STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Youth Development Center

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

Review Date(s): August 27-30, 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:

Shakela Minns, Office of Program Accountability, Lead Reviewer (Standard 1)
Christina Calvert, Office of Program Accountability, Regional Monitor (Standard 4)
Shantia Daniel, Palm Beach Youth Academy, Assistant Facility Administrator (Standard 2)
Peter Keelan, Office of Education, Southeast Region Education Coordinator (Standard 2 Education Services)
Gary Mogan, Office of Program Accountability, Regional Monitor (Interviews)
Patrick Morse, Office of Program Accountability, South Regional Supervisor (Standard 3)
Tiffany Patrick, Senior Juvenile Probation Officer, DJJ Probation, Circuit 15 (Standard 2)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Okeechobee Youth Development Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County County / Circuit 19
Review Date(s): August 27-30, 2019

MQI Program Code: 1160
Contract Number: 10188
Number of Beds: 32
Lead Reviewer Code: 159

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
2.09 Performance Plan Development, Goals and Transmittal *	3.07 Treatment and Discharge Planning *
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	5.04 Ten Minute Checks *
4.01 Designated Health Authority/Designee *	5.15 Outside Contractors
5.24 Controlled Observation	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Limited
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 *	Failed
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Failed
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	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	Failed
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	Limited
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 Development Center (OYDC) is a thirty-two bed program, for thirteen to twenty-one-year-old males located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC through a contract with the Department. The program provides mental health overlay services, substance abuse prevention and counseling, case management, life and social skills training, behavior modification, release and transition planning, recreation and leisure activities. In addition, the program fosters each youth by providing Skillstreaming the Adolescent, Anger Management for Substance Abuse and Mental Health Clients Teen Relationships, Young Men's Work, Thinking Feeling Behaving, Living and Balance, The Passport Program, Towards no Drugs, Thinking for a Change, and Impact of Crime. Additional treatment services provided includes individual and family therapy. The program administration team is comprised of administration, superintendent, assistant superintendent, facility administrator, unit manager, clinical director, and director of case management. Case management services are provided by one director of case management, three case managers, and one transition service manager. Mental health staff at the program includes one clinical director, two therapists, and one treatment director. Medical services are offered twenty-four hours a day, seven days a week and are provided by the designated health authority, one health service administrator, and four registered nurses. Educational services are provided by the Okeechobee County School District. The layout of the program includes three buildings: one administration building, one cottage for all the youth, and the program school area with the attached cafeteria. The program has a total of thirty-two cameras. Three cameras were not functioning during the week of the annual compliance review; however, other cameras were adjusted to capture all blind spots. The superintendent reported the program has a potential vendor to repair the cameras. At the time of the annual compliance review, the program had ten vacant positions which included two therapists, one case manager, one master control technician, and six youth care worker positions.

Standard 1: Management Accountability

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

The program has a written policy and procedures regarding initial background screenings. Initial background screenings are conducted for all new employees, interns, volunteers, and mentors. Eighteen staff and three volunteers were hired since the last annual compliance review and each had a background screening completed prior to their start date. The program did not have any contracted staff, interns, or mentors applicable for an initial background screening since the last annual compliance review. The program reviews each staff's criminal history report, the Department's Central Communications Center (CCC) person-involvement report, Staff Verification System (SVS), and the Florida Department of Law Enforcement's background screening results. A review of the background screening documentation for the newly hired staff and volunteers found all have been determined to have an eligible rating prior to having contact with youth. Reviewed documentation found none of the eighteen staff required an exemption. Each staff completed the pre-employment assessment tool and received a passing score which was filed in each personnel record. All staff and volunteers were added to the providers Clearinghouse employment roster. All teachers are background screened by the Okeechobee County School District. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was completed and submitted to the Department's Background Screening Unit (BSU) on December 11, 2018, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the Department's BSU on December 10, 2019 meeting the annual requirement.

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

The program has a written policy and procedures regarding five-year rescreening based on the initial hire date of each staff. Staff rescreening is submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the staff's five-year anniversary date of hire. A review of the program's staff roster documented there were a total of ten staff applicable for a five-year background rescreening. The program did not have any volunteers or mentors applicable for a five-year rescreening since the last annual compliance review. All staff and contracted staff rescreening were completed prior to the five-year

anniversary date. Each staff and contracted staff's five-year rescreening was submitted to the BSU at least ten business days prior to the five-year anniversary.

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 has a written policy and procedures for reporting abuse, providing an abuse free environment and reporting all allegations of suspected child abuse to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) for youth who are eighteen years old. The policy indicates youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. Each staff signs a written acknowledgement of their understanding of the code of conduct, located within the employee handbook, at their time of hire. Documentation within five personnel records validated each had a signed employee handbook acknowledgement. A resident handbook is provided to each youth upon admission and details the rights of youth, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and the CCC. Observations during the program tour confirmed telephone contact numbers, both for the Florida Abuse Hotline and the Department's CCC contact information, were posted throughout the program for youth and staff to access. During the week of the annual compliance review, the program's telephone for contacting the Florida Abuse Hotline was not operational. The facility administrator indicated there was an open work order to correct the issue immediately. The program's current practice until the telephone is repaired is for the youth to be taken to the case manager's office or therapist's office to place an abuse call. The youth will then place a confidential abuse call by dialing the Florida Abuse Hotline which is posted throughout the program. The program's normal practice for a youth to report abuse is to directly call the Florida Abuse Hotline, by having the youth to pick up the telephone in the dormitory with 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, and the shift supervisor will take the youth to the telephone in the dormitory area. The youth will pick up the telephone with a direct connection to the Florida Abuse Hotline to place the call. For

youth eighteen years of age or older, they may request a call to the Department's CCC through the youth care worker and/or on-duty shift supervisor. The youth care worker will use the radio to call the shift supervisor, and the shift supervisor will take the youth to an available telephone to place the call. A review of abuse allegations since the last annual compliance review reflected eight calls were reported to the Florida Abuse Hotline and the Department's CCC. Five abuse allegations were reviewed. Documentation reflected four of the five allegations were unsubstantiated and one was substantiated. All staff received training based on the outcome of an investigation. An interview with the facility administrator (FA) confirmed each staff acknowledges receipt of the program's code of conduct and are expected to adhere to it. The FA was aware of the program's incident reporting process and able to explain the process in its entirety. An informal interview with the program's training coordinator in comparison with five pre-service staff training records validated the program completed a TRACE self-assessment. Five interviewed youth stated they never had to contact the Florida Abuse Hotline or the Department's CCC. One youth stated he has never seen staff stop any youth from calling the Florida Abuse Hotline or the Department's CCC. Each youth stated they felt safe in the program and staff are respectful when talking to youth. Two youth reported never hearing staff use profanity when speaking to youth. Three youth reported hearing staff use profanity occasionally when speaking to youth. This information was provided to the program's administration team during the week of the annual compliance review. Five interviewed staff reported they allow the youth to contact the Florida Abuse Hotline or the Department's CCC. Four staff also reported they would notify the supervisor or program director. Each staff reported never observing a co-worker telling a youth they could not call the Florida Abuse Hotline. All five staff reported never observing a co-worker using profanity when speaking to youth, using threats, intimidation, or humiliation when interacting with youth.

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

The program has a written policy and procedures addressing allegations of physical, psychological, and emotional abuse. A review of the Department's Central Communications Center (CCC), and internal incidents documented the program had eight incidents of physical, psychological, or emotional abuse since the last annual compliance review. Five abuse allegations were reviewed during the annual compliance review period. It is the program's practice to conduct an initial internal investigation on all staff complaints and to remove a staff from contact with youth when necessary. Reviewed documentation of internal incident reports reflected management staff took immediate corrective action, when applicable, to address incidents of physical, psychological, or emotional abuse. An interview with the facility administration (FA) indicated staff receive knowledge about the Florida Abuse Hotline during in-service and pre-service trainings. It is further noted, information is posted on the walls in the program cottages, and youth are allowed to call the Florida Abuse Hotline or the Department's CCC upon their request.

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 has a written policy and procedures regarding the incident reporting process. A review of the Department's Central Communications Center (CCC) reports for the past six months revealed the program had a total of twenty-eight reported incidents to the CCC and five reports were randomly selected for review. All five incidents were reported within the required two-hour time frame. Four out of five incidents were documented in the logbooks. One incident was not documented. The administration team was made aware the incident was not documented in the logbook during the week of the annual compliance review. There were no internal incidents or grievances which should have been reported to the CCC. The program's CCC's rate has increased slightly from twenty-two reports to twenty-eight reports since the last annual compliance review. The facility administration (FA) reported the program continues to provide training to all staff to reduce the number of CCCs reported. During the interview, the FA reported staff are required to immediately notify the shift supervisor on duty of any incidents. The shift supervisor will immediately notify the FA. The staff must then write an incident report before they leave their shift. The assistant facility administrator (AFA) and FA will then contact the Department's CCC within two hours to report 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 has written a policy and procedures concerning the use of Protective Action Response (PAR). The program's PAR plan was approved by the Department's Office of Staff Development and Training on December 21, 2018. Reviewed documentation found the program submits a PAR summary to the Department monthly. The program had two PAR reports since the last annual compliance review. Each PAR incident report was completed by the end of each staff member's workday and included statements from all staff involved. None of the reports indicated any injuries were sustained to the youth or staff, nor did the youth allege abuse. None of the reports indicated a need for medical review. In both reports, a PAR certified instructor or supervisory staff completed a review and a post-PAR interview with the youth was conducted, all completed within the required time frames. All PAR reports are maintained in a central folder. The program's PAR rate during the annual compliance review period was 0.68, which is below the statewide Residential PAR rate of 1.59. The facility administrator (FA) reported during an interview a PAR report must be completed before the end of the shift from which the PAR occurred. A review of the document is then completed by the shift supervisor, unit manager and FA. 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 has a written policy and procedures in place regarding pre-service training. The program maintains a written pre-service training plan, which was reviewed and approved by the Department's Office of Staff Development and Training on January 16, 2019. A review of five applicable pre-service staff training records indicated all five staff were certified within 180-days of hire as required. All staff were certified in cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Each staff was trained in Protective Action Response (PAR), suicide prevention, professionalism and ethics, emergency procedures, Prison Rape Elimination Act (PREA), and child abuse reporting. There were no additional trainings required by this contract. The program also reported the recreational therapist is counted in the staff-to-youth ratio during the annual compliance review. Reviewed documentation confirmed the recreational therapist had all required pre-service training. All staff training was documented in the Department's Learning Management System (SkillPro) reflecting their completion of over 120 hours of pre-service training. Documentation indicated all trainings were 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 has a written policy and procedures in place regarding in-service training. The program submitted, in writing, a list of pre-service trainings to the Department's Office of Staff Development and Training, including course names, descriptions, objectives, and training hours for all instructor-led training. The training plan was approved on January 16, 2019. Five staff training records, including two supervisor training records, were reviewed for completion of in-service training. Two applicable supervisory staff completed at a minimum eight hours of management training. Two supervisor training records were reviewed for completion of eight hours of management/supervisory training relating to leadership, personal accountability, management, employee relations, communications skills, and fiscal. All staff exceeded the twenty-four hours of mandatory annual in-service training. All staff completed cardiopulmonary resuscitation (CPR) annual in-service training, automated external defibrillator (AED), first aid, and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, as well as the required six hours of suicide prevention. There were no additional trainings required by this contract. Reviewed documentation confirmed each supervisor exceeded this requirement. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). Reviewed documentation validated the program has an annual in-service calendar which is updated as changes occur.

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 regarding the youth grievance process. The process is a three-tiered system with an informal phase, formal phase, and an appeal phase. The program also utilizes "Let's Talk" forms, an alternative informal form as a first opportunity to voice an objection and informally resolve a complaint prior to a youth filing a grievance. The program's grievance process is explained to each youth at the time of admission and orientation, and further explained in the youth's handbook. Once a youth submits a grievance, the facility administrator (FA) or designee has seventy-two hours to investigate and render a decision in writing to the youth. If the youth is still dissatisfied with the outcome of the grievance, they may file an appeal. The FA has seventy-two hours to determine whether the grievance was handled appropriately or if there should have been a different outcome. During the annual compliance review, observation showed the program had grievance and "Let's Talk" forms located on each dormitory. Observations also validated the program's practice of maintaining formal and informal grievances in separate binders for a period of at least one year. The program had five grievances filed since the last annual compliance review. Each reviewed grievance was handled in accordance to the program's policy. A review of five staff in-service and pre-service training records confirmed staff received the required training regarding the program's grievance process and procedures during orientation, and on-the-job training. An interview conducted with the FA confirmed the program's grievance process. Five youth were interviewed and were able to explain the process for completing a grievance. Each youth indicated they may request assistance, if needed, when completing the grievance form. Five interviewed staff had knowledge of the program's grievance process and were able to explain the process.

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

The program provides delinquency interventions such as Thinking for a Change (T4C) and Impact of Crime (IOC). Reviewed documentation of sign-in sheets confirmed the curriculum is being delivered at least eighty percent of the youth's waking hours. Reviewed sign-in sheets for T4C and IOC documented groups are being delivered, as designed. However, reviewed documentation for the period of April 16 - May 7, 2019 found a gap in IOC services. This information was shared with the program's administration team during the annual compliance review. The facility administrator reported staff vacancies impacted the program's ability to provide IOC services during this timeframe. Each of the listed interventions are on the program's daily activity schedule. A review of five youth records confirmed two youth were actively participating in the T4C group and one youth was participating in IOC. All three youth had goals in each of their performance plans to address the delinquency needs. Two of the youth records showed the youth are on the waiting list to attend the group. An interview with the

facility administrator (FA) indicated youth are matched during the intake process. At each youth's classification meeting, the team reviews the youth's history, special needs, risk factors, alerts, and also identifies safety and security risks which will directly impact living unit assignments, group placement, or room/dorm assignments. The FA also reported staff are required to have the appropriate education and experience to perform their job duties. The FA had full knowledge of the delinquency intervention models in place at the program.

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

The program has a written policy and procedures regarding life skills training provided to youth. The program's mental health staff provide life skills groups and instruction to the youth at the program. The therapist conducting the groups received formal training and on the job training to deliver these groups. The clinical staff conducts groups on various topics including Teen Relationship, Living in Balance, The Passport Program, Skillstreaming the Adolescent groups, and Young Men's Work. Life skills training is used as targeted group intervention to address needs identified within each youth's Individual Performance Plan (IPP). A review of five youth records found individualized needs outlined on the IPP. The daily activity schedule indicated youth are to participate in group interventions seven days a week. A review of sign-in sheets confirmed groups were delivered, as required. An observation of a Skillstreaming the Adolescent group found nine youth were in attendance. Five youth were interviewed and indicated they participate in life skills training. Youth also indicated they have learned coping skills through participation in the groups. An interview with the clinical director confirmed the program's practice.

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

The program's restorative justice instruction and activities included utilizing the Impact of Crime (IOC) curriculum. IOC is considered a practice with demonstrated effectiveness, according to the Department's Sourcebook of Delinquency Interventions. The curriculums assist youth in accepting responsibility and teach youth about the impact of crime on victims, and their families, and their communities. Reviewed documentation reflected staff delivering the curriculum were trained in IOC, as required. Five youth case management records were reviewed. Each youth participated in several restorative justice projects throughout the year, to include sending apology letters, participating in community service projects and paying restitution fees, which is geared towards increasing youth personal accountability for their criminal actions and harm to others. Youth participate in IOC groups, which occurs two days a week. A review of sign-in sheets validated groups are being delivered as designed. The daily activity schedule validated restorative justice activities were provided. An interview with the facility administrator indicated, the youth completes apology letters, community services, and pays restitution in which the youth demonstrate personal accountability.

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

The program has a written policy and procedures to address the provision of gender-specific programming. The program provides gender-specific programming to youth at the program through the Young Men's Work (YMW) curriculum and 24:7 Fathering. The curriculum addresses the need for young men to work together to solve problems without resorting to violence. The model concentrates on real life experiences, emotions, and topics include power and violence, bullies, parenting, relationships with women and men, race and culture, drugs, and family. The groups are held twice every Wednesday for one hour. The gender-specific programming groups are facilitated by the mental health clinicians. A review of the material used to educate the youth reflected it was geared towards gender-specific issues. Reviewed documentation validated the program maintains a binder with sign-in sheets reflecting the names of youth attending the groups, the name of the facilitator, the lesson for the day, and the date/time of the groups. An interview with the facility administrator (FA) indicated YMW is a group which takes place to show strong male leadership and behaviors. The FA explained the youth participate in competitive football, basketball, and other sporting tournaments during the weekends and recreation time.

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

The program has a written policy and procedures in place outlining the program's internal alert system. The program's internal alert list is accessible to all program staff and keeps them alerted about youth who are a security or safety risk, health related concerns, food allergies, and special diets. These alerts are also updated in the Department's Juvenile Justice Information System (JJIS). The program also has an alert board located in master control, which identifies any youth placed on mental health alert, escape risk, gang affiliation, special alerts, and medical alert. Reviewed documentation and observations of a shift briefing reflected the alert reports are reviewed daily during shift briefings by the program's supervisory staff. A review of the program's logbooks reflected alerts were documented according to policy. A review of five youth records documented alerts were accurately entered into JJIS by the appropriate staff. All applicable internal alerts were downgraded or discontinued by the appropriate staff. A review of JJIS in comparison with the program's internal alert list found no inconsistencies. An interview with the facility administrator revealed alerts are discussed at each morning's management meeting. Alerts are closed by the appropriate staff, including medical and case management

and updated as needed. Five interviewed staff indicated they are made aware of alerts by reviewing the alert board and shift briefings.

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 official case records, clearly labeled "confidential" for each youth. The program separates the youth records into individual records for healthcare, mental health, and case management, and all are kept in hardbound notebooks secured in a metal file cabinet labeled 'Confidential' within the respective offices not accessible to youth. Five youth case management records were reviewed. All records were labeled confidential. All youth records contained the youth's name, Department of Juvenile Justice identification number (DJJID), date of birth, county of residence, date of admission, and committing offense. All case management records contained the sections to include legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous.

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

The program has a policy and procedures which addresses a formal process to promote constructive input by youth. The program utilizes various avenues such as the youth advisory board and "Let's Talk" forms which gives youth an opportunity to address both positive and negative issues they may have. The youth advisory board meets twice monthly to discuss various topics. Additionally, the program has an open floor forum daily where youth express issues and concerns relating to all areas of the program. A review of the youth advisory board's notebook reflected an agenda, sign-in sheets, along with meeting minutes summarizing the subject areas which were discussed. Five interviewed youth reported the program has a process which allows each youth to provide input about what happens at the program. An interview with the facility administrator confirmed the program's practice.

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 written policy and procedures to address a community advisory board. The program has a community advisory board, which meets quarterly. The board is comprised of local law enforcement, local school board, the local judiciary, a parent/guardian of a youth previously in the program, the business community, the faith-based community, and a child victim advocate. The program maintained a notebook listing all the partnership agencies and businesses. Reviewed documentation validates the program sends emails to solicit active involvement of interested community partners. During the annual compliance review, contact was made with a board member to determine the level of involvement with program activities. The board member reported the meeting is held quarterly and the community advisory board discuss various topics to help improve the program. The advisory board rotates meetings

between locations. The meetings are held at Okeechobee Juvenile Offender Correctional Center (OJOCC), Okeechobee Youth Development Center (OYDC), and Okeechobee Girls Academy (OGA) each quarter. The advisory board works to provide services within each program. All programs come together to form the advisory board, which consists of all required parties as outlined in the Department's policy. All members of the advisory board participate, and the advisory board meetings are held at different locations rotated quarterly. During the advisory board meetings, the members discuss each of the program's current issues and status. A review of the advisory board meeting minutes, sign-in sheets, and agendas confirm the meetings occurred in March, June, and September 2019. The next community advisory board meeting is scheduled to occur in December 2019. Documentation confirms each of the contracted programs are discussed individually during these meetings. An interview with facility administrator (FA) indicated the Kiwanis Club of Okeechobee County, local businesses, several churches, juvenile probation officers, parents/guardians of youth who left the program all make up the advisory group. They also provide information on community service activities the youth in the program could benefit from. The Kiwanis club has also provided Christmas gifts and extra hygiene items for the youth in OYDC. The FA indicated the community advisory board works to provide services and extra supplies in OJOCC, OYDC, and OGA programs when possible.

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

The program has a policy and procedures in place regarding program planning designed to establish a system of communication, facilitating staff involvement, discussing program issues and the development of policies, procedures, and programs. The program administration conducts comprehensive quarterly youth and staff surveys through the survey monkey system. The program also conducts parent/guardian surveys upon each youth's release. The surveys are designed to allow the youth and parents/guardians to provide feedback. The results of the surveys are discussed in detail at the corporate office and during monthly staff meetings. The program conducts morning management meetings daily. The monthly staff meetings allow all staff an opportunity to provide input and feedback pertaining to operations. All areas of facility operations are discussed in the meetings addressing subjects such as alerts, safety and security, youth progress, medical and mental health updates including alerts, and security updates. The Comprehensive Accountability Report (CAR) data is also shared with staff at the monthly staff meetings. The program has recognitions for staff such as employee of the month, employee referral bonus, and the above and beyond award. A review of sign-in sheets and agendas validated the program's practice for conducting monthly meetings. A review of documentation to minimize staff turnovers and boost staff morale was also provided. Five staff were interviewed. Four staff reported meetings are held monthly and daily at the program. All staff were able to explain the topics discussed during meetings and believe it is valuable information. Two staff reported being briefed on annual reports, youth, and parent/guardian survey results. Three staff reported not being briefed on the surveys. Three staff reported communication amongst staff at the program is effective. One staff indicated communication is fair and another indicated communication is poor. All staff reported they are able to provide feedback into the facility operations. An informal interview with the facility administrator (FA) confirmed daily meetings are held daily at the program. A mandatory all-staff meeting is held each month for all staff. This meeting provides necessary information to staff about changes and new developments within the program. The FA indicated CAR reports, youth and parent/guardian surveys are covered in meetings to track trends, recidivism rates, and other important information. The FA also indicated the program is working hard to keep staff onboard by hosting job fairs and recruiting online. The program has a morale committee which meets

once a month to identify different ideas to build staff morale on a daily basis. The program also provides training onsite to help develop staff, so they will be comfortable in their field in order to reduce staff turnovers.

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

The program has a policy and procedures regarding staff performance and evaluations, which states staff will be evaluated after their initial ninety-day probationary period and annually thereafter. Performance and evaluations covering areas inclusive of job knowledge, reliability, attendance, education and training, initiative, adherence to policy, interpersonal relationships, judgement, competency, and goals achieved. Documentation supported the program maintained position descriptions for each position title with corresponding performance standards. A review of the position descriptions outlined the job functions and duties required of each position. Five staff personnel records were reviewed. Each was evaluated on their understanding and implementation of the program's positive performance system including consistency in providing rewards and/or consequences for behavioral violations. Two of five interviewed staff reported receiving an annual evaluation, two reported receiving an evaluation every six month and another reported receiving an evaluation monthly. The facility administrator (FA) reported staff receive an annual evaluation completed by their immediate supervisor and are discussed and signed. The evaluations are then forwarded to the human resource department for placement in staff records. The annual evaluation is to determine how staff performed throughout the year. Also, the evaluation is a tool used to identify different incentives the staff could receive 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 policy and procedures to address recreation and leisure activities. A review of the program's activity schedule and logbooks verified a variety of activities are provided to the youth, including leisure and recreational activities to promote cognitive skills development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. Observations of youth during outside recreation verified youth participate in teamwork, healthy competition, and physical fitness. The program utilizes a watercooler, which is placed outside during recreation, to prevent youth from over-exertion, heat stress, and dehydration. An indoor and outdoor recreation schedule is posted in each dorm which identifies individual and team recreational activities as well as the days the activities will take place. A review of the program's contract indicated the program is required to have a recreational therapist for Okeechobee Youth Development Center. The contract indicates the recreational therapist shall hold a bachelor's-level degree in recreational therapy or a bachelor's degree in a related field such as; recreation, leisure studies, or physical education which included an internship or practicum experience. The program hired a recreational therapist who holds a bachelor's-level degree in youth and family studies and an associate's-level degree in physical education. Reviewed documentation confirmed the recreational therapist had over one year of related experience working with youth. A review of five youth case management records indicated the program incorporates therapeutic activity into the youth's treatment plan based on the development levels and needs of the youth. Five staff were interviewed and indicated youth are provided a variety of recreation and leisure activities for at least an hour each day. Five youth were

interviewed and indicated they are allowed to participate in a variety of recreation and leisure activities at least one hour daily. All youth indicated they are provided with varying degrees of mental and physical exertion throughout the day.

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 in place regarding parental notification and court notification. The program requires phone contact with the parent/guardian within twenty-four hours, a written correspondence to the parent/guardian mailed within forty-eight hours, and notification to a youth committing court within five days of admission. Five youth case management records were reviewed. Three out of five reviewed records documented the parent/guardian was notified by telephone within twenty-four hours of admission. Two records did not contain supporting documentation the parent/guardian was notified by telephone within twenty-four hours of admission. Three records included written documentation of the parent/guardian being notified within forty-eight hours of the youth's admission and two did not. Three youth's juvenile probation officer (JPO), and/post residential services counselor, and committing court was notified within five working days. Two records did not contain supporting documentation to confirm the youth's juvenile probation officer (JPO), post-residential, and committing court was notified within five working days. Both youth records showed the court notification were sent approximately seven days late.

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 written policy and procedures in place regarding youth orientation. A review of five case management records found three records included documentation of the youth receiving orientation on the day of admission. A review of five case management records found three youth records contained an orientation checklist acknowledgement form signed by each youth confirming completion of an orientation on the date of admission. Two youth records did not have supporting documentation of an orientation being completed on same day of the youth's admission. One youth's acknowledgment form was signed ninety-eight days later. Another youth's acknowledgment form was signed seven days later. Orientation to the program included all the required topics outlined in Florida Administrative Code. During the annual compliance review, there were no new admissions into the program. Five interviewed youth confirmed receiving an orientation within twenty-four hours of their admission to the program.

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

The program has a written policy and procedures to obtain written consent of any youth eighteen years of age or older prior to discussing or providing the parent/guardian any

information related to the youth's physical or mental health screening or assessment. One of the five reviewed youth case management records were eighteen years of age. Two additional record was requested for review. Each applicable record included written consent granting the program permission to provide or discuss information related to the youth's physical or mental health with the youth's parent/guardian.

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

The program has a written policy and procedures in place regarding the classification system. The program's classification system promotes safety and security, as well as effective delivery of treatment services. The program's classification factors included physical characteristics, age, maturity level, history of violence, gang affiliation, criminal behavior, physical and sexual aggression level, suicide risk, as well as the youth's current risk to reoffend. A review of five youth case management records reflected three youth had an initial classification and Vulnerability to Sexual Aggressive Behavior (VSAB) Assessment completed upon admission. All three records confirmed the program utilized a classification system in accordance with the Florida Administrative Code, promoting safety and security as well as the effective delivery of treatment services. Two youth's case management records did not have supporting documentation to confirm an initial classification or VSAB was completed on the date of the youth's admission as both were not dated. This information was shared with the program's administration team during the annual compliance review. Five reviewed records included documentation of the youth's individualized performance plan and performance summaries to indicate each youth was reassessed and reclassified prior to being considered for an increase in privileges or participation in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape. None of the reviewed youth were applicable for off-campus activities. The program has an internal alert system in addition to the use of the Department's Juvenile Justice System (JJIS). Alerts are used to promote safety and security, as well as medical, mental health, and or special needs services identified during the classification process and are entered into the system. The program has an alert board and alert list located in the master control listing all alerts pertaining to the youth for accessibility. All staff are advised during shift briefings of all alerts. The facility administrator (FA) reported classification meetings take place during morning meetings on the day of the youth's arrival to the program. The case manager also completes a risk assessment during the intake process and then every month following to make sure there are no issues.

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 written policy and procedures in place addressing gang identification and notification to the school district and law enforcement. Five case management records were reviewed and two were applicable for possible gang involvement. One additional record was selected and reviewed. Each of the three youth records confirmed the notification to the law enforcement was made to the identified local law enforcement agency. In addition, documentation supported the educational staff and the youth's assigned juvenile probation officer (JPO) were also notified. Each youth's record contained a documented alert in the Department's Juvenile Justice Information System.

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

The program has a written policy and procedures to ensure youth identified as gang related are provided gang prevention and intervention activities. Five case management records were reviewed, and two youth were applicable for possible gang involvement. One additional record was selected and reviewed. Each of the applicable records included a gang intervention outlined in the youth's Individual Performance Plan for completion before leaving the program. The program's gang prevention and intervention strategies included use of the Gang Resistance and Drug Education (GRADE) curricula by the Coral Springs Police Department Youth Liaison Unit. The seven lesson curriculum consists of group activities, essays, questionnaires and reading assignments.

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 has a written policy and procedures which outlines all initial Residential Assessments for Youth (RAY) be completed within thirty days of admission. Five youth case management records were reviewed. Four youth case management records indicated the RAY was completed within thirty days of each youth's admission to the program. One youth's initial RAY was completed thirteen days later. This information was presented to the program's administration team during the week of the annual compliance review. The initial RAY was maintained in each youth's case management record and located in the Department's Juvenile Justice Information System. Five records were applicable for a RAY Reassessment. Four out of five reassessments were completed within ninety days of the initial assessment. One reassessment was completed sixteen days late.

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

The program has a written policy and procedures to ensure Youth Needs Assessment Summary (YNAS) is conducted within thirty days of youth admission into the program. Five reviewed case management records contained a completed YNAS. Three of the records documented the YNAS was completed within thirty days of the youth's admission. Two youth's YNAS were completed within the required thirty-day period. One youth's YNAS was ten days late and the other was twenty-two days late. All five records indicated the YNAS was documented in the Department's Juvenile Justice Information System.

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

The program has a written policy and procedures in place regarding the Individual Performance Plan (IPP) being developed within the initial thirty days of each youth's admission. A review of five youth case management records revealed three contained an IPP created within thirty days of the youth's admission. Two youth's IPP were not developed within thirty days of the youth's admission. One youth's IPP was fifty-two days late and the other youth's IPP was thirty-four days late. Four youth records documented the youth's plan was developed with participation with the treatment leader, youth, parent/guardian, administrative representative, medical representative, mental health representative, living unit representative, and education staff. One youth's IPP was missing the signature page. There was not an explanation provided to the review team during the week of the annual compliance review regarding the missing signature page. Each youth's IPP outlined all the required elements, such as the youth's individualized goals, top three criminogenic needs, youth and staff responsibilities, delinquency interventions, court sanctions, target dates completion, and goals for transition. Each IPP outlined staff and youth responsibilities to accomplish the goals. Three records contained documentation indicating a copy of the IPP was sent to the committing court, assigned juvenile probation officer (JPO), and parent/guardian. Two records did not contain supporting documentation to validate a copy of the youth's IPP was mailed to the committing court, assigned juvenile probation officer (JPO), and parent/guardian. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD) or the Department of Children and Families (DCF). Five youth were interviewed, and each indicated they participated in the creation of the IPP and was provided a copy of their IPP.

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

The program has a written policy and procedures to address the revision of each youth's performance plan revisions based upon the Residential Assessment for Youth (RAY). Five reviewed youth case management records found performance plan revisions for four of the five records. One record was not applicable for a revision. Revisions were made to two of the youth's Individual Performance Plans (IPP) due to failure to progress within goals. Two IPPs were updated due to transition services being rendered. A review of three closed case management records indicated, based on the transition conference, the intervention and treatment team revised the youth's IPP, as needed, to facilitate transition activities targeted for completion during the last sixty days of the youth stay in the program.

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

The program has a written policy and procedures to address the completion of performance summaries and the transmittal of the summaries. Five open youth case management records were reviewed, and each were applicable for the completion of a ninety-day summary. Summaries included reports on education, mental health, performance plan goals progress, staff and peer interactions, the youth's level of motivation to change, significant events and anti and pro-social behaviors. All five youth were provided the opportunity to review the performance plan and add comments. Two of the five records contained a release summary which was sent to the committing court within the required time frame. All of the records reviewed reflect the required signatures of the youth, treatment team leader, the staff whom prepared the summary, and the facility administrator or designee. Four youth records showed copies of the summary being sent to the committing court, juvenile probation officer (JPO), and parent/guardian within the ten-day requirement. One youth record reflected no evidence the performance summary was sent to the appropriate parties within the ten-day time frame. The summary was signed on May 24, 2019 and the letter was sent on May 17, 2019. Three closed youth case management records were reviewed and revealed each youth's performance summary was completed every ninety days or less. All three records showed a summary with justification for release sent with a Pre-Release Notification to the supervising JPO. None of the records contained an objection by the court or was applicable for the sexually violent predator program.

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 extends invitations to each youth's parent/guardian encouraging their participation in the intervention and treatment team meeting for the purpose of developing the Individual Performance Plans (IPP). Five youth case management records were reviewed. Four youth case management records contained documentation the parent/guardian participated in the development of the IPP and treatment team meetings. One youth's IPP was missing the signature page to confirm the parent/guardian participated in the development of the IPP. Each record contained documentation of attempts through telephone contacts and mail to involve the parent/guardian in the case management process. If unable to attend, the program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting. During the annual compliance review, treatment team meetings were not observed due to the program conducting treatment team meetings the week prior to the annual compliance review. The facility administrator (FA) reported the case manager contacts the parent/guardian within twenty-four hours of the intake process. A written welcome letter is also mailed parent/guardian within forty-eight hours. The parents/guardians are notified from medical anytime a youth has any medical issues. The youth are allowed telephone calls once a week and the parents/guardians are encouraged to call the conference line during treatment team meetings every month. Four out of five interviewed youth confirmed their parents/guardians are involved in their case management process. One youth reported being eighteen years of age or older and does not require parent/guardian participation.

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 written policy and procedures in place which addresses the treatment team process and the members of the treatment team. The program's treatment team members consist of the case manager who served as the treatment team leader, youth, representatives of program administration, the youth's living unit representative, clinical staff, education staff, medical staff, and, when applicable, the program's gang prevention specialist, as well as the youth's juvenile probation officer (JPO) and parent/guardian. Formal and informal treatment teams are held biweekly for each youth at least once every thirty days. Five youth case management records were reviewed and contained supporting documentation of each youth treatment team meeting comprised with signatures of each required member attendance. Reviewed documentation confirmed the parent/guardian and JPO participation was noted by telephone. There were no youth applicable for a thirty-day treatment team meeting involved with the Department of Children and Families (DCF) services. However, the program's practice is to send an invitation in advance to the DCF representatives to participate in the meetings. During the annual compliance review, treatment team meetings were not observed due to the program conducting treatment team the week prior to the annual compliance review.

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 has a written policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's Individual Performance Plan. Five youth case management records were reviewed. Each record documented incorporation of the youth's treatment and education plans into the IPP. All five case management records indicated the program incorporates therapeutic activity into the youth's treatment plan based on the development levels and needs of the youth. At the time of the annual compliance review, the program had one youth involved with the Department of Children and Families (DCF). A review of the applicable youth's record confirmed the incorporation of the plan with the DCF plan. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures in place regarding formal and informal treatment team meetings. Five case management records were reviewed. Four youth records documented formal treatment team reviews were conducted at least once every thirty days. One youth's formal treatment team meeting was held ten days late one time. Informal meetings were held with each youth bi-weekly to review each youth's performance, including progress on the individual performance plan goals. The performance plan included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions based on the initial Residential Assessment for Youth (RAY) tool. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were encouraged to participate and were notified in advance. In all instances of when the youth's juvenile probation officer (JPO), parent/guardian, or other pertinent parties were unable to participate in person, they were invited to participate by telephone or provide written input. Reviewed documentation confirmed treatment team meeting attendees consisted of the youth, case management staff, clinical staff, education, medical, and living unit representative. During the annual compliance review, treatment team meetings were not observed due to the program conducting treatment team meetings the week prior to the annual compliance review. Five interviewed youth confirmed the program provides opportunities for youth to demonstrate acquired skills from the program during treatment team meetings. Each youth confirmed staff review their performance plan during treatment team meetings, including their progress on goals, positive and negative behaviors, and their progress in treatment.

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, and 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. The Building Construction Technology curriculum is offered which provides construction skills subject area knowledge including the use of tools, as well as providing hands-on training opportunities. 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 those 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	Satisfactory Compliance
The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The program contracts with the Okeechobee County School District to provide educational services to the youth at the program. Reviewed documentation and an interview with the lead educator indicated each youth in the program was provided a minimum of 250 days during the calendar year, with a minimum of twenty-five hours of instruction weekly. Ten days are set aside for teacher planning and professional development. A review of the facility logbook in comparison with the program's posted daily schedule found minimal interference. Five interviewed youth reported never having educational classes interrupted.

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 completes educational transition plans for each youth including provisions for continuation of education and/or employment. Three closed case management records were reviewed. Documentation reflected each youth's education transition plan was completed prior to the youth being released from the program. All reviewed records validated each youth had an individual transition plan based on each youth's specific post release goals, beginning at

admission to the program, as required. Each reviewed record contained evidence of services and interventions provided based upon the youth's assessed educational needs. Documentation indicated all required participants provided input regarding each youth's education transition plan. All 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. Documentation indicated the youth's case manager and parent/guardian was aware of the post-release discharge plan.

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

The program has a written policy and procedures regarding transition planning and transition conference requirements. Reviewed documentation validated a transition conference was held at least sixty days prior to the targeted release date. The program sent written notification to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. The youth, treatment team leader, clinical, medical, and education staff participated in the transition conference as evidenced by the signatures on the transition plan signature page. The JPO and parent/guardian participated by telephone. Each youth's JPO, parent/guardian, education staff and any other pertinent parties were invited to provide written input if they were unable to participate in person. Two of the three closed youth records did not document the facility administrator or designee's signature. All reviewed records identified the target completion dates and identified the individuals responsible for completion of the transition goals. Two of the three closed youth records confirmed the youth participated in a Community Re-Entry Team (CRT) meeting prior to their release from the program. One youth's case management record did not have supporting documentation to confirm the youth participated in a CRT meeting.

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

The program has a written policy and procedures pertaining to exit portfolios. Three closed records were reviewed for compliance with the completion of exit portfolios. All records contained documentation the exit portfolio was discussed and started at or prior to each youth's transition conference. All exit portfolios included the transition plan, completed assessments, a

résumé, employment application, educational records, a calendar with dates, times, and locations of follow-up appointments within the community, and vocational certifications when applicable. Each record contained a copy of the youth's birth certificate, social security card, and State issued identification card.

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 has a written policy and procedures addressing the exit conference. A review of three closed case management records found an exit conference was conducted within fourteen days prior each youth's release date. Reviewed documentation confirmed the youth's juvenile probation officer (JPO) was notified of each youth's release prior to the program conducting an exit conference. The exit conference was documented including dates and signatures of all participants. The program staff noted participants attending by telephone on the signature line when applicable. The date of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation supported the case manager, parent/guardian, education staff, JPO, youth, and other applicable parties participated in the exit conference.

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 serves as the program's designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, with an expiration date of March 31, 2021. The DMHCA is full-time, working Monday through Friday from 8:30 a.m. to 5:30 p.m. The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health and substance abuse (MHSA) services at the program. The DMHCA position was vacant from January 7, 2019 through July 31, 2019. During this timeframe, the campus-wide director of treatment services served as the interim DMHCA. On July 31, 2019 the DMHCA transferred from Okeechobee Youth Treatment Center to serve as the DMHCA for Okeechobee Youth Development Center and Okeechobee Youth Correctional Center. The DMHCA is responsible for providing clinical supervision to the program's therapists on a weekly basis, review and sign off on comprehensive MHSA evaluations, Assessments of Suicide Risk, individualized MHSA treatment plans, and treatment plan reviews. In addition, the DMHCA ensures the comprehensive mental health treatment services are implemented in accordance with Florida Administrative Code and contract. The DMHCA is also responsible for ensuring youth receive evidenced-based group therapy from qualified and supervised clinicians, receive the required Standardized Program Evaluation Protocol (SPEP) services, as well as supplemental mental health overlay services (MHOS). The DMHCA participates in weekly meetings with the psychiatrist and nursing staff to discuss youth receiving psychiatric services. An interview with the psychiatrist validated their participation in the weekly medication management meetings. A review of the position description indicated the DMHCA acts as the program's MHSA authority. The DMHCA ensures compliance with MHOS and ensures proper completion of documentation and integration of a mental health delivery system meeting all state and federal guidelines and has the responsibility for directing the program's psychological and treatment services to include technical and administrative duties, testing, individual, group, and family therapeutic activities, research, and participation in overall institutional programming and administration and does related work as required.

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). The LCSW serves as the designated mental health clinician authority (DMHCA) working Monday through Friday, from 8:30 a.m. to 5:30 p.m. In addition, the program has access to the campus-wide director of treatment services who assists in providing oversight for the five program's on-site and the regional director of clinical services. The regional director of clinical services is on-site multiple times throughout each month and documents provided services on the Regional Clinical Director Feedback Report form. The information is utilized to ensure fidelity of services and provide training. The program maintains an independent contractor agreement with a State of Florida board-certified licensed psychiatrist effective August 1, 2018. The psychiatrist is scheduled to be on-site every Monday for approximately one to four hours, depending on need. The program maintains an agreement with a board-certified psychiatrist to serve as a back-up for scheduled absences performing all necessary duties. The program also utilizes a certified behavioral analyst (CBA) for youth identified in need of specialized services through treatment team. The CBA works primarily with the school to assist youth with behavioral issues. The reviewed licenses found each was clear and active in the State of Florida. The reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. Reviewed documentation supported each licensed staff maintained a position description and/or agreement identifying the position expectations and essential functions. The DMHCA 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	Limited Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program's contract requires four non-licensed therapists; however, at the time of the annual compliance review the program had two non-licensed, master's-level therapists. One therapist position was full-time and went to part-time on January 28, 2019 and the therapist resigned on May 31, 2019. There was no documentation to support the other half position was filled during this time frame. The position has been vacant since May 31, 2019. The other therapist position became vacant July 3, 2019. The two currently employed therapists' credentials were reviewed and found one maintains a degree in social work and the other is a doctoral candidate in psychology. Both clinicians work under the direct supervision of the designated mental health clinician authority (DMHCA). The program also has a non-licensed, master's-level group facilitator working under the direct supervision of the DHMCA. The program maintains an independent contract agreement with master's-level board certified behavior analyst (CBA). The CBA is scheduled to be on-site for approximately four to six hours weekly combined for all programs on-site. At the time of the annual compliance review, the CBA maintained a caseload of one for this program. The CBA gathers information from the clinical team, management team, and floor staff, and based on negative reports from the previous week, the CBA reviews the

mutually established goals and monitors behavioral progress in the program's behavior management system (BMS). The DMHCA communicates between the clinical staff through informal daily communications, formal clinical supervision weekly, and coaching sessions, as needed. The DMHCA provides weekly clinical supervision to the master's-level non-licensed therapists. Documented supervision for each clinician's accuracy of assessments and referral skills, appropriate treatment and/or service interventions, treatment service effectiveness as reflected by the youth meeting individual goals, cultural competency issues, and legal aspects of clinical practice and professional standards. In addition, the DMHCA reviews a sample of each non-licensed therapist' work and provides a summary of directions, instructions, and recommendations. A review of the clinical supervision log from January 2019 through August 2019 found the non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA. The reviewed documentation found the clinical supervision log included all required elements, as outlined in Chapter 397, Florida Statutes. The form utilized to document the direct supervision includes all information, as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. Training records for the two non-licensed clinical staff validated each has completed the required twenty-hours of training, as well as supervised experience in assessing suicide risk mental health crisis intervention, and emergency mental health services. The training included the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk (ASR) 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 ensures mental health and substance abuse (MHSA) services are available to all youth who are determined to meet clinical criteria to receive such services. MHSA treatment is provided on-site through the provision of mental health overlay services (MHOS). The program has a policy and procedures to ensure each youth's MHSA needs are identified through a comprehensive screening process. Immediately, upon the youth's arrival to the program, an initial MHSA screening process is initiated by the multidisciplinary treatment team staff to ensure the identification of MHSA issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. As a key component of the initial intake process, following the completion of the Facility Entry Physical Health Screening form conducted by nursing staff, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) is administered by a trained staff member in the Department's Juvenile Justice Information System (JJIS). Five youth MHSA records were reviewed and confirmed the MHSA staff reviewed all available information included in each youth's commitment packet regarding MHSA histories, as documented on the program's Records Review Form. The information collected identifies prior inpatient MHSA treatment services, outpatient MHSA treatment, treatment with psychotropic medications, emergency evaluations, suicide risk, self-injurious behaviors, drug and alcohol use or possession, emotional stability, history of significant trauma, and history of mental illness in the family. The form also identifies protective factors and risk factors. Each record review form is signed by the therapist completing the form and the licensed mental health therapists documents their review and signs the form. Reviewed documentation supported each youth

received a MAYSI-2 on the day of admission completed in JJIS. The reviewed staff training records validated each staff completing the MAYSI-2 was trained to do so. Although only one of the five reviewed MAYSI-2 indicated further assessment is required, it is the program's practice to conduct a further evaluation on each youth admitted regardless of the MAYSI-2 results. In addition, each youth was screened for suicide utilizing the Department's Assessment of Suicide Risk (ASR). None of the youth indicated an elevation in suicide risk; however, all five youth received an ASR, as is the program's practice for each youth to be assessed upon admission. All five youth received a new comprehensive MHSA bio-psychosocial evaluation. An interview with the facility administrator indicated when youth arrives, they are 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, they immediately go on suicide alert and then they are immediately given an ASR to see if they need to stay on suicide alert or suicide precautions, or if they can be removed and go on standard observation in the program. The program nurse is responsible for the completion of a urine drug screening as part of the medical intake process to assist in determining the youth's substance use prior to admission to the program. Consent forms for urine collection and analysis are obtained from the youth and parent/guardian. In addition, the Youth Consent for Release of Substance Abuse Treatment Records and Youth Consent for Substance Abuse Treatment forms are obtained during the admission screening process. The youth are also provided information regarding client rights and responsibilities and on what a youth needs to know about sexual assault, harassment, and abuse. The youth are provided a list of telephone contacts identifying the Florida Abuse Hotline, Department's Central Communications Center, local Department of Children and Families, and the Poison Control. The program's practice is to assess each youth upon admission utilizing the Department's ASR, Adolescent Psychopathology Scale – Short Form (AFS-SF), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Trauma Symptom Checklist for Children (TSCC), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Adolescent Substance Abuse Subtle Screening Inventory – Third Edition (SASSI-3), and the American Society of Addiction Medicine patient placement criteria.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse (MHSA) services which was approved by the designated mental health clinician authority (DMHCA) on September 4, 2018 and the new DMHCA on August 20, 2019. The psychiatrist documented a review of the plan on August 31, 2018. As part of the evaluation process used to assist in the development of the youth's individualized treatment plan, a comprehensive MHSA bio-psychosocial evaluation is completed. The bio-psychosocial evaluation is completed with the youth, parent/guardian, applicable Department of Children and Families (DCF) family services counselor, and others involved in the youth's care. The comprehensive MHSA use, emotional and behavioral functioning, social roles, and other areas impacting the youth's overall level of functioning. The youth's primary therapist is responsible for the completion of the bio-psychosocial evaluation and must be completed within thirty days of the youth's admission. The evaluation can be expedited should a youth pose a safety risk to self, youth, and/or staff. Each therapist completing a comprehensive MHSA evaluation is trained to complete evaluations/assessments and the licensed mental health therapist attests to the training completion and competency. The program's designated mental

health clinician authority (DMHCA) is responsible for reviewing each comprehensive MHSA bio-psychosocial evaluation and indicates a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review. The DMHCA is also responsible to provide a provisional diagnosis and sign the evaluation within ten days of completion. A review of five youth (MHSA) records found three youth had a completed MHSA bio-psychosocial evaluation completed within the required thirty-day time frame and two youth had the evaluation completed twelve days late and twenty-three days late, respectively. Each reviewed bio-psychosocial evaluation contained all required elements, as outlined in Florida Administrative Code 63N-1. All completed evaluations were conducted by the DMHCA or non-licensed master's-level clinician and reviewed by the DMHCA.

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 provides on-site mental health overlay services (MHOS) to all youth determined with mild to moderate mental disorders who may have a co-occurring substance-related disorder. History of mental health treatment, psychotropic medication, hospitalizations, and maladaptive behavior due to mental illness/emotional disturbance is considered in assessing the duration and severity of mental disorder. All youth were pre-screened by the Department and have been determined to meet the criteria for specialized services provided within the program. Mental health and substance abuse (MHSA) treatment is guided by an initial treatment plan and an individualized treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment is provided by the licensed clinical social worker (LCSW) or non-licensed master's-level therapist working under the direct supervision of the LCSW. Five interviewed staff validated the clinical staff facilitate MHSA groups. The program maintains a written policy and procedures outlining a comprehensive plan for MHSA services. Each youth receiving ongoing mental health and/or substance abuse treatment shall have an individualized MHSA treatment plan completed within thirty days of the youth's admission to the program. The individualized MHSA treatment plan is developed by the treatment team based upon the areas of need identified within the comprehensive MHSA bio-psychosocial evaluation. The primary therapist develops treatment planning strategies based upon the youth individualized treatment needs and treatment is provided by staff trained to perform services being administered. A review of five youth MHSA records found each youth was assigned to a multidisciplinary treatment team upon admission into the program. Reviewed program policy indicates the case manager, therapist, nurse, and facility administrator (FA) are identified as members of the multidisciplinary treatment team. Reviewed admission card forms identified the therapist, case manager, and personal physician. The program does not identify all applicable treatment team members to the youth until the development of the initial treatment plan developed on the day of admission. Each youth had an initial treatment plan completed by the treatment team on the day of admission identifying the youth, parent/guardian, mental health/substance abuse therapist, case manager, licensed therapist, and FA. There was no documentation to support the education/vocation staff and medical staff were members of the multidisciplinary treatment team developing the initial treatment plan. The living unit representative had a signature line; however, none were signed. Reviewed documentation

validated each youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each youth record also had a signed Youth Consent for Substance Abuse Treatment form and a signed Youth Consent for Release of Substance Abuse Treatment Records form. In addition, each youth signed a client rights and responsibilities form, consent for urine collection and analysis, and signed for a list of telephone numbers which included the Florida Abuse Hotline, Department's Central Communications Center, local Department of Children and Families office, and the Poison Control. Weekly progress notes found the program documented in the format outlined in Florida Administrative Code 63N-1 and the Department's Counseling/Therapy Progress Note form. Progress notes also confirmed each youth is receiving services as stipulated in their individualized MHSA treatment plan. A review of five youth records reflected the program provided MHSA evaluations and groups, treatment planning, monthly individual therapy, daily group therapy, monthly family therapy when feasible, support services, substance abuse therapeutic activities, psychiatric services, suicide prevention services, and individualized transition services. All youth receive a psychiatric evaluation within one week of admission. Medication management is conducted every thirty days for youth prescribed psychotropic medications. Observations made during the annual compliance review week supported youth group participants were less than ten for mental health groups and less then fifteen for substance abuse groups. Five interviewed youth indicated each was participating in groups to include substance abuse treatment and receiving therapy. Five interviewed staff indicated direct care staff do not conduct groups; however, three indicated they sit in the room to supervise the youth.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse (MHSA) services. MHSA treatment services are provided through the provision of mental health overlay services (MHOS). All MHSA treatment services conducted at the program are provided by or under the direct supervision of the licensed clinical social worker (LCSW). Youth determined to have a mental health and/or substance abuse Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, shall have an initial and individualized MHSA treatment plan. Upon release from the program, all youth 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. A review of five youth MHSA records confirmed an initial MHSA treatment plan was developed for each youth on the date of admission. The initial treatment plans were documented on a form containing all required elements, as outlined in Florida Administrative Code 63N-1, and on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed plan contained MHSA planning for the youth. One of five reviewed youth records was applicable for prescribed psychotropic medications at admission and the initial diagnostic interview was conducted within the required fourteen days of admission. The one applicable reviewed initial

plan documented the prescribed medication, dosage, and frequency of monitoring by the psychiatrist. Reviewed initial treatment plans found each was signed by the treatment team members and the youth. However, the living unit staff, education, and nursing staff signatures were missing for all five youth. A review of five case management records supported during the classification meeting where the initial treatment plan is developed validated the living unit representative and nursing staff were in attendance for all five reviewed youth records. A review of five youth MHSA records found each contained a completed individualized MHSA treatment plan, of which three were developed within thirty days of the youth's admission. Two plans were completed late with one sixteen days late and the other sixty-nine days late. The program did not provide a reason as to why they were late. One of five reviewed individualized plans was applicable for psychotropic medications, with one youth admitted on psychotropic medications and one youth subsequently prescribed, and each documented the prescribed medication, dosage, and frequency of monitoring by the psychiatrist. The program had only two youth on prescribed psychotropic medications at the time of the annual compliance review. Each individualized plan reviewed was signed by some of the treatment team members; however, three plans did not have the living unit representative signature, five did not have the nursing staff and education staff signatures, and one did not have the recreation therapist, and one did not have the facility administrator signature. The program did provide supporting documentation to validate the education and nursing staff provided written progress reports for each individualized MHSA treatment plan review. The program maintains an independent contractor agreement with a certified behavioral analyst (CBA) who is responsible for monitoring the program's positive performance system (behavior management system). The CBA reviews the positive performance system, incident reports, and/or special treatment team meeting documentation to determine if any youth is having behavioral issues, difficulty in meeting their strategies and goals, and then develops a plan for the youth to get on track. The information is shared with the multidisciplinary treatment team. The program has a full-time recreational therapist who works with the youth by conducting recreation therapy assessments and developing wellness plans. The recreation therapist is a direct report to the designated mental health clinician authority (DMHCA). The wellness plans are discussed with the assigned therapist and assigned case manager to create a goal in the individualized MHSA treatment plan and the individualized performance plan. The psychiatrist meets with the DMHCA and the assigned therapist every week to discuss medication adjustments, treatment, and overall progress. Psychiatrist / Treatment Team Meeting Verification Sheet attendance logs are maintained for each meeting. All treatment team reviews were conducted as required. The program conducts formal treatment team meetings once a month and none were held during the annual compliance review week. A review of three closed youth MHSA records found the MHSA treatment discharge summaries each documented the youth's relevant mental health and substance history and reason for recommending on-going treatment. The issues which were the focus of the mental health and/or substance abuse treatment were identified, as well as the summary of the youth's progress in treatment while participating in the program. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. There were no applicable youth released with an identified suicide risk alert. Each reviewed discharge summary contained recommendations for continuing mental health and/or substance abuse treatment within their home community along with applicable referrals for continued services. Reviewed documentation supported the discharge summaries were discussed with the youth and parent/guardian and assigned juvenile probation officer (JPO) at the exit conference. Reviewed documentation did not support each was provided a copy of the discharge summary; however, the program was able to provide a copy of the Acceptance of Custody for Release form documenting who the youth was released to and also documenting a copy of the discharge summary was provided to the youth and

parent/guardian. The program did not provide documentation to support the assigned JPO received a copy.

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

A review of the program's contract, clinical program description, and interview with the facility administrator indicated the program provides on-site mental health and substance abuse (MHSA) services through the provision of mental health overlay services (MHOS). MHSA treatment is guided by an individualized treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment is provided by the licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA) or a non-licensed therapist working under the direct supervision of the DMHCA. Each youth is assessed upon admission for MHSA utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). In addition, each youth is assessed utilizing the Adolescent Psychopathology Scale – Short Form (AFS-SF), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Trauma Symptom Checklist for Children (TSCC), Reynolds Adolescent Depression Scale – Second Edition (RADS-2), Adolescent Substance Abuse Subtle Screening Inventory – Third Edition (SASSI-3), and the American Society of Addiction Medicine patient placement criteria. The program's specialized MHSA treatment services include individual therapy on a bi-weekly and/or monthly basis, family therapy sessions monthly, and group therapy sessions seven days a week. Supportive counseling is provided on an as-needed basis. Other services include initial screening process, clinical intake interviews, clinical assessments and evaluation, record review, bio-psychosocial evaluation, medical/psychiatric services, treatment plan development, daily therapeutic activities, and behavior modification. Additional mental health services include screening, crisis intervention and crisis management, suicide prevention services, and twenty-four-hour response capability with access to an acute care setting and MHSA emergency management services. Each youth's individualized MHSA treatment plan identifies the appropriate level of care. A review of five youth MHSA records validated each youth received individualized mental health services and substance abuse services as prescribed on the individualized MHSA treatment plan. Fidelity of MHSA services is completed in the weekly face-to-face supervision meetings and in the weekly review of documentation by the DMHCA to ensure services match the treatment needs outlined on the youth's individualized MHSA treatment plan. In addition, the regional director of clinical services provides on-site fidelity services several times monthly and documents provided services on the Regional Clinical Director Feedback Report form.

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 contractor agreement with a State of Florida, board-certified licensed psychiatrist effective August 1, 2018. The psychiatrist is scheduled to be on-site every Monday for approximately one to four hours, depending on the need. The program maintains an agreement with a board-certified psychiatrist to serve as a back-up for scheduled absences performing all necessary duties. In the event the psychiatrist is on scheduled leave or out sick, there is a State of Florida licensed and practicing psychiatrist appointed to cover scheduled clinic duties at the program. The program does not utilize an advanced registered nurse practitioner (ARNP). Reviewed written psychotropic medication management policy and procedures validated the psychiatrist reviewed and approved the policy and procedures on August 31, 2018. A review of the psychiatric visitor's log confirmed the psychiatrist has been on-site at least once a week during this annual compliance review period and is available for emergencies and consultation twenty-four hours a day, seven days a week. The designated mental health clinician authority (DMHCA), psychiatrist, and nursing staff meet weekly to discuss and review each youth receiving psychotropic services and their progress as documented on the Psychiatrist / Treatment Team Meeting Verification Sheet. Interview with the DMHCA validated this practice. A psychiatric list is developed to identify youth who will be evaluated and receive medication management during each visit. A review of five youth mental health and substance abuse records indicated one youth was admitted to the program prescribed psychotropic medications and one youth subsequent to admission. The program practice is for all youth to receive a new psychiatric evaluation completed within one week of admission. Each youth's psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and program-specific form, which were completed within the required time frame, as outlined in policy. Two applicable reviewed youth records indicated the youth were on prescribed psychotropic medications, with one youth admitted with prescribed psychotropic medications and one youth subsequently prescribed psychotropic medications. Each youth prescribed psychotropic medications received medication reviews at least every thirty days. The parent's/guardian's verbal consent for psychotropic medication was documented through the CPPN on page three, and written consent was documented on the Acknowledgment of Receipt of CPPN Form or Practitioner Form, in accordance with Rule 63N-1.0085, Florida Administrative Code. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. Interview with the psychiatrist validated he is on-site weekly and provides evaluations and medication management.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The MHSA plan was

updated and approved by the designated mental health clinician authority (DMHCA) on September 4, 2018 and by the new DMHCA on August 20, 2019. The program's written plan detailed suicide prevention procedures and included all required elements as outlined in Florida Administrative Code 63N-1. The plan outlined the identification and assessment of youth at risk of suicide through the screening or alert process and any time subsequently, as well as suicide precautions and the levels of supervision. The plan addressed the requirements for staff training as it relates to suicide prevention, the implementation of suicide precautions, and to recognize verbal and behavioral cues. The plan included the referral process, communication, notification, documentation, immediate staff response, and review process. An interview with the DMHCA and the facility administrator indicated the program provides suicide prevention training throughout the year and conducts quarterly mock emergency mental health drills on each shift to include emergency response to suicide attempts or self-inflicted injury. Documented drills validated the practice.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The plan was approved by the designated mental health clinician authority (DMHCA) on September 4, 2018 and the new DMHCA on August 20, 2019. The psychiatrist documented a review of the plan on August 31, 2018. The program maintains a complete suicide response kit located in each sub-control and in the medical department. Separate knife-for-life tools are maintained in each of the five secured first aid kits. Observations during the annual compliance review confirmed both kits contained the knife-for-life, wire cutters, and needle nose pliers. Five interviewed staff were able to identify the locations of the suicide response kits. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services. A review of five youth MHSA records found each youth was screened upon admission utilizing the Department's Assessment of Suicide Risk (ASR) to determine if the youth had elevated suicide risk factors. Each completed ASR determined the youth were not at risk of suicide and were placed on standard supervision. A review of two additional youth records supported each youth had two separate ASRs completed, based on staff observations, and were placed on precautionary observation (PO). Three of the four ASRs were completed by the trained non-licensed mental health therapist and one by the licensed therapist. All four ASRs indicated the youth remained on PO until a Follow-Up ASR was completed and the youth was subsequently stepped down to close observation. During the time the youth was on PO, suicide precaution observation logs

were maintained. Discontinuation of close observation was documented in accordance with the program's suicide prevention plan. Reviewed practice found the program documented the parent/guardian and assigned juvenile probation officer were notified when a youth was placed on PO. The reviewed training records for the non-licensed therapist validated each completed the required twenty hours of training and five supervised assessments completed under the direct supervision and within the presence of the DMHCA. While on PO, mental health staff provided supportive services as reflected on the Suicide Precautions Observations Logs. The licensed therapist and the facility administrator documented their communication prior to stepping down the youth's level of supervision, the program's logbooks documented when the youth were placed on PO, and when they were stepped down to less restrictive supervision. Youth placed on any elevated level of supervision due to suicide risk has an alert placed in the program's internal alert system, program logbook, and the Department's Juvenile Justice Information System (JJIS). Reviewed JJIS alerts validated the alerts were entered and removed, as required. Reviewed policy and procedures indicate the program does not utilize secure observation. Five interviewed staff indicate when a youth expresses suicidal thoughts, the youth care workers are responsible for notifying mental health, search the youth and room for sharp objects, place the youth on constant sight and sound, and document the supervision. The program utilizes New Horizons of the Treasure Coast and Okeechobee as the crisis stabilization unit.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure which includes all required elements as outlined in Florida Administrative Code 63N-1. A review of five youth MHSA records found no youth were applicable for elevated suicide risk. The program had two additional youth records whereby each youth was placed on precautionary observation (PO) on two separate occasions. A review of the Suicide Precautions Observation Logs validated the program was utilizing the Department's form and were maintained for the duration the youth was on PO. Reviewed documentation supported staff maintained the appropriate level of supervision and observations of the youth's behavior and each was documented in real time and did not exceed thirty-minute intervals. Applicable warning signs were documented. Each log was reviewed and signed by the shift supervisor and mental health clinical staff and safe housing requirements were documented as required. The program does not utilize secure observation.

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's comprehensive mental health and substance abuse plan outlines all staff will receive intensive training on suicide prevention. The training will consist of a thorough review of the suicide prevention plan and will include detention techniques, behavioral cues, and recommended responses. The program's suicide prevention plan indicates the program provides training to both full and part-time staff working in direct contact with youth. A review of

five staff training records demonstrated each staff completed two hours of suicide prevention training in the Department's Learning Management System (SkillPro) and six hours of instructor-led training for a total of eight hours. Within pre-service training, staff are provided a module on mental health and adolescent behavior, identifying the typical behaviors of youth with mental health needs as well as the strategies for working with the youth. Staff are provided with an overview of recognizing signs and symptoms of emotional disturbance and mental health illness in children and adolescents. Lectures and practical application are used to address suicide precautions, levels of supervision, crisis response, and documentation. Training includes signs and symptoms and stages of suicide. Six hours of suicide precautions and prevention will be provided as part of the annual staff training. Mock drills in response to suicide attempt and/or serious self-injurious behaviors are conducted once a quarter on each shift. This is documented and placed in the staff training records. The drills are reviewed with each staff in the program during the monthly all-staff meetings to guarantee understanding and compliance with the procedures. Reviewed mental health drills reflected clinical drills simulating a youth suicide attempt were conducted on each shift for each quarter. Each reviewed drill documented the description of the mock incident, a synopsis of the response, any applicable deficiencies identified, and any applicable corrective action required. Participating staff signed the emergency drill participation log and the information is also shared during the all-staff meetings for the staff who did not physically participate. All staff with direct contact with youth, on a day-to-day basis, did participate in a mock drill at least one time semi-annually.

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

The program maintains a written comprehensive plan for crisis intervention services in order to respond to youth in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the program. The crisis intervention plan was updated and approved by designated mental health clinician authority (DMHCA) on September 4, 2018 and the new DMHCA on August 20, 2019. The plan detailed crisis intervention procedures to include notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and the review process. Low level crisis intervention is typically provided by the program's direct care staff and/or supervisor staff through interventions within the positive performance system (behavior management system). Crisis intervention will be provided as-needed in a one-to-one setting for youth who require immediate processing related to the specific intent. Crisis intervention may be provided for, but not limited to, anger control issues, depressive symptoms, threats of harm toward others, maladaptive coping mechanisms, and impaired impulse control. Youth demonstrating acute emotional, psychological distress, or behavioral issues are referred immediately to the mental health clinical staff for crisis intervention, assessment, and counseling. Any youth identified as having acute emotional or behavioral problems, or acute psychological distress which may pose a safety or security risk must be brought to the attention of the facility administrator and program staff through the alert system. A youth can be placed on a mental health alert by direct care staff and/or clinical staff when a youth is identified as having a mental disorder or acute emotional distress which may pose a safety/security risk. All

mental health alerts shall be entered into the Department's Juvenile Justice Information System and shall be notated on the program's alert communication board and in the facility logbook.

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

Reviewed policy and procedures ensure when a youth is in crisis the program utilizes the Department's Crisis Assessment Form completed by the clinical staff and approved by the licensed clinical staff. Five youth mental health and substance abuse records were reviewed and found one was applicable for a crisis assessment. The youth determined to be in crisis received a crisis assessment completed the same date. Interviews with program clinical staff indicated this was the only example since the last annual compliance review. Reviewed crisis assessment documented the reason for the assessment mental status examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, and treatment recommendations. In addition, the crisis assessment documented the recommendations for follow-up and/or further evaluation and documented the notification by telephone and time to the parent/guardian. A mental health alert was placed in the Department's Juvenile Justice Information System (JJIS) and was removed when the youth was no longer determined to be in crisis. Reviewed documentation supported while the youth was placed on a mental health alert, the mental health alert observation logs were maintained. Reviewed logs supported they were documented in real time and warning signs were documented.

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

The program maintains a written comprehensive emergency mental health and substance abuse services plan. The plan was updated and approved by the designated mental health clinician authority (DMHCA) on August 5, 2018 and by the new DMHCA on August 20, 2019. The emergency care plan included procedures for immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. In addition, the plan outlined documentation requirements and staff training requirements to include recognizing signs and symptoms of emotional disturbance, substance abuse, and mental health illness. Staff training specific to emergency care needs is provided within each staff member's orientation training and staff participate in mock training situations at least semi-annually. Mock drills are used to review procedures for emergency responses to include suicide attempts and serious self-inflicted injury situations. The emergency

care plan is reviewed with each staff member to ensure staff are aware of emergency identification and responses necessary to ensure the safety of the youth. On-site training includes egress plans and the location of all safety equipment include the suicide response kits, suicide rescue tools, first aid kits, and automated external defibrillator. The program utilizes New Horizons of the Treasure Coast and Okeechobee as the crisis stabilization unit for Baker Act and Marchman Act proceedings.

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

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

Standard 4: Health Services

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

The program maintains a written policy and procedures to identify the authority responsible for the provision of health services at the program. The program's current designated health authority (DHA) was hired and began working at the program during the annual compliance review on August 28, 2019. An interview with the program's regional nursing director explained the program's corporate office was working to complete an independent contractor agreement; however, a confirmation letter of agreement between the DHA's provider, Elevate Healthcare Consultants, and the program supported the hiring. The current DHA is a licensed osteopathic physician (DO). A review of the license confirmed it was clear and active in the State of Florida with an expiration date of March 31, 2020. Three DHA's, a back-up medical doctor (MD), and the corporate office MD provided services to youth at the program since the last annual compliance review. The program had an independent contractor agreement with a licensed MD who resigned in December 2018 due to health reasons. The program then developed an independent contractor agreement with a licensed medical doctor (MD). However, reviewed documentation indicated the MD did not sign the agreement. The MD was hired and began working at the program in January 2019 and garnered his resignation effective April 2019. From May through August 2019 the program had an independent contractor agreement with a third medical doctor who was terminated by the program effective August 5, 2019. The program's regional nursing director reported a fourth DHA was hired to replace the terminated DHA and scheduled to start providing 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. August 5, 2019 through August 28, 2019 the program's corporate medical doctor provided DHA coverage. The program's back-up MD was also utilized during the DHA's absence since the last annual compliance review. The three DHA's, the corporate MD, and the back-up MD were all licensed physicians in the State of Florida, with the responsibility for the overall administrative and clinical healthcare services provided to youth in the program. The current DHA's education and specialty training is in family practice. The corporate MD and back-up MD's education are both in general medicine. The current physician serves as the program's DHA and according to the reviewed agreement letter, is scheduled to be on-site two hours each week. The program's policy and procedures outline specific duties of the DHA to include conducting on-site gender-specific medical evaluations and treatment through performing 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 shall 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). An interview with the corporate medical doctor indicated the DHA performs all Comprehensive Physical Assessments, chronic clinics, and sick call referrals and follow-up appointments. Additionally, the DHA is required to meet at least quarterly with the facility administrator (FA) and all disciplines providing or overseeing the provision of physical and mental health care. A review of the sign-in logs for the past six months validated a DHA, corporate MD or back-up physician was on-site weekly with a single exception. Reviewed documentation found there was no DHA coverage August 6, 2019 through August 21, 2019, which was more than nine days between services. An interview with the regional nursing director explained a new DHA was scheduled to start on August 12, 2019 and did not call or come to work. On August 22, 2019 coverage was provided by the corporate MD. Six months of

sign-in logs also determined there were seven weeks where the DHA was not on-site for two hours as required by contract. Sign-in logs for March through April 2019 showed there were five separate visits whereby the DHA was not on-site for a minimum of two hours as required in contract. The program previously identified this, and the regional nursing director and the health services administrator discussed this with the previous DHA prior to his subsequent resignation in April 2019. A review of sign-in logs from May through August 2019 showed an additional two instances where the DHA and/or designee provided less than two hours of services on-site.

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 (FOP) for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation supported two previous DHAs signed all healthcare policies and procedures on August 30, 2018 and July 22, 2019. The corporate medical doctor (MD) signed on August 22, 2019, the facility administrator (FA) signed on March 1, 2019, and the corporate officer signed on July 10, 2017. The program also documents the annual review of unchanged DHA treatment protocols to include admission, standing orders, non-licensed medical and emergency protocol guides, body mass index protocol, and first aid kits. This annual review documented signatures by the FA on July 1, 2019, the previous DHA on July 8, 2019, and the corporate MD on August 22, 2019. The program maintains one full-time and one-part-time registered nurse. Additionally, the program shares five additional RNs and a health services administrator (HSA) working a rotating coverage schedule campus-wide with four additional programs under the same contract number. A review of the FOPs cover-page documented signatures of all medical staff at least annually, and when changes occurred. The program had no new nursing staff since the last annual compliance review; however, the program maintains a training requirement whereby newly employed healthcare personnel shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures 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 parents/guardians are afforded the right to give or withhold consent regarding the healthcare provided to youth at the program. Five Individual Healthcare Records (IHCRs) were reviewed for the presence of the Department's Authority for Evaluation and Treatment (AET) form. One youth was over the age of eighteen and the youth signed a Release of Information Authorization Form for youth eighteen years of age or older. The program also utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the form and to whom the information can be released and shared. The remaining four IHCRs contained a legible copy with the word "Copy" stamped on the AET. No reviewed IHCRs were applicable for a court order being filed in the record due to the youth being in the care of the Florida Department of Children and Families. Each reviewed record contained completed parental notifications behind the AET in the IHCR. An interview with the program's health service administrator (HSA) reported the facility administrator and case manager are immediately notified when an AET is needed. The facility administrator and/or case manager will then

contact the youth's assigned juvenile probation officer for assistance in obtaining a valid AET for the youth. An interview with the HSA also reported when youth turn eighteen the AET becomes invalid and the program practice is to have the youth 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 written policy and procedures to ensure additional informed consent is obtained for special circumstances where care is not authorized through the Department's Authority for Evaluation and Treatment (AET) form. Five individual healthcare records (IHCRs) were reviewed for parental notification. One youth was over the age of eighteen and signed their own parental consents. The youth's record also contained a Release of Information Authorization Form for youth eighteen years of age or older. A review of the four remaining records showed two youth were applicable for six separate events requiring parental consent for over the counter (OTC) medications beyond those covered on the AET. Three of the events documented parent/guardian verbal consent was obtained and witness prior to the administration of medications. The remaining three events occurred prior to April 16, 2019 and the proper consents were not obtained. The program was using blanket consents for OTC medications not included on the AET through April 16, 2019. The program's health services administrator (HSA) reported the program was informed by the corporate office blanket consents shall no longer be used on April 16, 2019 and a change was immediately imposed. The HSA provided meeting minutes and training records documenting the change. Additional youth records were requested to determine sustainability of the changed practice. Youth medical records are not maintained after release from the program; however, two actively enrolled youth were applicable for five events requiring parent/guardian consent for OTC medications beyond those covered by the AET after April 16, 2019. The five events occurring subsequent to the change in practice clearly documented proper consents were obtained through a witnessed telephone call and a letter mailed to the parent/guardian. In total, three of eleven separately reviewed events where the parent/guardian consent was required did not contain the proper consents. None of the four records applicable for parental consent were applicable for vaccinations, discontinuation of medications, off-site emergency care, hospitalizations, invasive surgeries, and/or dental procedures outside of routine care. An interview with the program's HSA reported in the case of medical emergencies the parent/guardian, designated health authority (DHA), HSA, and facility administrator (FA) are notified of the event following the determination a youth is safe. Two records were applicable for a significant change in existing prescribed medications and a telephone call and letter to the parent/guardian were clearly documented. There were no records applicable for youth being in the care of the Florida Department of Children and Families. The program maintains a policy and procedures for obtaining consent for all discontinuations, significant changes, and newly prescribed psychotropic medications. The program utilizes the third page of the Department's Clinical Psychotropic Progress Note (CPPN) form as required. The program's practice is for all youth to receive a comprehensive psychiatric evaluation within fourteen days of admission. The program's practice is to also complete page three of the CPPN regardless of prescribed medications. Each of the four applicable records contained documentation of a completed psychiatric evaluation and page three of the CPPN sent to the parent/guardian. Each of the four applicable records documented a staff member witnessed all telephone call conversations on the third page of the CPPN where treatment recommendations, applicable prescriptions, and diagnostic information was discussed with the parent/guardian. Reviewed documentation

showed each CPPN was sent to the parent/guardian with a corresponding cover letter. The program's HSA reported the consent is documented on the third page of the CPPN and then mailed by certified mail to the parent/guardian for signature and return. No records were applicable for youth in the care of the Department of Children and Families (DCF), where there was a termination of parental rights. The program maintains a policy and procedures to ensure relevant information regarding a youth's vaccination/immunization history is obtained and youth receive proper vaccinations/immunizations. Five Individual Healthcare Records (IHCRs) were reviewed and each was applicable for vaccinations being verified within thirty days of admission. Each record documented receipt of the youth's vaccination history on the day of admission. No reviewed records were applicable for a Religious Exemption from Immunization form filed in the IHCR. The program does have a policy and procedures in place in cases where the parent/guardian does not authorize vaccinations/immunizations at the time the AET is signed. No records were applicable for a parent/guardian refusing to consent to vaccinations/immunizations. The program documents vaccination/immunization consent by way of the Department's Parental Notification of Health-Related Care Vaccinations/Immunizations form. An interview with the program's HSA confirmed each youth's vaccination/immunization record not documented in the youth's IHCR upon admission, will be obtained through the Florida Shots system on the day of admission.

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

The program maintains a written policy and procedures to ensure youth receive routine healthcare screenings and evaluations upon admission. An interview with the program's health services administrator (HSA) reported all newly admitted youth are seen immediately upon admission. It was also reported the program's registered nurse (RN) completes the Department's Facility Entry Physical Health Screening (FEPHS) form and notifies the designated health authority (DHA) of the youth's admission. The program's HSA reported the RN notifies the designated health authority (DHA) by telephone or verbally, if on-site, with the youth's history and identified chronic condition and documents the notification on the DHA notification form and in the nursing admission chronological notes. A review of five youth Individual Healthcare Records (IHCR) confirmed each youth was screened by the program's RN upon admission to the program. Each youth was screened using the Department's FEPHS form. The program maintains a written policy and procedures to ensure a rescreening and the completion of a new FEPHS form occurs anytime the youth returns to the program following a physical custody change. The program's rescreening process ensures youth can be placed back into the general population and are not in need of immediate medical attention. A review of five youth IHRCs found one was applicable for a change in physical custody occurring. Two additional applicable IHRCs were reviewed for a sample size of three. Reviewed documentation supported all three youth received a healthcare admission rescreening utilizing the Department's FEPHS form. Each FEPHS form was completed by an RN. An interview with the program's HSA reported when youth return to the program the RN immediately completes the FEPHS.

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

The program maintains a written policy and procedures to ensure all youth admitted to the program are oriented upon admission to the program's healthcare systems. The health education shall be provided by the healthcare staff, in writing and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. When applicable, the orientation/admission health education will be provided in Spanish as well as any other language a youth uses as a primary language. For youth with cognitive deficits, the teachers in the program shall provide information as to how to present the information to the youth who are impaired. A review of five youth Individual Healthcare Records (IHCRs) validated each youth received a healthcare orientation on the day of admission. Each healthcare orientation was documented on the Department's Health Education Record form. Each youth received a health education packet specifically designed for male adolescents. Reviewed documentation showed youth and nursing staff signed each health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay which is documented in the IHCR. Each reviewed IHCR validated this practice.

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

The program maintains a written policy and procedures regarding notifying the designated health authority (DHA) telephonically, or verbally of all new admissions, regardless of any identified medical conditions, on the same day of admission. The program policy dictates healthcare staff will provide the DHA with a comprehensive overview of all applicable admission orders, medication orders, preliminary laboratory studies, applicable diet orders, activity restrictions, and specific treatment orders for all youth with an identified health related condition. Five Individual Healthcare Records (IHCRs) were reviewed for DHA admission notification. Each youth's record documented the DHA notification was made by telephone on the day of admission. Nursing staff document the notification on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form during the next site visit. Each reviewed record contained a Notification of Admission form filed in the practitioner's section of the IHCR. In addition, the nurse documents the DHA notification on the Nursing Chronological/Notification Progress Note - Male Admission form and are filed in the nursing chronological notes section of the IHCR. One IHCR was applicable for a known or suspected chronic condition. The nursing staff also updated the Chronic Conditions Log after the notification was completed. None of the reviewed records reflected the youth was in need of an emergency response. An interview with the program's health services administrator reported the admitting nurse notifies the DHA right away by telephone to make them aware 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 written policy and procedures outlining the completion and/or update of the Department's Health-Related History (HRH) Form upon admission. A review of five Individual Healthcare Records (IHCRs) documented each youth received a newly completed HRH within seven days of admission, and prior to the completion of the Comprehensive Physical Assessment (CPA). Each was completed on the day of admission. All five reviewed HRHs were completed by a registered nurse (RN). The documentation also showed the designated health authority (DHA) reviewed the HRH in each record. Each reviewed IHCR showed 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's health service administrator reported the program practice is for the RN to complete the HRH on the admission date for all youth.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other strenuous activity. A review of five youth Individual Healthcare Records (IHCRs) validated the program utilizes the Department's Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA) and/or designee. All sections of the CPA were completed in full utilizing "O" with no applicable "X". Reviewed documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. The program maintains a written policy and procedures for the screening of infectious diseases including tuberculosis (TB). The policy states youth will not be placed into the general population until their healthcare needs identified are deemed not to require immediate medical attention and/or a referral for further assessment by healthcare staff. A review of five youth IHCRs validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to TB. In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening. All tier I TB screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were included on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. An interview with the program's health service administrator (HSA) reported youth are assessed at the time of admission with the FEPHS. Additionally, PPDs are administered annually, and if deemed applicable, at the time of admission for all youth. There were no current youth with symptoms suggestive of active TB. Program procedures outlined if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the designated health authority.

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

The program maintains a written policy and procedures 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 five youth Individual Healthcare Records (IHCRs) found each youth was clinically screened and evaluated for STIs. Each of the five youth were referred to the DHA for further evaluation and referrals were documented in the youth's 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 and/or requiring a rescreening due to presenting symptoms. An interview with the program's health service administrator (HSA) reported youth are screened for STIs at the time of admission. It was further reported 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 maintains a 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 five youth IHCRs validated each youth was offered the opportunity to receive counseling and testing for HIV of which two consented, two did not consent, and one was not indicated for needed testing. An additional record was reviewed for a sample size of three. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's HIV Antibody Test Youth Consent form. The program's DHA and designee both carry a medical doctor license and are authorized to provide pre-counseling, testing, and post-counseling. Each of the three records applicable for HIV testing contained results placed in a sealed envelope marked personal and "confidential" including 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 the lab. Post-HIV counseling is then completed by the DHA. Signed HIV consent forms are located on the Department's Infectious and Communicable Disease (ICD) form section of each IHCR, documented on the youth's health education record, and within the nursing chronological notes. Five 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 ensuring all youth shall be able to make Sick Call requests and have their complaints treated appropriately through an established Sick Call system. The program identifies Sick Call as the official method for a youth to request healthcare services for an illness or injury. Sick Call care, including dental complaints, shall be available to all youth. The Sick Call process is intended to provide care in response to non-

emergent illness or injury requiring some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's Sick Call process upon admission. Sick Call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program maintains DHA approved protocols for non-licensed staff to deal with healthcare situations. The protocols clearly indicate no substitutions are permitted without the authorization of the DHA. Completed Sick Call Request forms are filed in chronological order in the nurses 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. Sick calls are scheduled Monday through Friday at 6:00 a.m. and 12:00 p.m., and Saturday and Sunday at 8:50 a.m. and 5:30 p.m. All scheduled sick calls are conducted a licensed registered nurse (RN). The program's two living units have Sick Call forms located on the wall and a deposit box is located outside of the cafeteria accessible to all youth. The program practice is to check the boxes every two hours. A review of five youth IHCRs reflected three youth completed a Sick Call Request form at least once during their stay. 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 applicable youth who presented a similar sick call complaint three or more times within a two-week period. However, program procedures outlined the healthcare staff will automatically refer all youth submitting a Sick Call Request to the DHA or dentist for an evaluation and treatment. Reviewed IHCRs indicated each sick call incident was documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the program's Electronic Medical Record as well as the IHCRs. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the shift supervisor for review. The supervisor is required to review the Sick Call complaint promptly, but no longer than two hours after the request was submitted. The supervisor will then determine if the Sick Call requires immediate attention. The DHA and/or designee, and the health services administrator (HSA) are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. An interview with the HSA reported all supervisors are trained on the Sick Call process in pre-service training and refresher training is provided annually. An observation of sick call during the annual compliance review showed the youth was escorted to the nurse's station by a Protective Action Response (PAR) certified youth care worker. The youth provided verbal and initialed consent for regional monitor to observe the Sick Call process. The youth was seen in a private area within the medical clinic on an exam table. All aspects of the Sick Call process where thorough and informative. The program's RN identified why the youth was there and asked the youth to initial the Sick Call form. The RN was knowledgeable of the youth's condition and offered over the counter (OTC) medication not included on the Department's Authority for Evaluation and Treatment form (AET). The youth was over the age of eighteen and parent/guardian notification was not required. The youth was educated on the OTC medication provided, the youth's allergies were confirmed, and the Medical Administration Record was updated. Five interviewed staff indicated nursing staff or the doctor conduct Sick Call. Five interviewed youth found two indicated they can be seen immediately once they submit a Sick Call Request form, and three indicated within one day. Five interviewed youth indicated they can see a dentist in the event they have tooth pain and/or doctor if needed 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 ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. The program requires each 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 this 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. The program also maintains a written policy and procedure ensuring the program-based automated external defibrillators (AEDs) are properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. A review of five youth Individual Healthcare Records (IHCRs) found two youth required episodic and/or first aid care during their stay in the program. One additional IHCR was requested and reviewed for a sample size of three. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic/First Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Care Log. The program maintains three AEDs located in the main master control, sub-master control, and the program's administrative building. All staff, volunteers, and interns are authorized to provide assistance to victims of sudden cardiac arrest, if they have been trained in the use of the AED, as documented in their respective training record. The program maintains six first aid kits. Three kits were located in main master control, two of which were designated for the program's transportation vans, two in sub-master control, and one in the administrative building. The program also maintains two complete suicide response kits located in main master control and sub-master control. The program also places a knife-for-life within each of the program's six first aid kits. The first aid kits, AEDs, and suicide response kits are inventoried monthly by nursing staff to ensure they are fully stocked and operational. The AED procedures were observed as audio and written instructions and each AED was demonstrated by the nursing staff during the annual compliance review. Reviewed AED batteries expire on May 2022, July 2022, and October 2022. Reviewed AED pads found two expire on December 2020 and the other on April 2021. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. Additionally, all nursing staff maintained current certifications in CPR and AED. A review of the program's mock emergency medical drills reflected twenty-six drills have been conducted in the last twelve months. Each reviewed drill included CPR/AED demonstration. The program 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. Observations during the tour of the program found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were located in main master control and the medical clinic inaccessible to youth. Reviewed training records supported all supervisory staff have been trained in the administration of the Epinephrine Auto Injector. Five interviewed staff reported they could personally call 9-1-1 or have master control staff call 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 a written policy and procedures for the provisions of off-site emergency and non-emergency referrals for medical care and treatment. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of five youth Individual Healthcare Records (IHCRs) found two youth requiring off-site care and/or emergency care. The program reported no additional enrolled youth were applicable for off-site care. One of the two youth was eighteen years of age or older; however, did provide consent for parental notification. The remaining reviewed youth IHCR indicated the youth was under eighteen years of age and the parent/guardian was notified. The Summary of Off-Site Care Form was completed for each youth and was filed in the appropriate section of the IHCR. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care Form and discharge paperwork as evidenced by signature and date. Each youth required follow-up care and received services as prescribed. An interview with nursing staff indicated the registered nurses (RNs) track follow-up testing, referrals, and appointments on the Medical Services Tracking form, Physician's Weekly Clinic List Form, and Sick Call/Referral Log Form. The RNs place all off-site care findings, instructions, and information in the DHA folder for review and documentation of signature. Both records contained a Summary of Off-Site Care form and applicable follow-up and discharge paperwork. Both reviewed applicable records showed the DHA and/or designee reviewed off-site care findings, instructions, and information. An interview with the program's health service administrator (HSA) reported the program calls the DHA after all off-site visits are completed and the RN receives telephone orders from the provider. The program's regional medical doctor reported all off-site care orders are reviewed by the DHA or designee during the next on-site visit. The HSA also reported the DHA documents review on the Off-Site Care form and nursing staff track any follow-up appointments through an appointment calendar.

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

The program maintains a written policy and procedures to provide guidance to health services personnel in the areas of chronic illness monitoring and clinic establishment guidelines. The program defines a chronic medical condition as an illness, disability or condition which is permanent or persists longer than six months, except for allergies, hearing/speech/visual impairment, developmental disability, or mental deficiencies. The program develops and maintains treatment plans through physician progress notes specifying a youth's course of therapy, identifies the role of qualified health professionals in carrying it out, and updates the plan as needed. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of five youth Individual Healthcare Records (IHCRs) indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening (FEPHS) form. All three youth were classified with a medical grade of two through five. Two youth were taking

prescribed medication on an ongoing basis and there was one youth currently 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 identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations as required. An interview with the corporate medical doctor indicated chronic conditions are monitored at least every sixty days and this is also documented in the designated health authority's (DHA's) physician order log. An interview with the program's health service administrator (HSA) reported youth identified with a chronic condition are placed on the medical tracker to ensure the DHA follows-up with each applicable youth. The psychiatrist indicated the youth are evaluated every thirty days. There was no indication of lapses in care or missed periodic evaluations in each of the reviewed records. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. All three IHCRs documented updating of the Department's Problem list as changes occurred. An interview with the program's corporate medical doctor confirmed monthly and quarterly meetings are conducted with the program staff, nursing staff, psychiatrist, consultation pharmacist, and DHA to discuss the care and conditions of youth at the program.

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

The program maintains a written policy and procedures to ensure youth's medications are verified upon arrival. A review of five youth Individual Healthcare Records (IHCRs) indicated two youth were admitted into the program on prescribed medications. One additional applicable youth IHCR was reviewed for a sample size of three. Reviewed nursing admission notes and Facility Entry Physical Health Screenings (FEPHS) documented the youth's current medications in each instance. Each designated health authority (DHA) Notification of Admission form documented current prescribed medication and verbal notification by telephone to continue medication was also received. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the continuation of medications. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The program maintains a written policy and procedures to ensure there is no lapse in the youth's medication regimen. The program ensures all prescribed medications are never delayed or withheld for funding reasons. All prescribed medications are obtained from a licensed vendor, according to a contractual agreement between the program and the vendor. The program has a contract with a pharmacy. The program may obtain emergency prescriptions from a local pharmacy, when necessary. A review of five youth Individual Healthcare Records (IHCRs) validated three were applicable for prescribed medication while attending the program. Each documented a current and valid prescription order. Each of the IHCRs were applicable for the youth being admitted on medications, a change to medications, or a new medication being ordered. In each instance, the doctor's order sheet clearly documented the medication and dosage. An interview with the program's health service administrator (HSA) reported all medications are verified with the youth's parent/guardian and the pharmacy. The verification is then documented by the registered nurse (RN) in the chronological section of the IHCR. Five reviewed IHCRs found each youth had a MAR outlining over-the-counter medications (OTC) approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. All five youth were prescribed

OTC medications approved through the AET and reviewed documentation supported the program utilizes a pre-printed MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. Two reviewed IHCRs indicated youth were taking prescribed medications upon admission and an additional record was requested for a sample size of three. The initial MAR for each record matched the medication(s) listed. Observations found the medications are procured through the contracted pharmacy. 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 inventories of controlled medications are conducted by two registered nurses. All three reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. The program's nursing staff maintain a locked tackle box within the clinic with OTC medications listed on the AET form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on-site. A review of the Department's Central Communications Center (CCC) reports validated there were no incidents of missed medications at the program since the last annual compliance review. Two records were applicable and the reviewed MARs clearly documented refusal of medications. Observation of one medication administration by nursing staff during the annual compliance review validated the medication cart was secured when not in use. Observations of the medication cart found it clean and organized with medications separated. The Six Rights of Medication Delivery/Administration was maintained for the youth. The program maintains 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 four controlled medications on-site during the annual compliance review week and observations showed medications were 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. Five interviewed youth all indicated nursing staff provide medication to youth. Five staff were interviewed regarding the administration of medication at the program and all reported the doctor or nurse administer the medications. All staff also reported the shift supervisor can assist with the self-administration of medications after nursing hours.

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 to ensure all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of, and properly maintained in accordance with federal and state laws. Observations found all medications securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter (OTC) medications were placed in a locked box on the wall of the clinic. Observations made during the annual compliance review also revealed oral medications were not stored with injectable or topical medications. The

program maintains one refrigerator for medications. There were no medications requiring refrigeration during the annual compliance review week. The program securely stored sharps and syringes separate from medications. Syringes and sharps are counted through a perpetual inventory and are verified weekly. All controlled substances are maintained in the locked box within a locked medication cart located in the medical clinic. The program's medications are procured through 1st Choice Pharmacy. The medications are in blister packs documenting the number of pills in each prescription order. The program contracts with with a pharmacy and a State of Florida licensed consultant pharmacist. The program's pharmacy license issued through the Department of Health, Division of Quality Assurance, expires on February 28, 2021. The consultant pharmacist license expires December 31, 2020. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. Reviewed documentation and nursing interviews confirm all OTC medications are inventoried perpetually and weekly. The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained supervisory staff. Non-licensed supervisory staff shall provide self-administration medication only when there is no licensed healthcare staff 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 prescribed 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 four youth prescribed a controlled medication during the annual compliance review. A review of three controlled medications were randomly selected for inventory and all were accurate. The nurse reported the consultant pharmacist is on-site monthly for inspection and attends quarterly meetings at the program. The program's HSA reported the consultant pharmacist assists in checking all nursing units, medication carts, over the counter medications, controlled substances, sharps containers, count sheets, refrigerators, and emergency kits. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator and registered nursing staff. Observations conducted during the annual compliance review week supported three youth prescribed medication inventories were accurate. Three OTC medications and three sharps were reviewed, and inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with inventory counts. The program maintains a current agreement with Stericycle, Inc. for biomedical waste treatment with an operating permit with the State of Florida, Department of Health with an expiration date of September 30, 2020. Stericycle, Inc. picks up medical waste monthly.

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

The program maintains a written policy and procedures ensuring there is an approved plan for infection control 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 outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Center for Disease Control and Prevention (CDC) guidelines. The plan was reviewed and approved by the facility administrator on July 1, 2019, the previous designated health authority (DHA) on July 8, 2019, and the corporate medical doctor (MD) on August 22, 2019. The plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. The plan also includes 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 any other infectious agent, whether spread directly or indirectly to include pediculosis and/or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA), food-borne illnesses such as those caused by Escherichia Coli (E. Coli), and bio-terrorists agents. The program's plan also outlines procedures regarding chemical exposures and universal precautions. The program provides all staff with the opportunity for Hepatitis B immunizations and access to protective equipment. An interview with the program's health service administrator (HSA) reported there were no instances in which the local health department, CDC, and or the Department's Central Communications Center (CCC) should have been notified for an infectious disease. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator (FA) has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. An interview with the program's FA explained the program's Exposure Control Plan/Infection Control Plan is located in the medical office and the administration building. The FA also indicated the Exposure Control Plan/Infection Control Plan is reviewed with all staff during new hire training and reviewed each June and December during an all staff meeting. The bi-annual recertification training is led by the licensed HSA. An interview with the program's HSA reported, and a review of youth records supported, all youth receive infection control training upon admission and annually.

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 has a written policy and procedures in place regarding youth supervision. The program staff promote safety and security by maintaining active supervision of youth including interacting positively with youth, engaging youth in a full schedule of meaningful activities, monitoring youth behavior and changes in behavior, and applying the program's behavior management system (BMS). Youth and staff observations were conducted for four days during the annual compliance review week. The observations included youth movement from the dorm to the outdoor recreation area, from the cafeteria to school, from classroom to classroom, transport of a youth returning back to the program, and work detail. During each observation, staff were actively supervising the youth and, when requested, staff immediately provided an accurate count of youth in their supervision. A review of master control logbooks verified at least six formal youth counts were documented in the log within every twenty-four-hour period. Interviews conducted with staff revealed staff understand the steps to take when there is a discrepancy in youth counts. Youth-to-staff ratios were in compliance with the program's contract. The program's head counts and youth movements are maintained in the facility logbook, which is maintained by program staff in master control. Youth counts are consistently conducted during each shift and the master control staff calls for a count from each youth care worker. Observations found the program staff interactions with the youth were positive and followed the program's BMS. The program has a daily schedule posted in the dormitory activity area and the cafeteria. An informal interview with several staff revealed their knowledge of the process for reconciling discrepancies in youth counts. Staff explained what procedures are implemented when youth counts cannot be reconciled to include performing a recount, performing an emergency count, notification to the supervisor and facility administrator, securing youth, conducting a facility and perimeter search, and notification to law enforcement and the Department's Central Communications Center.

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

The program has a written policy and procedures which indicates all consequences and sanctions for violation of the program rules shall be directly related to the seriousness of the inappropriate behavior exhibited, consistent with the sanctions detailed in the youth's handbook, and applied immediately. The program's behavior management system (BMS), is a multi-level system designed to increase desired behaviors using reinforcements and decrease unwanted behaviors through various appropriate violations. The written description is provided to youth in

the youth's handbook during orientation to allow easy access for youth, including rules governing conduct, and positive and negative consequences for behavior. In four of the five reviewed youth records, documentation of acknowledgement receipts was found confirming each youth received the youth handbook at orientation, one was not completed. The BMS is reviewed with the youth by the staff completing the orientation phase. The youth's handbook included a list of behavioral infractions and rewards they can earn for positive behavior. The BMS is a level system and rewards are generated through a point system which youth earn daily. The program has an annual in-service and pre-service training plan, which includes the BMS for all staff. A review of five staff in-service and five staff pre-service training records found staff are being trained on the BMS. Five interviewed youth were able to explain the BMS and what rewards could be earned with positive behavior. The youth indicated a variety of rewards are provided to them which consist of special snacks, extra television time, move to the next level, and later bedtime. During the annual compliance review week, staff were observed implementing the BMS during interactions with the youth to include lunch time, leisure time, and during groups. Staff acknowledged youth's positive and negative behaviors at a four-to-one ratio. Documentation confirmed youth and staff are surveyed quarterly by the program to ensure fairness and consistency with the BMS. Five interviewed youth reported staff give rewards and consequences correctly and on a consistent basis. According to the youth interviews, all five youth rated the BMS good. An interview with the facility administrator indicated the program used a positive performance-based BMS which is based on a tracker level system, youth successful completion of treatment plan goals, performance plan goals, daily performance, and increasing social skills.

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

The behavior management system (BMS) is designed to maintain order and security, provide constructive discipline, and positive and negative consequences to encourage youth to meet behavior expectations. The program's BMS requires all staff to be responsible for monitoring and addressing behavior. Case managers are responsible for tracking youth violations and utilizing the BMS when confronting the youth about their behavior. The youth's handbook informs each youth of the program's responsibility to the youth and the youth's responsibility and expectations to the program. The BMS reminds the youth of their responsibility to follow all program rules, follow staff directives, and always exhibit appropriate behavior. An interview with the facility administrator (FA) indicated the BMS reminds the youth of their responsibility to follow all rules, always exhibit appropriate behavior, and ensure all staff having direct contact with youth are trained. The program's BMS includes a process wherein staff explain to the youth the reason for sanctions being imposed, and the youth are allowed an opportunity to explain their behavior. Observations of youth and staff interactions during the annual compliance review week showed the exchange of open communication between youth and staff in relation to youth actions and behavior. Youth length of stay is not increased subsequent to engaging in negative

behavior, nor are youth denied basic rights or services. Youth grievances and “Let’s Talk” forms are mechanisms through which youth may voice their concern regarding the fair and consistent implementation of the BMS. All five interviewed youth stated they are not allowed to punish other youth. Five staff were interviewed regarding staff receiving feedback on the use of the BMS. All five staff indicated they receive feedback from supervisors regarding the BMS system.

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

The program has a written policy and procedures regarding ten-minute checks. The program has a total of thirty-two cameras and two 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. According to the program’s policy, staff assigned to each dormitory will conduct ten-minute checks on all youth in the dormitory by utilizing a flashlight to ensure skin or a body part is seen to confirm the youth’s presence, and the shift supervisor is required to complete a minimum of three walkthroughs for each dormitory each night. Documentation showed a random review of video footage is conducted weekly and documented on the program’s safety inspection form. A random review of ten-minute checks found staff documented youth checks on the program’s approved ten-minute room check form. A random review of ten-minute room check sheets and video footage for Campanella dormitory on August 1-2, August 21-22, and August 24-25, 2019, during various times was completed for A and B-shifts from two cameras for two hours each. In the Campanella dormitory, a review of ten-minute check logs and video footage showed staff conducting the last ten-minute checks at 5:55 a.m. and the last youth exited the room at 6:50 a.m. on August 2, 2019. There were no ten-minute checks conducted during the time period the youth were in their rooms. On August 21-22, 2019, a review of video footage displayed the staff conducting ten-minute checks. However, the staff failed to document the ten-minute checks on the log. In addition, ten-minute checks were not consistently completed during the time period the youth were in their rooms from 6:05 a.m. to 7:14 a.m. A random review of ten-minute room check sheets and video footage for Omega dormitory on August 9-10, August 18-19, and August 27-28, 2019, during various times was completed for A and B-shifts from two cameras for two hours each. In the Omega dormitory, it was discovered ten-minute checks conducted on August 10, 2019, at 7:00 a.m. and 7:10 a.m., did not occur as it was documented. The staff was observed sitting down with a blanket on a chair and was sleeping. The incident was reported and accepted by the Department’s Central Communications Center (CCC). The video footage also showed the staff conducting a ten-minute check at 7:28 a.m. and the youth exited their rooms at 8:07 a.m. There were no ten-minute checks conducted during the time period the youth were in their rooms. On August 28, 2019, there were no ten-minute checks conducted from 5:55 a.m. to 6:20 a.m. while the youth were in their rooms. The youth exited their rooms at 6:26 a.m. The ten-minute checks were conducted as required for seven of the twelve reviewed date and documented in real time. Reviewed documentation found ten-minute checks were conducted as required for seven out of the twelve reviewed dates and documented in real time. During the week of the annual compliance review, the program provided documentation to validate the staff members received a coaching session and a written reprimand in reference to ten-minute checks. The program’s facility administrator (FA) stated a training will be conducted for shift changes during morning ten-minute checks while the youth are in their rooms. An interview with five staff reported room

checks are conducted every ten-minutes when a youth is placed in their room for sleeping reasons.

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

The program has a written policy and procedures in place for tracking counts and maintaining a census. A review of the program's logbooks from February to August 29, 2019, revealed a daily census of youth in the program. The program has one program logbook, which master control staff oversees and maintains. Master control staff document head counts at the beginning and ending of each shift and outdoor activities. Master control staff conducted at least six formal head counts within a 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 youth accounted for. Emergency counts were observed in the logbooks and accounted for the basis of the count, time, location, and number of youth accounted. A review of the logbook indicated the documentation of daily counts, head counts, youth movements, admissions, releases, and youth temporarily away from the program. The staff highlight in yellow head counts of youth and any emergency situations. During the annual compliance review week, the review team observed headcounts being called several times during the day on a two-way radio. Observations of youth counts were made and reflected prior to any youth movement, master control was contacted to inform of the number of youth being moved and to what location. There are two tracking boards in the master control office. The first tracking board in master control documented the daily census for the program which keeps the daily totals, admissions, releases, and youth temporarily off-site/campus. The second tracking board in master control identified each youth by their photo with their name, date of birth, Department identification number (DJJID), assigned cottage, medical alert, mental health alert, and security risk alert. An interview with five staff reflected each are aware of the program's policy and procedures on adequate supervision of youth, and discrepancies in youth counts as well as conducting counts during an emergency.

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

The program maintains a program logbook containing a chronological record of events, incidents, and activities. The program logbooks were reviewed from February to August 29, 2019, and revealed the logbooks were bound with no loose or missing pages and all pages were numbered. All logbook entries were brief and legible, written in ink, and included the date and time of the event. The entries consistently included the full name and the signature of the staff making the entry. All entries had consistent color-coded highlighting. Any errors were struck through with a single line and initialed by the person making the correction. The program conducts shift briefings prior to each shift with significant issues identified on the previous shift. The shift briefing's information is documented in the shift reports and all staff signed the report at the end of briefing to reflect they have been informed of any issues. The shift supervisor is assigned to maintain the report and make entries regarding chronological events for their shift. Shift entries were inclusive of population counts, perimeter, and other security checks. A review of the program's shift reports verified information is shared with incoming staff prior to the beginning of the shift. The program's logbook was reviewed for reporting incidents to the Department's Central Communications Center (CCC) and four of the five CCC report numbers were documented in the logbook. One incident was not documented in the logbook. A review of the logbooks also verified internal incidents were reported to the Florida Abuse Hotline and/or the Department's CCC.

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 regarding key control. The program's key policy includes procedures for assignment of the keys, usage, restrictions, inventory, tracking, and storage. The policy also includes a procedure for reconciling missing, damaged and/or lost keys. Documentation of permanent issue keys included the chip identification of keys on the key ring, key identification number, and the names and title of the person issued the permanent keys. All program keys are maintained within master control and are housed within a central key cabinet, which remains locked when not in use and youth do not have access to the program keys. In order to provide strict accountability of program keys, master control staff is responsible for the inventory, inspection, return, and documentation of active, restricted, and emergency keys. Staff must turn in their personal keys in order to obtain the program keys prior to entering the program grounds. Staff must return the assigned keys upon completion of their shift in order to obtain their personal keys. If a staff did not have personal keys, the staff key tag is placed in the slot of the issued key. Master control staff are required to sign-in and out for keys daily. Observations of key exchange confirmed the program practice. Restricted keys are maintained

in a separate key box located in master control. Medical staff are the only staff with access to the restricted key box. When medical staff report to work, they enter master control, obtain their program keys, and deposit their personal keys in the medical key box. A random check of three staff keys was conducted during the week of the annual compliance review. The program's unit manager and two youth care workers each had the appropriate number-coded key. A review of the program's daily key logs from February to August 29, 2019, revealed the program's sign-in and out for keys was consistently tracking keys and assigning keys. An informal interview with master control staff and the physical plant worker indicated the program has not had any incidents of missing or lost keys in the last six months. An interview with five staff confirmed all staff are aware of the program key control protocols regarding lost/missing, damaged keys, and restricted keys.

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

The program has a written policy and procedures in place regarding contraband. The policy includes items considered contraband and consequences for having contraband. The program's policy regarding contraband aligns with the Department's recommended guidelines for contraband. The program's prohibited list includes personal cellular telephones and electronic devices capable of taking pictures and/or audio/video recordings. The policy states unannounced random searches of youth sleeping rooms shall be done on an irregular, unpredictable basis, but at a minimum must be done weekly. Youth are provided a resident's handbook which outlines the behavior management system and includes a list of items considered as contraband. The youth's parents/guardians are mailed a handbook which outlines a list of items considered as contraband and the program visitation procedure. The program staff stated all searches are conducted unannounced daily. A random review of daily search reports from February to August 2019, documented the following contraband items have been found including pencils, tape, extra snacks, and juices. Documentation of the contraband is found in the contraband binder. Youth who are found with contraband will have a behavior report and a special treatment team meeting for the violation. A review of the program master control logbooks and safety perimeter check inspection reports for the past six months confirmed searches and program checks are conducted daily on each shift. An interview with the facility administrator (FA) reported contraband not considered illegal is immediately removed and forwarded to the FA's office.

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

The program has a written policy and procedures in place referencing the proper procedure for conducting searches and full body visual searches to include when and how they are to be conducted. Searches are conducted on every youth after all movements by the same gender staff member as the youth. Observations of youth searches from classroom to classroom, classroom to lunch, and common areas to recreation verified compliance with youth search procedures. Youth are advised of the search process and basis for the search. Observations of a youth being transported during the annual compliance review week found the youth was informed of the search process, asked to turn, and the full body visual search was completed with dignity by the male staff. The search was conducted in a positive manner not causing stress or embarrassment to the youth. Additionally, the full body visual search of the youth was conducted according to the Protective Action Response (PAR) requirements. Observation of incoming staff found all staff received a security check utilizing an electronic metal detector when entering the program. An interview with five staff confirmed all staff had knowledge of how and when to conduct youth searches. An interview with five youth confirmed searches occur when items are missing, after visitation, after meals, after outdoor activities, when returning from off campus, 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 written policy and procedures in place regarding transportation, vehicles equipment, and maintenance. The program has two vehicles to transport the youth. Each vehicle received an annual safety inspection, and required maintenance, with documentation of services completed on each of the vehicles. Each vehicle used to transport youth was observed to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, and a fire extinguisher. First aid kits are maintained inside master control until the vehicles are in use and transport staff brings the designated first aid kits with them on all transports. A check of both transport vehicles at the program found each was locked when not in use and both vehicles have an inspection sheet. A transport was observed which confirmed the youth and staff wear seatbelts and in compliance with the staff to youth ratio. An informal interview with the transport staff confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt. Five interviewed staff confirmed the program provides them with a cellular telephone for use during transports in case of an emergency or if there are any issues with the vehicle while in use.

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

The program maintains a written policy and procedures regarding transporting youth and the use of communication devices. The program has two operable vans utilized to transport youth. Observation of a youth transport returning to the program during the annual compliance review week reflected youth are not left unattended in a vehicle. Observation of the transport found the program followed the staff-to-youth ratio requirement, the staff and youth were wearing seat belts, and had a cellular telephone for communicating with the program during the transport. The van used for transporting the youth has rear and side doors and the van was equipped with a safety screen separating the driver's compartment from the passenger's compartment. The program has two staff conducting youth transports and one of the staff members is the same gender as the youth being transported. A review of the vehicle inspection sheets dated for the past six months, indicated the program met the Department's requirement for each vehicle used to transport youth and passed an annual safety vehicle inspection. The program's policy states staff are not allowed to transport youth in their personal vehicles, nor are youth allowed to operate program or staff vehicles. A random check of ten staff personal vehicles and two transport vehicles at the program found all vehicles were locked and secured when not in use. The program maintains a driver's list which includes the staff member's name and title. The list was approved by the program's facility administrator (FA) and Human Resource Department. All staff on the driver's list have a current driver's license. The program's human resource staff checks each staff driver's license and updates the list monthly. An interview with five staff confirmed a cellular telephone is provided during transports and they are not allowed to transport youth in their personal vehicles.

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

The program has a written policy and procedures in place regarding weekly safety and security audits. The policy meets all the requirements of Florida Administrative Code 63E-7. The program's facility administrator (FA) and unit manager are responsible for conducting the weekly security audits, documenting the outcome, and recommendations on the inspection logs. The weekly security audits and safety inspections address camera surveillance, digital video recorder (DVR), radios and communication devices, perimeter, and fencing to ensure all areas are secure. A review of the program's security audit and safety inspection logs showed the program is conducting weekly safety and security audits for the past six months. An informal interview with the program's FA indicated there's a process in place to correct and track all deficiencies identified during the weekly safety and security audits. Documentation showed the program addresses any deficiencies found and documents the course of action needed to correct the deficiency.

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

The program has a written policy and procedures on tool management, preventative, and corrective maintenance which provides instructions and procedures regarding storage and

tracking of tools. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department has a total of five different buildings which house tools and other supplies needed for maintenance, and one van used by maintenance to transport and store tools. An informal interview with the program's physical plant manager confirmed all tools stored in various buildings and inside of the van are Class A tools. The tools are secured in locked cabinets inside the buildings, the physical plant staff are the only workers assigned keys to unlock the buildings. An inventory of the tools and chemicals are completed daily and weekly. Observations of the maintenance building, garage, offices, carpenter warehouse, supply warehouse, and one van used as a maintenance vehicle support the practice of daily and weekly inventories. The physical plant manager maintains a perpetual inventory of all tools and chemicals which is attached to the door of each locked cabinet containing tools and/or chemicals in the various buildings. The staff sign-out and sign-in the tools as they use them. The program has a list of Class B tools to be maintained in a locked room in the cottage. An inventory of the Class B tools is maintained by the program's unit manager. The kitchen knives are locked in a shadow box in the main kitchen. Kitchen staff inventory all knives daily. Youth are trained to use mops and brooms. A review of five staff in-service and five staff pre-service training records found staff are being trained on Class A and Class B tools. Five youth were interviewed regarding what tools they use in the program and all five youth responded mops and brooms. Five interviewed staff reported youth in the program are allowed to use mops, brooms, and scrub brushes.

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

The program has a written policy and procedures in place regarding supervising youth handling tools. Youth are only allowed to use Class B tools under direct supervision of staff. The staff-to-youth ratio during work detail activities is one-to-five. Youth are searched to ensure no contraband has been removed upon completion of the work activity. Observations were made of youth completing work detail in the cottage area and cafeteria. There was one staff supervising three youth during the work detail. A review of five youth case management records found risk assessments were completed monthly. Documentation indicated certain youth are qualified to use Class A tools; however, the program does not allow youth to use Class A tools. Searches are conducted after each activity involving the use of tools. Five interviewed staff reported youth are permitted to use mops, brooms, and scrub brushes. Five interviewed youth reported youth can use mops and brooms.

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

The program has a written policy and procedures in place regarding outside contractors and requirements the contractor must adhere to while working on-site at the program. An interview with the physical plant assistant and the program's regional compliance manager confirmed the program's practice is to have all contractors sign acknowledging the program's contraband list and the Prison Rape Elimination Act (PREA) guidelines. The contractors sign-in and sign-out on the contractors log each time a repairman enters the program to perform a work project. The program's policy states all contractors, while on-site, must be in direct supervision of the physical plant worker or authorized staff. A random review of five of the outside contractor's

sign-in and sign-out logs found the contractors were not consistently signing-out when exiting the program. Documentation did not support the contractor's tools were checked upon their arrival and departure from the program for the past six months. Documentation did not support the program's practice of searching contractor's tools upon arrival and departure from the program. Florida Administrative Code 63E-7 indicates the program must check tools upon the worker's arrival and departure from the program. The program's administration staff stated the physical plant assistant will develop a process on how to document the contractor's tools when their entering and exiting the program. There were no reports of missing contractor tools during the annual compliance review period. The program's policy outlines who is responsible for providing approval/permissions if a contractor's personal cellular telephone and/or equipment/electronic devices are required.

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

The program maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on May 17, 2019. The COOP requires the program to conduct safety, disaster, fire, and evacuation drills on a random basis, for each shift, monthly, and under varying conditions when the majority of the youth are available. Furthermore, the COOP requires the program to conduct unannounced fire drills once a month for each shift. During an interview, the facility administrator (FA) and the program's regional compliance manager stated fire drills are always conducted monthly and unannounced on each shift. Reviewed documentation of drills confirmed the program completed drills in accordance with their COOP. The program conducted six COOP drills relating to safety, evacuation, escape, lightning in the area, disaster, and chemical spill within the last six months. All five interviewed youth reported the program conducted a lot of fire drills and too many to recall. All five youth reported they have been instructed what to do in case of a fire. Five interviewed staff indicated they have participated in fire, escape, chemical spill, flood, weather-related drill, major disturbance, hostage situation, and bomb threat drills. The FA also reported drills are completed once a month on each shift.

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

The program has a written policy and procedures in place regarding the Continuity of Operations Plan (COOP). The COOP included all required elements of Florida Administrative Code 63E-7. The COOP was submitted and approved by the Department on May 17, 2019, by electronic mail. The facility administrator (FA) reported the COOP is available to all program staff and is located in master control office and inside the program's administration office. The program maintains critical identifying information and a current photograph verifying the youth's identity in a hard-copy record which is easily accessible to staff in the event of an emergency

situation. The administrative hard-copy record for each youth included face sheet, admission card, alert list, court order, and photograph of youth. A review of five staff in-service and five staff pre-service training records found staff were trained on the COOP. All completed training was documented in the Department's Learning Management System (SkillPro).

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

The program has a written policy and procedures in place regarding the control of hazardous materials. These items are stored in a metal cabinet inside building number thirty-two identified as flammables and are inaccessible to the youth in the program. The Safety Data Sheets (SDS) book is located with the chemical items, which includes a photograph of the item along with the perpetual inventory for each item. A review of three chemicals in comparison with the inventory sheet matched the actual chemicals stored. The program's physical plant manager maintains a list of materials, an authorized staff list for access to chemicals posted on the outside of the door, and a permanent log to display the signing in/out of chemicals. The program records the daily use of chemicals on a daily chemical usage log to include the initial of the authorized staff using each chemical. Additionally, all of the chemicals are inventoried one time a week by the program's physical plant worker. The storage area was well-organized, clearly marked hazardous chemicals, items were numbered by the building number followed by item number and color-coded to easily identify them.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

The program has a written policy and procedures in place which prohibits the handling of flammable, poisonous, and toxic items and materials by youth. The program's physical plant manager maintains strict control over the flammable, poisonous, toxic items and materials stored in building thirty-two, which is not accessible to the youth. During the annual compliance review week, youth were observed mopping and sweeping the activity area in their cottage and three youth were observed completing work detail during lunch in the cafeteria. The youth were never observed holding any cleaning products. Five youth were interviewed about what type of chemicals they have handled since being at the program. All youth reported they do not use any chemicals and/or cleaning products.

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

The program has a policy and procedures in place regarding the disposal of flammable, poisonous, toxic items, and materials. The physical plant worker is authorized to dispose flammable, toxic, poisonous, and caustic items. An interview with the physical plant manager verified all supplies are used until exhausted. However, when there is a need the program will utilize Okeechobee County's free Amnesty Day to dispose any unused flammable, poisonous, and toxic items. The program maintained a disposal log to document chemical disposal as needed. The program maintains all chemical materials in building number twenty-one inside a locked room. The program policy is to dispose of items in accordance with the Occupational Safety and Health Administration (OSHA) standards 29 CFR 19.10.1030. The program continues to maintain a contract with KRK Enterprises Inc. to dispose of kitchen grease accumulated from cooking on a quarterly basis. Interview with the facility administrator verified the program's practice for the disposal of flammable, poisonous, toxic items and materials.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures to ensure youth are provided opportunities to participate in visitation and family reunification activities. Upon admission to the program, a letter and a copy of the parent/guardian handbook are mailed to each parent/guardian, which contains information about visitation, telephone calls, and letter writing. The program maintains a visitor list in a single binder. The program holds quarterly family days and the next family day is scheduled for September 6, 2019. Visitation is conducted on each Saturday from 1:00 p.m. to 4:00 p.m. Youth letters are mailed weekly Monday through Friday and youth are not limited in the number of letters they can send. The program provides alternative visitation days for families who are unable to come during scheduled visitation, which involves the therapist and case manager. The program utilizes the alternative visitation day as a family session for the youth and the family if youth and their family come to an agreement for face-to-face family group session. A review of chronological documentation and telephone logs

confirmed youth made contact with their family members or parent/guardian once a week. A review of visitation sign-in and sign-out logs documented youth visitation with family members or parent/guardian on each Saturday and on a quarterly basis. Five youth interviews confirmed youth have been given the opportunity to communicate with their family members by mail, during visitation, and by telephone.

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

The program has a written policy and procedures in place for searches and inspections of Controlled Observations room. During the last six months review period, the program utilized Controlled Observation fifteen times. A total of five Observation Log Sheets were reviewed. All five Observation Log Sheets document staff conducted an inspection of the room prior to placing youth inside the room or leaving them alone in the room. All five reports showed youth searches were completed by the same gender as the youth prior to youth placement in Controlled Observation. Observation showed the rooms meets the size and other requirements for Controlled Observation.

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

The program has a written policy and procedures for the use of Controlled Observation. The program utilized Controlled Observation fifteen times within the last six months. A review of five Controlled Observation Reports was conducted. All five Controlled Observation Reports identified youth were not exhibiting behaviors indicative of a mental health crisis or suicide attempts. Reviewed documentation reflected Controlled Observation was authorized by a supervisor staff prior to placement. Five youth were placed in Controlled Observation due to active aggression towards others, violent behavior, and physically out of control which if continued likely to result in immediate injury to self or others. Reviewed documentation of the five Controlled Observation Reports showed staff discussed with the youth the reason for placement in Controlled Observation and expected behavior for removal. Four of the five reports indicated a health professional or staff of the same gender as the youth did not complete the Health Status Checklist. The fifth Health Status Checklist was completed by the nursing staff. Four of the five reviewed placements lasted longer than two hours and one was less than two hours. Each of the four applicable youth in Controlled Observation for two hours were given an extension by the approval of facility administer or designee. The approval was a continuation of the placement for at least two hours, and at the end of the two-hour interval another extension had to be given for the placement to continue. An interview with five youth reported they have not been sent to their room for punishment reasons.

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

The program has a written policy and procedures 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 five Controlled Observation Safety Check forms was conducted. Each reviewed Controlled Observation Report documented staff making placement completed the first page of the Controlled Observation Report and submitted to a supervisor. Documentation showed staff conducted and documented safety checks in all five Controlled Observation Reports every fifteen minutes or less. Each entry indicated the time, code explaining youth's behavior while observed in controlled observation, and the staff's initials who observed the youth. All five Controlled Observation Reports showed youth's release from Controlled Observation was based on the determination the youth was no longer a threat to self or others. A review of the five Controlled Observation Reports documented the facility administrator (FA) 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. Each report was reviewed and approved by the FA within fourteen days of the youth's release from Controlled Observation to determine if placement was warranted and handled appropriately. Documentation showed an in-house alert was warranted for three of the five youth when the youth were released from Controlled Observation, two were not applicable. In all three applicable Controlled Observation Reports, documentation showed the in-house alerts were entered for each youth. The designation for Controlled Observation is included in the program's Facility Operating Procedures.

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

A review of five youth case management records was conducted in reference to a safety planning process for each youth. Reviewed documentation showed the program has developed a program's Safety Plan form which identifies stimuli including positive and negative effects on the youth. The program's Safety Plan form included an initial and a review planning process. The initial planning process is initiated by each youth's case manager within fourteen days of the youth admission to the program. However, none of the plans met the fourteen-day intake requirement during the annual compliance review period due to this being implemented at the beginning of July 2019. The safety plans are jointly prepared by the youth, parent/guardian or family member, case manager, and clinical staff. The plans are reviewed and signed by all staff involved and the youth. Thereafter, the youth's safety plan will be updated every thirty-days to include signatures and date of the youth and staff. The program's safety plan form included the youth's warning signs, baseline behaviors gathered from collateral contacts, crisis recognition, jointly developed coping strategies, intervention strategies, and debriefing preferences. Five youth's safety plans were reviewed. Each youth's safety plan was updated every thirty days and followed any significant behavioral or mental health event identified by the youth's intervention and treatment team. All five youth's safety plans incorporated recommendations of previous and

current clinical assessments as required. The youth's safety plans were maintained in a centralized binder inside sub-control room and easily accessible to all staff.