed in chronological order in the nursing progress note section of the individual healthcare record (IHCR). In addition, all sick calls are documented on the Department's Sick Call Index and on the Sick Call Referral Log. A review of three youth IHCRs reflected none of the youth completed a sick call request form at least once during their stay. Therefore, three additional applicable records were reviewed in order to achieve the minimum required sample size. In each instance the RN documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There were no instances of a youth presenting with a similar sick call complaint three or more times within a two-week period. An interview with the program nurse reported all sick call referrals are documented on the sick call log and in the IHCR chronological notes. The program nurse also reported youth have the availability for sick call services outside of scheduled sick call hours when needed. The program nurse additionally reported sick calls are conducted by RNs in the clinic to ensure youth privacy. Three program staff were interviewed regarding who conducts sick call and each reported sick call is conducted by the program's nurse. A sick call was unable to be observed during the annual compliance review, as no sick call requests were submitted. Three interviewed staff indicated the RN conducts sick call. Two of the three interviewed youth indicated they can be seen immediately once they submit a Sick Call Request form and three indicated within one day. Three interviewed youth indicated they can see the nurse either immediately or within one day of submitting a sick call request. They are able to see a doctor if needed and a dentist in the event they have tooth pain while at the program.

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

The program maintains a written policy and procedures to requiring a comprehensive process for the provision of episodic and first aid care to youth including twenty-four-hour emergency medical, mental health, and dental care. The program requires each episodic encounter to be documented on the Department's First Aid/Emergency Care Log form. Any episodic care provided by a non-licensed staff person must have a follow-up evaluation by a licensed healthcare professional the next time the person is on-site or sooner, if indicated. The healthcare staff then documents the follow up evaluation on a nursing chronological note. All program staff must be able to respond to unexpected illnesses, accidents, or conditions requiring immediate attention or an immediate professional assessment to determine their severity and responding staff are to provide first aid care within three to four minutes.

A review of three youth individual healthcare records (IHCRs) found two youth requiring episodic and/or first aid care at the program. Therefore, one additional applicable record was reviewed to reach the minimum required sample size. All treatment services were provided by nursing staff. Each of the reviewed nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) format. Nursing staff also maintained an episodic/first aid/emergency care log documenting all incidents of care by date, as well as the 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). The program maintains two automated external defibrillators (AED) which are located in the master control which is adjacent to the secure program and within the program's sub-master control office. The AED procedures were observed as audio, written instructions, and each AED was demonstrated by the assistant facility administrator during the annual compliance review. Reviewed documentation confirmed the program's AEDs were checked monthly by nursing staff according to the program's policy. Reviewed AED batteries expire in October 2022 and July 2022. Reviewed AED pads expire in April 2021 and December 2020. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. Additionally, all nursing staff maintained current certifications in CPR and AED. The program also maintains five first aid kits with three kits located in master control, two of which were designated for the program's transportation vans, one in the program's sub-master control office which was specifically identified for use in the maximum risk program, and one in the program's medical clinic. Inspected first aid kits were sealed with plastic snap-tabs and were fully stocked with the list of items approved by the DHA and contained no expired items. The first aid kits and suicide response kits are inventoried weekly and perpetually by medical staff and observed documentation validated the practice. The program maintains one epinephrine auto injector which is maintained in the program's medical clinic in a locked medical cart. Reviewed training records supported all supervisory staff completed training in the administration of the epinephrine auto injector. The program maintains a written policy and procedures which require the program to conduct three drills monthly with one on each shift. A review of the program's mock emergency medical drills reflected thirty-four drills were conducted over the previous twelve months. There were no documentation to indicate drills were conducted in November 2018 on the C shift or on the B shift in August 2019. Twenty-two drills included CPR/AED demonstration with the demonstration occurring at least once on each shift each quarter. The program's practice is to review all medical drills during the program's morning management meetings Monday through Friday and during the mandatory monthly all-staff meetings.

Emergency telephone numbers were located in master control and the medical clinic which are areas inaccessible to youth. Three interviewed staff reported they can call master control over the two-way radio to have master control staff make the call to 9-1-1 when a youth has been identified with a medical emergency.

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

The program maintains written policy and procedures for the provision of off-site emergent and non-emergent referrals for medical care and treatment. Evaluations conducted off-site must be recorded on the Department's Summary of Off-Site Care Form attached to the off-site care instructions which must be reviewed, signed, and dated by the designated health authority (DHA). A review of three youth healthcare records (IHCRs) found one youth requiring off-site care and/or emergency care. The program reported having only one additional record applicable for off-site care during the review period which was reviewed to reach the minimum required sample size. Both reviewed IHCRs indicated the youth was under eighteen years of age and each parent/guardian was notified of the provision of off-site care. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the IHCR with the discharge paperwork. The DHA reviewed both completed Summary of Off-Site Care Forms and discharge paperwork as evidenced by signature and date. One of the two youth required follow-up care and services were received as prescribed. An interview with the program's health service administrator (HSA) reported the program notifies the DHA as soon as each youth returns from an off-site visit and all documentation is placed in the youth's chart for the DHA to review upon return to the facility. An interview with health services administrator also revealed follow-up testing, referrals, and appointments are tracked by healthcare staff on the laboratory log, the transportation calendar, the appointment calendar, as well as the health service provider tracker.

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

The program maintains a written policy and procedures to ensure youth with chronic conditions receive regularly scheduled evaluations and necessary follow-up care. The program defines a chronic medical condition as an illness, disability, or condition which is permanent or persists longer than six months apart from allergies, hearing/speech/visual impairment, developmental disability, or mental retardation. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of three youth individual healthcare records (IHCRs) indicated two were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. Therefore, one additional applicable record was reviewed in order to achieve the minimum required sample size. Three reviewed applicable IHCRs confirmed all three youth were classified with a medical grade of two through five. Two youth were taking prescribed medication on an on-going basis and one youth was undergoing treatment for physical health condition which included a body mass index greater than thirty. The program maintains a youth

roster of youth requiring periodic evaluations which identifies the youth's name, date of admission, whether the youth was admitted while taking prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations as required and there was no indication of lapses in care or missed periodic evaluations. All three reviewed applicable records documented updating of the Department's Problem List as changes occurred. An interview with the designated health authority (DHA) indicated chronic conditions are monitored as needed and at least every sixty days. Reviewed documentation indicated the DHA notates placement or discharge from chronic clinic on the DHA's physician order sheets.

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

The program maintains a written policy and procedures to ensure youth's medications are verified upon arrival. Nursing staff are to complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. When a youth arrives to the program with medication(s) or an order/prescription for medication, the healthcare staff are to conduct a preliminary assessment and interview to determine the medication is verified and indicated. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. An interview with the health services administrator (HSA) indicated only a registered nurse completes admissions and any applicable medications are verified with the medical records with the youth's parent/guardian and or the prescribing pharmacy. The verification is then documented by the registered nurse (RN) in the chronological section of the individual healthcare record. A review of three youth individual healthcare records (IHCRs) and an interview with the HSA indicated there were no youth in the program at the time of the annual compliance review admitted into the program on prescribed medication. It was also reported there were no instances during the review period where a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The program maintains a written policy and procedures to ensure there is no lapse in the youth's medication regimen. All prescribed medications are obtained from 1st Choice Pharmacy, a licensed vendor under contractual agreement with the program. The program may obtain emergency prescriptions from a local pharmacy, when necessary. One record was applicable for a youth having a new medication ordered by the DHA after the youth was admitted to the program; therefore, the record was also reviewed. In that instance, the doctor's order sheet clearly documented the medication and dosage. Three reviewed youth IHCRs found each youth had a Medication Administration Record (MAR) outlining over-the-counter medications (OTC) approved through the AET form and when applicable, the medication was administered in accordance with the approved protocols and physician's order. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. The medications are maintained in blister packs documenting the number of pills in each prescription order. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventory of controlled medications are conducted by two RNs. The MAR clearly indicated medication start and stop dates. Licensed nursing staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. The program's nursing staff maintain a locked wall-mounted box within the clinic with OTC medications listed on the AET form for trained non-

licensed staff to utilize when nursing staff are not on-site. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications at the program since the last annual compliance review. One record was applicable and the reviewed MAR clearly documented one refusal of medication. Observation of one medication administration by nursing staff during the annual compliance review validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with oral and topical medications separated. The Six Rights of Medication Delivery/Administration was maintained for the youth. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program had one controlled medication on-site during the annual compliance review week and observations indicated the medication was stored behind two locks and inventoried, as required. The program maintains one locked refrigerator in the medical clinic for the storage of medication; however, there were no applicable medications requiring refrigeration during the annual compliance review week. Three staff were interviewed regarding the administration of medication at the program and three staff stated the nurse provides medication to youth. One staff indicated the doctor provides the medication and two staff responded the trained supervisor provides medication. Three interviewed youth all indicated they do not take medication at the program.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations found all medications securely stored in the locked medical clinic which is inaccessible to youth. All non-controlled medications were stored separately in a secure, locked medication cart and a small amount of over-the-counter (OTC) medications were placed in a locked wall-mounted box in the medical clinic. Observations made during the annual compliance review also revealed oral medications were stored separately from topical medications. There were no injectable medications at the time of the annual compliance review. The program maintains one refrigerator for medications; however, there were no medications requiring refrigeration on-site during the annual compliance review week. The program securely stored sharps and syringes separately from medications. Syringes and sharps are counted through a perpetual inventory and are verified weekly. All controlled substances are maintained in a locked metal box within the locked medication cart which is maintained in the medical clinic. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The program's medications are procured through 1st Choice Pharmacy in blister packs documenting the number of pills in each prescription order. The program's pharmacy license issued through the Department of Health, Division of Quality Assurance expires on February 28, 2021 and the consultant pharmacist license expires on December 31, 2020. The program's process for the disposal of medication is for all medication to be disposed in the physical presence of the consultant pharmacist utilizing the Drug Buster® medication disposal system. Reviewed documentation and nursing interviews validated all OTC medications are inventoried perpetually and weekly. The program maintains a written policy and procedures for youth self-administration of oral, topical, or inhaled prescribed medications assisted by non-licensed trained supervisory staff. Non-licensed supervisory staff are to assist with self-administration of medication only when licensed healthcare staff are not on-site. A review of training logs indicated all program supervisors received training for youth self-administration of medications by the program's

licensed health services administrator (HSA). All youth medications are administered by nursing staff when they are on-site. Each youth's individual controlled medication inventory record is updated after each administration and shift-to-shift inventories are conducted by two registered nurses. The program had one youth with a prescribed controlled medication during the annual compliance review. The inventory for the one controlled medication was accurate. The nurse reported the consultant pharmacist is on-site monthly for inspection which reviewed documentation validated. The HSA reported the consultant pharmacist assists in checking all nursing units, medication carts, over-the-counter medications, sharps containers, medication count sheets, refrigerators, and emergency kits. Reviewed documentation evidenced the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator and licensed healthcare staff. Observations conducted during the annual compliance review week supported three youth prescribed medication inventories including one controlled mediation were accurate. Three OTC medications were reviewed and inventories were confirmed to be accurate. Three sharps were reviewed and inventories were also accurate. A review of the program's counts from the previous six months indicated there were no discrepancies identified with the counts. The program has a written biomedical waste plan signed by the designated health authority (DHA) and also maintains a current agreement with Stericycle, Inc. for monthly biomedical waste treatment and removal. Stericycle, Inc. has a State of Florida, Department of Health operating permit which expires on September 30, 2020.

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

The program maintains a written policy and procedures requiring an approved plan for infection 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 includes prevention, containment, treatment, and reporting requirements related to infectious diseases as specified by the Occupational Safety and Health Administration (OSHA) standards and the guidelines of the Centers for Disease Control and Prevention (CDC). The plan was reviewed and approved by a corporate officer on July 10, 2017, the facility administrator on August 5, 2019, the current DHA on September 23, 2019, the corporate medical doctor (MD) on August 22, 2019, and a previous DHA on August 30, 2018. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, C, and human immunodeficiency virus (HIV), and infectious diseases caused by blood-borne pathogens. The plan includes procedures for other outbreaks or epidemics caused by other infectious agents, pediculosis and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), food-borne illnesses including those caused by Escherichia Coli (E. Coli), bio-terrorist agents, and procedures regarding chemical exposures and universal precautions. All program staff are provided the opportunity to receive Hepatitis B immunizations as well as access to protective equipment. An interview with the program's health service administrator reported there were no instances of an infectious disease in which the local health department, the Center for Disease Control and Prevention, and or the Department's Central Communications Center should have been notified. The

program reported there were no incidents involving a contagious disease requiring the quarantining or hospitalization of any youth or staff. The program's plan includes universal standard precautions and a comprehensive process for needle stick post-exposure evaluation. There were no documented instances of staff having experienced an occupational exposure since the last annual compliance review. An interview with the program's FA revealed a copy of the program's exposure control and infection control plans are maintained in the medical clinic as well as the administration building. The program's policy and procedures indicates and an interview with the FA reiterated the exposure control plan/infection control plan is included in all new hire training. Additionally, the plans are reviewed twice annually in June and December during all staff meetings where the training is provided by the licensed health service administrator (HSA). Reviewed documentation and an interview with the program's HSA validated all youth completed infection control training at the time of their admission to the program and annually, thereafter.

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

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

Standard 5: Safety and Security

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

The program maintains written policies and procedures which clearly outline the active supervision of youth. The program promotes safety and security by maintaining supervision of youth which includes interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing the behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system. The program has a daily schedule posted in the youth living areas and throughout the facility. Youth and staff observations were conducted each day of the annual compliance review. Observations made throughout the review week included youth movement from cottage to classrooms, classroom to classroom, classroom to treatment team meeting, and from cottage to the outdoor recreation area. During outdoor activities and/or movement, staff were observed to be strategically positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Observations of interactions with program staff and the youth reflected they were positive and followed the program's behavior management system. Informal interviews were conducted with supervising staff each day of the review and confirmed staff understood the procedures to take when there is a discrepancy in youth counts. Staff explained the procedures included stopping movement, performing a recount, performing an emergency count, notification to the supervisor and facility administrator, securing youth, conducting a facility and perimeter search, notification to law enforcement, and notification to the Department's Central Communications Center (CCC) if not reconciled within two hours. Observations of active youth supervision made during the week of the review coupled with reviewed video surveillance recordings during ten-minute checks of youth supervision reflected staff-to-youth ratios were observed to be compliant with the program's contract of one staff for every eight youth during day time activities and one staff for every twelve youth during night time (sleep) activities. All youth and staff movement as well as youth counts made throughout the day are documented in the facility logbook which is maintained by the program staff in master control. The master control operator staff documented all youth movement throughout the day in the facility logbook. Youth counts are consistently conducted during each shift and the master control staff calls for a formal count from each youth care worker by way of two-way radio. Prior to any movement, staff informed master control of the count and waited for permission to move the youth.

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

The program has a clearly written policy and procedures regarding their behavior management system (BMS) which the program refers to as their positive performance system. A written description of the BMS is provided to each youth in the program's youth handbook. This is provided to youth upon orientation to allow easy access for youth to the BMS including rules governing conduct and positive and negative consequences for behavior. The youth handbook included a list of behavioral infractions and rewards youth can earn for demonstrating positive behavior. The BMS is a five-tiered level system which is designed to decrease unwanted behaviors and increase desired behaviors through reinforcements as well as foster accountability for behavior and compliance with the residential community's rules and expectations. The five levels include Level One: Orientation/Assessment, Level Two: Trainee, Level Three: Maintenance, Level Four: Independent, and Level Five: Honors. The BMS outlines daily, weekly, and monthly incentives to include responsibilities, expectations, and level advancement. The BMS is reviewed with the youth by the staff completing the orientation phase. A review of three youth case management records confirmed youth are oriented upon their admission to the program through the program's youth handbook. The program has an annual in-service and pre-service training plan which includes the BMS for all staff. A review of three staff's pre-service training records and three staff's in-service training records confirmed each were trained in the BMS utilized at the program, as required. Furthermore, the program provided sign-in sheet documentation of staff members from the school board receiving training on the program's BMS. Observations made of the facility while on the facility tour reflected the program has postings of the BMS and a list of youth who earned privileges posted in the cottage. A review of the program's facility operating procedure coupled with an interview with administrative staff confirmed fidelity checks are used to monitor rewards to ensure rewards outnumber consequences at a minimum ratio of four-to-one positive to negative consequences. Rewards include but are not limited to later bedtimes, personal hygiene items, snacks, games, movies, and verbal praise. Negative consequences are in direct relation to the severity or seriousness of inappropriate behavior exhibited. Three interviewed youth each confirmed they were aware of the BMS, aware it is posted throughout the program, and were provided information on the BMS within their youth handbook. Two youth rated the BMS as fair while one rated it as good. The three interviewed youth each confirmed rewards include daily and weekly incentives such as extra snacks, hygiene items, and later bed times. Three interviewed staff each confirmed they were trained in the BMS and were able to explain their understanding of the BMS which reflected the program's policy. The interviewed staff confirmed reward incentives may include things such as later bed times, extra snacks, later bed times, more video games, and daily/weekly incentives. The facility administrator (FA) was interviewed and stated they use a BMS tracker/level system which includes orientation, trainee, maintenance, independent, and honors levels through treatment team behavior referrals and special treatment teams, when needed. Furthermore, the FA stated rewards outnumber consequences at a minimum of four to one and are monitored through their BMS tracker, level systems, and daily/weekly/monthly incentives.

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

The program has a clearly written behavior management system (BMS) which provides for positive and negative consequences in a ratio of four-to-one positive to negative consequences. The BMS is designed to maintain order and security, provide constructive discipline, and positive and negative consequences to encourage youth to meet behavior expectations. The program's BMS requires all staff to be responsible for monitoring and addressing behavior. Case managers are responsible for tracking youth violations and utilizing the BMS when confronting the youth about their behaviors. The youth handbook informs each youth of the program's responsibility to the youth and the youth's responsibility and expectations to the program. The BMS reminds the youth of their responsibility to follow all the program rules, follow staff directives, and always exhibit appropriate behavior. Observations of youth and staff interactions during the annual compliance review week reflected the exchange of open communication between youth and staff in relation to youth actions and behavior. The system makes provisions for staff to explain to the youth the reason for any sanctions imposed, youth to explain their behavior to staff, and gives staff and youth the opportunity to discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behaviors. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and constantly imposed. The BMS is not used solely to increase a youth's length of stay, deny a youth basic rights or services, promote the use of group punishment, allow youth to sanction other youth, or include disciplinary confinement. The program utilizes "Let's Talk" forms where the youth may submit a "Let's Talk" form to informally voice any concerns or requests with staff prior to filing a formal grievance. The program does not utilize room restrictions as a form of imposing sanctions for inappropriate behavior. A sample of randomly selected staff position descriptions were reviewed and reflected they specified implementation of the BMS as a job requirement. Reviewed documentation confirmed staff receive an initial ninety-day performance evaluation followed by an annual evaluation thereafter which includes an evaluation of the staff's implementation of the BMS. Three staff and three youth were interviewed and confirmed staff discuss sanctions imposed by the end of their workday, consequences, and alternative acceptable behaviors with the youth. Each of the interviewed youth were aware of the BMS, aware it is posted throughout the facility, and were provided information on the BMS within their youth handbook. Two of the three interviewed staff stated they received feedback from supervisors regarding their implementation of the BMS, while one stated they did not receive feedback and their one supervisor was not professional. This was advised to the facility administrator (FA) to follow-up with staff. Each staff was able to describe different types of rewards provided to youth which includes daily incentives, extra snacks, hygiene, and level parties. An interview was conducted with the FA regarding how the implementation of the BMS is monitored to ensure it is administered fairly and consistently among all staff. The FA confirmed the program utilizes a BMS tracker, the level systems, and daily/weekly/monthly incentives to monitor the

implementation of the BMS. Furthermore, the FA confirmed staff receive ninety-day evaluations after their hire date and have annual performance evaluations thereafter where they are evaluated on their implementation of the BMS.

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

The program has a written policy and procedures in place for staff to conduct and document ten-minute room checks every ten minutes on a ten-minute check log when youth are in their sleeping quarters. The program's policy requires staff to utilize a flashlight, which is issued through master control, to inspect the youth and the room when the lights are dimmed for sleeping. Staff must ensure the youth's skin or a body part is seen to confirm the youth's presence. Staff are not allowed to enter a youth's room alone and must conduct a visual check from the door/window of the youth's room. An interview with the facility administrator (FA) confirmed the Kennedy cottage has a total of two cameras inside the cottage which were both operational. At the time of the review, there were outside contractors on-site installing a new fiber optics video recording system with new high-definition cameras. Reviewed documentation of the program's ten-minute check log binder reflected staff documented the actual time of the room check and initialed on the ten-minute check log sheets verifying who completed the room check. If a youth is not in their room, an "X" is marked in the box for the time of the room check. A review of ten-minute check logs from six randomly selected dates and different shifts along with the corresponding video recording, confirmed checks were conducted with a flashlight and with fidelity at least every ten minutes and staff were documenting the checks accordingly in real time on the log. The program's practice is to have master control staff notify staff of ten-minute checks by way of two-way radio communication of when checks are to be conducted. Supervisors are required to conduct three room checks each night and visibly see flesh of each youth in their room. The program's practice is for supervisors to document these checks in red on the ten-minute log sheets to include the time of the check and their initials. Reviewed documentation confirmed a supervisor conducted ten-minute checks, as required on the six different days reviewed and were documented in red on the ten-minute check logs. Three interviewed staff each confirmed room checks are conducted every ten minutes when a youth is placed in their room for sleeping or non-punishment reasons. The program's FA also advised a training was recently conducted with all staff on policy and procedures regarding ten-minute checks at night and during shift changes while the youth are in their beds sleeping.

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

The program has a written policy and procedures to track the daily census of youth. Youth are accounted for at all times by a physical count and through random head counts throughout each day when requested by master control. The program has one program logbook which the master control staff oversees and maintains. The daily census is documented in the facility's master control logbook by the master control staff operator. The program maintains two tracking boards in the master control office. The first tracking board in master control documents the daily census for the program which keeps the daily totals, admissions, releases, and youth temporarily off-site/campus. The second tracking board in master control identifies each youth by their photo with their name, date of birth, Department identification number, assigned cottage, medical alert, mental health alert, and security risk alert. A review of randomly selected dates and times in the facility logbooks for the past six months was conducted and reflected youth counts were completed at the beginning of each shift, after outdoor activities, and after movements from one area of the facility to another. Documentation in the logbooks also included youth temporarily away from the program, emergency counts, missed counts, and reconciliation of a count. Master control staff conducted at least six formal head counts within each twenty-four period and random informal head counts throughout each shift. All formal and informal counts in the logbook include the time of the count, location, and number of youths accounted. The staff highlighted in yellow, head counts of youth and any emergency situations. Observations of youth counts were made during the annual compliance review week and reflected prior to any youth movement. Master control was contacted by staff to inform them of the number of youth being moved and to what location. Staff waited for clearance from master control before moving the youth. Three staff were interviewed and each were aware of the program's policy and procedures on adequate supervision of youth as well as procedures if there are discrepancies in youth counts, including emergency counts.

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 has a written policy and procedures regarding logbooks to provide procedures and documentation for a daily account of routines and emergency situations involving youth. The program maintains a bound logbook with numbered pages which is stored within master control to document information and daily events at the facility. The master control operator is responsible for documenting the daily account of situations in chronological order in the program's logbook. Reviewed documentation confirmed the logbook documented population counts, perimeter checks, emergency situations, incidents, transports, removal of youth from population, admissions, releases, Central Communications Center (CCC) calls/incidents, Florida Abuse Hotline calls/incidents, and supervisors leaving special instructions pertaining to the supervision of specific youth. Reviewed documentation of randomly selected days within the logbooks reflected each entry was legible and made in ink with no erasures or white-out. All entries had consistent color-coded highlighting. Observations made while reviewing the logbooks reflected there were inconsistencies of errors made in the logbooks. Entries which contained errors were struck through with a single line and were initialed by the staff member making the correction; however, there were entries observed throughout the logbooks of errors made which were not struck through with a single line nor initialed by the staff member making the correction. In these instances, staff would write over the error in more bold ink or strike through the error without initialing next to the error/correction. This was brought to the attention of the program's regional compliance manager and the facility administrator to follow-up with staff. The program conducts shift briefings prior to each shift debriefing oncoming staff with significant issues identified on the previous shift. The shift briefing information is documented in the shift reports and all staff sign the shift report at the end of the shift briefing to validate they have been briefed about its contents. The shift supervisor is assigned to maintain the report and make entries regarding chronological events for their shift. Shift entries were inclusive of population counts, perimeter, and other security checks. Observations of a staff briefing could not be made during the week of the annual compliance review, as the program is continuing to have staff work twelve hour shifts from 6:00 a.m. until 6:00 p.m. and from 6:00 p.m. until 6:00 a.m. A review of the program's shift reports verified information is shared with incoming staff prior to the beginning of the shift and staff sign the shift reports to reflect they were briefed about its contents.

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

The program has a written policy and procedures for key control and security which includes assignment, inventory, tracking, and the storage of keys. The program has a daily tracking key

log which is utilized each day to track program keys. Reviewed documentation reflected the log indicates the name of the staff and what type of key they are assigned to according to their position duties. Facility keys are maintained in master control within a securely locked key box which remains locked when not in use and youth do not have access to the program keys. Facility keys are maintained on a tamper resistant color-coded ring which includes a brass colored tag with the initials of the staff positions and a tracking number. When staff arrive to the facility to begin their shift, they gain access to the facility by way of master control. Staff submit their personal keys to the master control operator and receive a facility key in exchange. Staff initial the key log next to their name before and at the end of each shift. Staff's personal keys are placed in the key box on the corresponding staff's key assignment/name. Restricted keys are maintained in a separate key box located in master control which is only accessible to medical staff. When medical staff report to work, they enter master control, obtain their facility key, and deposit their personal keys in the medical key box. Observations of key exchange confirmed the program's practice. The program maintains a list of staff who are assigned permanent keys. Staff who are authorized to possess permanent keys must sign an acknowledgment form indicating a key identification number and the number of keys issued. Reviewed documentation of the current key inventory was compared with the keys in use and the inventory matched the actual keys in use. A review of the program's daily key logs from the past six months revealed the program's sign-in and sign-out logs for keys were consistently used for tracking and assigning keys. The program's warehouse clerk is responsible for conducting a complete inventory of keys bi-annually. Reviewed documentation confirmed this practice. The master control operator was interviewed and advised damaged keys are turned over to master control in which maintenance personnel and administration is notified to have the key repaired or replaced. They also advised if lost keys have not been found within two hours, the incident is reported to the Central Communications Center (CCC). Staff were informally interviewed at random throughout the week of the annual compliance review and confirmed none had their personal keys in their possession. Three interviewed staff each were knowledgeable of the key control process including how keys are assigned and the process for missing or lost keys, damaged keys, and restricted keys.

5.08 Contraband Procedure	**Satisfactory Compliance**

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program has a written policy and procedures regarding contraband control and searches to maintain the safety and security of the program by searching for, detecting, storing, and disposing of contraband and/or unauthorized items within the program. The policy identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Each youth receives a youth handbook upon their admission to the program during orientation. Youth's parent/guardians are mailed a handbook which outlines a list of items considered as contraband and the program's visitation procedure. Visitors at the facility are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor contraband list verified it contains a list of the required unauthorized items not permitted which includes personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program's policy reflects unannounced random searches of youth sleeping rooms shall be done on an irregular, unpredictable basis but at a minimum, must be done weekly. Reviewed documentation reflected the program conducts contraband searches of the youth's rooms daily on each shift. Contraband searches are documented on a daily search report. If any contraband is found, this is documented on this form including the method of disposal. Youth who are found with contraband will have a behavior report and a special treatment team meeting for the violation. A review of the logbooks, daily search reports, and safety perimeter check inspection reports for the past six months verified searches and facility checks are conducted daily on each shift. An interview with the facility administrator indicated discovery of unauthorized contraband is confiscated and either discarded, returned it to the original owner, mailed to the youth's home, or stored and returned to the youth upon their release. Any illegal contraband will be confiscated and forwarded to the program's facility investigator and processed with the local police department.

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

The program has a written policy and procedures to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code. Youth are searched upon their admission to the program and before and after off-campus activities, outdoor activities, visitation, school, group, outdoor recreation, meals, and vocational or work projects involving the use of tools. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus, suspected of contraband, or are a security risk receive a full body visual search and are required to sign a search form indicating the search procedure was explained. Reviewed documentation confirmed searches occurred after these activities. Searches of the youth are conducted by two staff members of the same gender and the search is conducted in a private area. Parent/guardians are notified of searches during visitation by way of a parent intake letter. This letter is sent to the parent/guardian at the time of the youth's admission. Observations of searches were conducted throughout the week of the annual compliance review of youth moving from cottage to classroom, from classroom to classroom, after school, before group, and after daily cleaning activities. Youth were given instructions regarding the search and were searched by a staff member of the same gender. Searches were conducted in a manner not to degrade the youth and were based on the Protective Action Response training manual. Three interviewed staff each confirmed the process for conducting searches and stated youth are searched after every movement. Three interviewed youth each indicated searches occur when returning from off campus, after outdoor recreation, when items are missing, after visitation, after meals, and after work detail.

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

The program has a policy and procedures in place regarding transportation, vehicle equipment, and maintenance of vehicles. The program has a physical plant worker who maintains an active certification in automotive service excellence (ASE) and is a certified mechanic. This staff member performs regular maintenance and annual inspections on the program's vans. The program has two operable vans utilized to transport youth. Reviewed documentation of invoices confirmed both vans were found to have annual inspections completed; however, one was completed late. One of the two van's 2018 annual inspection was completed on August 8, 2018 and the 2019 annual inspection was completed on August 21, 2019. Each van was observed to be equipped with a safety screen separating the driver's compartment from the back seat/rear passenger's compartment and doors to the youth passenger area which cannot be opened from the inside when locked. Reviewed documentation confirmed transportation staff conduct daily and weekly inspections of the vehicles. Each vehicle was observed to be equipped with an up-to-date fire extinguisher, seatbelt cutter, window punch, and an appropriate number of seat belts. Each van is assigned to a first aid kit which is maintained and housed in master control until transports are ready to leave the facility. There were no transports applicable to be observed during the week of the annual compliance review. Informal interviews with transportation staff confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt and both youth and staff wear seatbelts during transportation. An inspection of approximately forty randomly selected personal vehicles was conducted throughout the week of the annual compliance review to determine if staff locked their personal vehicles while working on-site. The results of the inspection founded all inspected vehicles were locked, as required.

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

The program has a written policy and procedures to ensure the safety and security of youth, staff, and the community when youth are transported outside of the facility. The program has two operable vans utilized to transport youth. Observations made of each van confirmed each contained an up-to-date fire extinguisher, seatbelt cutter, and window punch. Each van is assigned to a first aid kit which are housed and remain in the master control area until transports are ready to leave the facility. Each van was observed to have rear passenger doors which were locked and unable to be opened from the inside. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate program or staff vehicles. The program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted monthly by the human resources manager. A youth transport could not be observed during the week of the annual compliance review due to none being scheduled. Review documentation of the vehicle inspection sheet dated for the past six months indicated the program met the Department's requirement for each vehicle used to

transport youth. Informal interviews with transportation staff coupled with a review of the program's policy confirmed the program maintains a minimum ratio of at least two staff for every five youth during any transport. Informal interviews also confirmed staff utilize a cell phone issued by the program to take with them on transports to communicate during any emergency situations when transporting youth. Staff never leave youth unsupervised while in a vehicle. An interview with three transport staff confirmed a program-issued cell phone is provided to transport staff during transports and they are not allowed to transport youth in their personal vehicles unless approved by the facility administrator.

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

The program maintains a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's policy meets all the requirements of Florida Administrative Code 63E-7.013(5). The program's physical plant manager or designee is responsible for conducting safety and security audits every seven days, monthly, quarterly, semi-annually, and annually. Reviewed documentation reflected the program's facility administrator and unit manager conduct the weekly security audits documenting the outcome and recommendations on the inspection logs. The program utilizes a Safety/Perimeter Check Inspection form to document the weekly completion of audits and documents any deficiencies which need to be addressed. A review of inspection forms was conducted and reflected there was documentation to support the process and forms are completed every seven days. The security audits and safety inspections address camera surveillance, digital video recorder (DVR), radios and communication devices, perimeter, and fencing to ensure all areas are secure. The program addresses any deficiencies found during the weekly inspections at the morning management meetings to discuss a course of action to correct the deficiency. A work order is submitted to the Department for any applicable physical plant deficiencies. An informal interview with the program's administrative staff and regional compliance manager confirmed the program's practice.

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

The program has a written policy and procedures for tool management to ensure the proper control of tools and kitchen utensils are used within the facility as part of an overall strategy to prevent escapes and eliminate the threat of harm against youth, staff, visitors, volunteers, and interns. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department has a total of five different buildings which stored tools and other supplies needed for maintenance. These five buildings include the auto mechanics building, plumbing building, carpentry building, a large warehouse, and the physical plant manager's office which is attached to the program's lock shop. In addition, maintenance staff also utilize a maintenance assigned van which is not used to transport any youth and is secured when not in use to transport and store tools across program grounds. An informal interview with the program's physical plant manager reflected all tools stored in these buildings and the van are classified as Class A tools. The tools are secured in locked cabinets inside the buildings and van and the physical plant staff are the only workers assigned keys to unlock the cabinets. Inventory of the tools and chemicals is completed daily and weekly. The physical plant manager maintains a perpetual inventory of all tools which is attached to the door of each

locked cabinet containing tools and/or chemicals in the various buildings. The staff sign-out and sign-in the tools as they use them. The inventory of tools was compared against actual tools at the program and there were no discrepancies noted. Observations of the maintenance building, garage, offices, carpenter warehouse, supply warehouse, and one van used as a maintenance vehicle supported the practice of daily and weekly inventories. Each tool is labeled, color-coded, stored on a shadow board layout, and are inventoried at the end of each day. Observations made of the tool storage areas indicated they were neat and organized. An informal interview with maintenance staff confirmed youth are not allowed to utilize Class A tools. The program has a list of Class B tools which are maintained in a locked closet within the cottage. Inventory of the Class B tools are maintained by the program's unit manager. The kitchen knives were observed to be locked in a shadow box in the program's main kitchen. These are inventoried daily by the kitchen staff from Linton. Youth are trained to use Class B tools such as mops and brooms. A review of three staff training records and three youth case management records indicated staff and youth are trained on the safe use of Class B tools only. Three interviewed youth each confirmed they use mops and brooms while two of the three youth also stated they use a scrub brush as well.

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

The program maintains a written policy and procedures regarding youth tool handling and supervision to ensure youth utilize tools safely and only under the direct sight and sound supervision of staff. An informal interview with the program's regional compliance manager and security specialist staff confirmed during active tool use, there is a minimum ratio of one staff to every five youth. The program has a locked storage closet located in each cottage which is designated for storage of a broom, plunger, mop bucket, and a dust pan. Youth are not permitted to use any Class B tools without staff supervision. The program does not allow youth to use Class A tools. The program completes a Youth Risk Assessment form on each youth at the time of their admission to the program and every thirty days thereafter, to determine if a youth is eligible to use Class B tools under staff supervision. A review of three youth case management records of youth who have used tools reflected a risk assessment was completed prior to each youth's handling of tools and confirmed this is completed monthly. One youth was observed sweeping the floor with a broom for daily cleaning activities. The youth was being directly supervised by staff and was searched after the completion of sweeping in accordance with the program's search procedures. Reviewed documentation confirmed this youth received a youth risk assessment prior to using the tool. Three interviewed staff each confirmed youth can use mops, brooms, and scrub brushes under direct staff supervision.

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

The program maintains a written policy and procedures to address outside contractors performing work projects at the program. The program's policy outlines who is responsible for providing approval and/or permissions if a contractor's personal cellular phone and/or equipment/electronic devices are required. The program restricts tools to only those necessary, checks tools upon the worker's arrival and departure, and ensures immediate reporting of any tool the worker cannot locate and follows up if any tool is missing. The program requires all

outside contractors to review and sign a Contractor's Guidelines form with an attached copy of the visitor's contraband list. Furthermore, contractors must also review and sign a Prison Rape Elimination Act (PREA) acknowledgment form to document their understanding and agreement with the rules, requirements, and guidelines to which the contractor must adhere to while working on-site at the program. A random selection of completed outside contractor forms compared with sign-in and sign-out logs and submitted invoices were reviewed from the last six months and confirmed the program's practice of having outside providers on-site. Sign-in and sign-out logs were reviewed from the last six months and reflected contractors were not signing out when leaving nor was there documentation to confirm their tools were inventoried upon arriving and leaving the program. An interview with the facility administrator and regional compliance manager confirmed the program has updated their form and practice at the end of August 2019. Documentation was provided for the months of August, September, and October 2019 reflecting the program's updated and/or current form and practice. The program's physical plant assistant updated the outside contractor form to include a column and row for staff to document if the outside contractor was searched and a column and row for the contractor to document when they signed out and exited the facility. During the week of the annual compliance review, the program had a lawn crew on-site mowing the grass and a camera company on-site installing cameras on the Kennedy cottage. Observations confirmed an assigned staff member was monitoring the outside contractors the entire time while they were on-site. There were no reports of missing contractor tools during the annual compliance review period. An informal interview with the facility administrator confirmed when a contractor is on-site, a maintenance staff is assigned to supervise the contractor until the work is complete and no youth are allowed in the work area while outside contractors are on-site.

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

The program maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on May 17, 2019. The COOP requires the program to conduct unannounced fire drills once a month for each shift. Drills are to be conducted on a random basis under varied conditions when a majority of the youth are available. Program staff document drills on a Facility Drill form which includes the beginning and ending time of the drill, the nature of the drill, participants, a brief scenario, and the findings/recommendations. Reviewed documentation of drills confirmed the program completed drills in accordance with their COOP. The program completed COOP drills each month on each shift relating to safety and/or evacuation involving a hurricane, flood, lightning in the area, terrorist threat, and a chemical spill. An interview with the facility administrator confirmed fire drills are completed once every month on each shift while COOP drills are completed quarterly. Reviewed documentation reflected the program's practice is to complete fire and COOP drills monthly on each shift. Three interviewed youth each confirmed they had been instructed on what to do in the case of a fire. An interview with three staff revealed they participated on various drills within the last six months including drill scenarios involving major disturbances, weather, bomb threats, chemical spills, flooding, terrorism, escape, medical emergencies, and fires.

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

The program has a Continuity of Operations Plan (COOP) which encompasses a coordinated disaster plan. The plan was approved by the Department on May 17, 2019 and provides for basic care and custody of youth in the event of an emergency or disaster. The COOP addresses phases of a disaster plan as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing has been identified should the program have to be evacuated due to an emergency or disaster. An informal interview with the facility administrator confirmed a copy of the COOP is maintained in master control, the medical office, and the administration building for staff to have access to. Reviewed documentation confirmed the program maintains critical identifying information in an administrative hardcopy binder, which is easily accessible and mobile in the event of an emergency situation resulting in the program relocating quickly or in the event needed information cannot be accessed electronically for all youth in the program. The binder was inclusive of documentation items such as each youth's face sheet and admission photo card which included all required elements.

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

The program maintains a written policy and procedures regarding the control of hazardous and chemical materials. Toxics are maintained off-site and are locked in the facility's maintenance building. The program's physical plant manager maintains a list of materials and list of authorized staff with access to chemicals posted on the outside doors along with a permanent log to show the sign-out and sign-in of chemicals. All caustic materials are stored according to type and use. A review of the flammable, poisonous, and toxic items lists compared with actual inventory verified the items stored. A Safety Data Sheet (SDS) logbook is located inside each storage area with a picture of each chemical and a number corresponding to the SDS. The program records the daily use of chemicals on a daily chemical usage log, inclusive of the name of the authorized staff using each chemical. Observations of the storage area indicated it is clearly marked hazardous chemicals and is securely locked. Items were neatly stored on metal shelving and were numbered and color-coded for easy identification. Flammable items are stored in a metal cabinet clearly marked as flammable items. Reviewed documentation reflected chemicals are inventoried one time a week by the program's physical plant worker.

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

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, or toxic items and materials. The program's physical plant maintenance staff maintains control over all flammable, poisonous, and toxic items in the program. These items are stored off-site with limited access. Observations made during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. The program utilizes a Preventive Maintenance Checklist to ensure maintenance schedules and repairs are being conducted. The program's daily cleaning schedule is set for early morning before school and late at night before bed time. An informal interview with the physical plant manager indicated youth are not allowed to handle or use any hazardous materials. Randomly selected video footage was reviewed of youth performing daily cleaning activities of sweeping the floor with a broom. The youth were being directly supervised by a direct care staff member and were searched after completing the detail. The youth were never observed holding any cleaning products. Three youth were interviewed and two stated they do not use any chemicals or cleaning products while one youth stated they use bleach. When asked to explain, the youth stated staff spray the bleach and youth wipe it up.

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

The program maintains a written policy and procedures for the disposal of chemicals. The policy was developed in accordance with Occupational Safety and Health Administration (OSHA) standards. The program's physical plant maintenance staff dispose of unused flammable, poisonous, and toxic materials during Okeechobee County's free Amnesty Day. This day is set by the county for disposal of such materials. Signed documentation from the county is received indicating what materials are being disposed. This was confirmed by review of the program's disposal log. The physical plant manager confirmed all supplies are used until exhausted. Reviewed documentation coupled with informal interviews with maintenance staff confirmed liquid waste not resulting from work details are disposed of in the plumbing area of each housing unit with a drain and liquid waste resulting from work details are disposed of in the plumbing drains located in the mop storage areas. The program has a contract with KRK Enterprises, Inc. to dispose of kitchen grease accumulated from cooking. The company comes

on-site and pumps out the grease trap for disposal and performs maintenance on a quarterly basis. An interview with the facility administrator confirmed the program's practice.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures regarding visitation and communication with family members to re-establish family and community ties with the youth. Upon admission, youth are informed of visitation during the orientation process and receive a youth handbook which outlines visitation. The program encourages communication and visitation from the parent/guardians by sending out a welcome letter upon the youth's admission to notify the parent/guardian of the days and times for visitation, who can visit, incoming and outgoing mail rules, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in each youth's case management record and within a single binder. Youth are provided writing material and a self-addressed stamped envelope to send letters to family

members. Youth have unimpeded access with the courts, attorneys, their juvenile probation officer, and/or their Department of Children and Families case worker, if applicable. Observations of the facility indicated the visitation schedules were visibly posted in the youth's living areas. Visitation is conducted each Saturday from 1:00 p.m. to 4:00 p.m. The program provides alternative visitation days for families who are unable to come during scheduled visitation which involve the therapist and case manager. Youth letters are mailed weekly, Monday to Friday and youth are not limited in the number of letters they can send. A review of three youth case management records indicated each record included a completed orientation check list which includes the process of visitation and communication at the program. Reviewed documentation confirmed each record contained an approved visitor list, telephone list, and mail list. A review of chronological documentation and telephone logs confirmed youth contacted their family members or parent/guardian. A review of visitation sign-in and sign-out logs documented youth visitation with family members or their parent/guardian each Saturday and on a quarterly basis for Family Day. Three interviewed youth each stated they are provided the opportunity to communicate with family members by phone, telephone, or at visitation.

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

The program maintains a written policy and procedures for the use of controlled observations. The program has two controlled observation rooms which meet the size and construction requirements required by Florida Administrative Code. Searches are conducted and documented on the Controlled Observation Report form within the narrative report section. Reviewed documentation confirmed the program utilized controlled observation two times within the last six months. A review of each Controlled Observation Report form confirmed each report documented the room and the youth were searched prior to placing the youth in controlled observation. Documentation indicated a staff member of the same gender as the youth completed each search of the youth before the youth was left alone in the controlled observation room.

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

The program maintains a written policy and procedures for the use of controlled observation. Reviewed documentation reflected the program utilized controlled observation two times within the last six months. Reviewed documentation reflected controlled observation was authorized by a supervisor prior to use to determine if it would further jeopardize the safety and security of the youth and others. Each youth placed in controlled observation was either deemed to be an imminent risk of physically harming self, staff, others, or the youth was engaged in major property destruction and was likely to compromise the security of the program or jeopardize the youth's safety or the safety of others. Reviewed documentation of each Controlled Observation Safety Check form confirmed the program conducted safety checks every ten minutes for each youth which exceeded the fifteen-minute requirement. Each controlled observation report contained a completed Health Status Checklist form as well. One of the two reports reflected staff discussed the reason for the controlled observation as well as expectations for removal with the youth while one did not. None of the two reviewed placements lasted longer than two

hours and did not require documentation of receiving extensions every two hours by the facility administrator or designee.

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

The program maintains a written policy and procedures for the use of controlled observation safety checks and for releasing youth from controlled observation. The policy requires safety checks to be completed every fifteen minutes on all youth placed in controlled observation. A review of two Controlled Observation Safety Check forms was conducted and found all observations were completed every ten minutes, exceeding the requirement. Each entry indicated the time, code explaining youth's behavior while observed in controlled observation, and the staff's initials of who observed the youth. A youth may be released from controlled observation when it is determined the youth is no longer an imminent threat to self or others. A review of each controlled observation report reflected the facility administrator (FA) or supervisor staff member authorized each youth's release from controlled observation based on the youth's verbal and physical behavior reflecting the youth was no longer an imminent threat of harm to self or others and an in-house alert was entered for each applicable youth. Each report was reviewed and approved by the FA or assistant facility administrator within fourteen days of the youth's release from controlled observation to determine if placement was warranted and handled appropriately.

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

A review of three youth case management records was conducted regarding a safety planning process for each youth. Reviewed documentation reflected the program developed a program-specific Safety Plan form which identifies stimuli which included positive and negative effects on the youth. The program's Safety Plan form included an initial planning process and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth's admission to the program; however, none of the plans met the fourteen-day intake requirement during the review period due to this being implemented at the beginning of July 2019. The safety plans are jointly prepared by the youth, parent/guardian or family member, case manager, and clinical staff. The plans are reviewed and signed by all staff involved and the youth. The youth's safety plans are updated every thirty-days to include signatures and the date of the youth and staff. The program's Safety Plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences. Three youth's safety plans were reviewed and each were updated every thirty-days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. All three youth's safety plans incorporated recommendations of previous and current clinical assessments as required. The youth's safety plans were maintained in the youth's mental health records and within a centralized binder inside the sub-control room easily accessible to all staff. Three youth were interviewed and each reported they did not know the process for reviewing their safety plan. Three staff were interviewed and two of the three

reported they were unsure if they were involved in the development of youth safety plans while one stated they were but was not sure what it was for. These interview responses were advised to the facility administrator and regional compliance manager to follow-up.