STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

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

Review Date(s): January 8-11, 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 that 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 that 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 that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

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

Yvrose Sylvain, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, Technical Assistance, (Standard 2 & SPEP)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 5)
Christine Calvert, Office of Program Accountability, Regional Monitor (Standard 4)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor (Standard 3)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 2 & Interviews)

Program Name: Okeechobee Youth Treatment Center | MQI Program Code: 1325
Provider Name: TrueCore Behavioral Solutions, LLC | Contract Number: 10188
Location: Okeechobee County / Circuit 19 | Number of Beds: 80
Review Date(s): January 8-11, 2019 | Lead Reviewer Code: 125

Methodology

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.

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- **1** # Case Managers
- **2** # Clinical Staff
- **1** # Food Service Personnel
- **3** # Healthcare Staff
- **1** # Maintenance Personnel
- **3** # Program Supervisors
- **7** # Staff
- **7** # Youth
- **3** # Other (listed by title): **Regional Compliance Manager, Program Superintendent, School Principal**

Documents Reviewed

- ☒ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- **7** # Health Records
- **7** # MH/SA Records
- **7** # Personnel Records
- **14** # Training Records/CORE
- **3** # Youth Records (Closed)
- **7** # Youth Records (Open)
- **4** # Other: **Additional youth records**

Observations During Review

- ☒ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

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	Limited
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Failed
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Failed
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	Limited
1.18	Program Planning	Satisfactory
1.19	Staff Performance	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	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Limited
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	Limited
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Failed
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	Limited
3.07	* Treatment and Discharge Planning	Limited
3.08	* Specialized Treatment Services	Limited
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Limited
3.12	* Suicide Precaution Observation Logs	Failed
3.13	* Suicide Prevention Training	Limited
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	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff 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	Limited
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	Limited
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins 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	Recreation and Leisure Activities	Failed
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Okeechobee Youth Treatment Center (OYTC) is an eighty-bed program, for thirteen to eighteen-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 (MHOS), substance abuse treatment overlay services (SAOS), social skills, life skills, on-site educational classes, and vocational programming services. In addition, the program fosters each youth by providing Thinking for a Change (T4C), Skillstreaming the Adolescent, and Impact of Crime (IOC). The three effective intervention groups are taught by specifically trained staff to assist youth in the program. The program also provides Living in Balance, Young Men's Work, Passport Program, Towards No Drugs, Pathways to Self-Discovery and Change, Strategies for Anger Management, Anger Management for Substance Abuse and Mental Health, Thinking Feeling Behaving, and The Teen Relationship. Additional treatment services provided includes group therapy seven days a week, and individual and family therapy once a month. Program administration is comprised of a superintendent, assistant superintendent, facility administrator, cottage managers, shift supervisors, health services administrator, food service director, compliance managers, and a human resource manager. Case management services are provided by the director of case management, transitional services managers, and case managers. In total, the program had nine case management positions. Mental health staff at the program includes a designated mental health clinician authority (DMHCA), director of clinical services, two recreational therapists, group facilitator, therapists, and an independent psychiatrist agreement with a licensed psychiatrist. In total, the program had fourteen mental health positions. Medical services are offered twenty-four hour a day, seven days a week. Sick call is offered seven days a week for youth who have health concerns and are provided by three registered nurses (RN), a health services administrator, and an independent contractor agreement with a licensed medical doctor, who serves as the designated health authority (DHA). Educational services are provided by the Washington County Public Schools. The youth receive academic credits and have the opportunity to work towards the General Educational Development (GED) test. At the time of the annual compliance review, the program had twenty-three vacant positions; which included twelve youth care workers, two recreational therapists, four therapists, three case managers, one group facilitator, and one clinical director. In addition, the campus had five vacant positions; which included one physical plant manager, one physical plant worker, one assistant facility administrator, one designated mental health clinician authority, and one designated health authority. The layout of the program includes six cottages, one medical building, one administration building, a cafeteria, school areas, a vocational building, and a master control building. The program has forty-three operating security cameras providing coverage. All the cameras were operational during the annual compliance review week. The digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

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

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

The program maintains a written policy and procedures requiring compliance with the Department's five-year background re-screening requirements. The program's human resource manager tracks the five-year anniversary of hire dates and processes the five-year re-screenings for all staff. A review of the program's staff roster and volunteer lists indicated there were no staff or volunteers who required five-year re-screenings since the last annual compliance review.

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

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

- *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse are 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.*
- *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.*

The program maintains a written policy and procedures outlining an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Observations made during a tour of the program found signs posted throughout the program listing the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC), and a telephone in the living area/dormitory. The program's practice is once a youth wants to call the Florida Abuse Hotline, the youth will pick up the telephone in the dormitory with a direct connection to the Florida Abuse Hotline to place the call. If the youth are not in the dormitory area, the youth care worker will use the radio to call the shift supervisor, the shift supervisor will take the youth to the telephone in the dormitory area, and 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, on-duty shift supervisor, cottage manager, and/or the program's facility administrator (FA). The youth care worker will use the radio to call the shift supervisor, and the shift supervisor will take the youth to go place the call. The program's policy stated allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline and CCC. The program's FA, cottage manager, or the on-duty supervisor will immediately begin a review of all documents, statements, and video as part of their internal review. Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. A review of seven staff personnel records documented the staff signed a form acknowledging their understanding of the code of conduct. The youth orientation handbook is provided to each youth upon admission. The youth's handbook includes the youth's rights, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and CCC. There was one reviewed abuse allegation reported to the Florida Abuse Hotline and CCC during the annual compliance review period and the investigation remained ongoing during the annual compliance review.

Seven interviewed youth reported never being stopped from reporting abuse to the Florida Abuse Hotline or CCC and staff are respectful when speaking with them or other youth. All seven youth reported never hearing staff use curse words when speaking to youth. All seven interviewed youth reported feeling safe in the program. None of the seven interviewed staff

reported ever seeing a co-worker deny a youth an abuse call. All seven staff were able to explain the process of allowing a youth to call the Florida Abuse Hotline or the CCC, in accordance with the Florida Administrative Code 63F-7. Six of the seven interviewed staff reported they had never observed a co-worker using profanity when speaking to youth and one reported not directly toward the youth. An interview with the FA reported all staff receive training on the Florida Abuse Hotline and the Department's CCC prior to having contact with the youth in the program. The program's FA reported youth and staff have unhindered access to report allegations of abuse to the Florida Abuse Hotline and if the youth eighteen years of age or older, to the CCC.

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

A review of the program's policy outlined procedures regarding abuse reporting in compliance with the Department's criteria for reporting abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff member from contact with youth, when necessary. The program had one allegation of abuse involving a staff member within the last six months. Reviewed documentation found management took immediate action regarding the staff-involved incident by initiating an internal investigation regarding staff. Documentation indicated the abuse allegation was under investigation and ongoing at the time of the annual review. The staff was not removed from direct contact with youth because the staff used a Protective Action Response (PAR) technique and was following the program's PAR policy and procedures.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

The program maintains a written policy and procedures regarding response to incidents, which is in accordance with Florida Administrative Code. The program had twenty-six reportable incidents during this annual compliance review period. A review of the five incident reports found four of the five were reported to the Department's Central Communications Center (CCC) within two hours of the incident or becoming aware of the incident. One incident was reported one hour and thirty-two minutes late. Two of the four applicable incidents were documented in the program's master control logbooks and two were not. In reviewing the program's internal incident reports and grievance reports, there were no incidents which should have been reported to the CCC which were not. The program has experienced a decrease in the number of reportable incidents to the CCC compared to the last annual compliance review period. An interview with the program's facility administrator confirms the program has a policy in reference to the CCC and they ensure all matters which require reporting is verbally reported within two hours of the incident or when the program became aware of the incident.

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

The program maintains a written policy and procedures regarding the utilization of physical intervention techniques in accordance with Florida Administrative Code. The program had four Protective Action Response (PAR) incidents in the past six months. There was documentation to support a monthly summary of PAR reports was submitted to the Department, as required. A review of the four PAR reports found all staff involved completed appropriate statements prior to the end of their shift. Each PAR report was reviewed and processed within seventy-two hours by all required parties, with the exception of one PAR report which was signed by the shift supervisor but not dated. All four PAR reports documented a Post-PAR interview was conducted with the youth by the facility administrator (FA) within thirty minutes after the incident. The program's PAR plan was approved by the Department's Office of Staff Development and Training on December 20, 2018. The program has experienced a decrease in the number of PAR reports compared to the last annual compliance review period. The program's PAR rate during the annual compliance review period was 0.00, which is below the statewide Residential PAR rate of 1.55. An interview with the FA confirmed staff were instructed to use appropriate de-escalation techniques with youth, and to always use verbal interventions as a primary method in dealing with difficult situations.

1.07 Pre-Service/Certification Requirements (Critical)	Limited Compliance
Contracted and State residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

The program maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training plan was approved by the Department's Office of Staff Development and Training on December 21, 2018. Pre-service training is provided through a combination of instructor-led and web-based courses. Seven staff training records were reviewed for pre-service certification. Six of the seven reviewed training records documented each staff completed the certification process within 180 days of hire. One staff record indicated the staff's pre-service training was not completed within 180 days of hire. The staff was hired on July 7, 2018 and completed 83.5 hours of training by July 30, 2018. There was no documentation to show the staff was in the process of completing the remaining pre-service training hours. There was no documentation of grievance process, infection and exposure control, and safe use of tools. Documentation showed the staff was assigned to a cottage and provided youth supervision fifty-five times from August to December 2018 without completing the minimum of 120 hours required training hours for pre-service. The staff completed the required trainings related to Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All completed trainings were documented in the Department's Learning Management System (SkillPro) and each was delivered by a qualified trainer.

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

The program maintains a written policy and procedures regarding in-service training for all staff. Seven staff training records were reviewed for in-service. Six of the seven reviewed staff training records documented each staff member exceeded the twenty-four hours of annual in-service training requirements. According to interviews with program administration, the seventh staff member was scheduled for the required training on several occasions; however, the staff never showed up. According to the interim superintendent, this was due to staff shortage and no one was available to cover. The seventh record showed the staff completed nine hours of in-service training. All seven staff had current certifications in Protective Action Response (PAR). Six of the seven staff had certification in first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). Five of the seven staff completed training in professionalism, ethics, and six hours of suicide prevention training. Two records showed the staff did not complete professionalism and ethics, or the six hours of suicide prevention training. Three applicable staff completed the eight hours of supervisory training. The program has a training calendar, which is updated as necessary. All trainings were delivered by qualified trainers and were documented in the Department's Learning Management System (SkillPro). The program maintains a written in-service training plan, which was submitted to the Department's Office of Staff Development and Training on December 21, 2018.

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

The program has a written policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. According to program policy, procedures are in place to confirm each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's grievance procedures include informal, formal, and appeal phases with timeframes of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are also provided with the opportunity to file an alternative informal request by utilizing a Let's Talk form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and Let's Talk forms were readily available to youth, as observed during the facility tour. Reviewed documentation showed the program had four grievances and thirty-eight Let's Talk forms submitted by youth since the last annual compliance review. A review of the four grievances revealed all the youth's grievances were resolved at the formal phase. Each grievance was addressed within the seventy-two-hour timeframe. Seven pre-service staff training records and seven in-service training records were reviewed. Thirteen of the fourteen training records documented each staff received the required training on the program's grievance process and procedures. One staff did not complete

grievance training for pre-service. During the annual compliance review, seven youth and seven staff were interviewed. The seven youth were able to explain the grievance process to include submission of a completed grievance form into the secured grievance box. All seven interviewed youth reported being able to request assistance in completing a grievance form, if needed. All seven interviewed staff were able to explain the grievance process. An interview with the facility administrator (FA) reported grievance forms are available to the youth on each dorm. The program's FA stated the grievance box are checked daily prior to the program morning management meeting. Then the grievances are reviewed in the morning meeting with the management team and addressed by the security officer who also serves as the grievance officer within seventy-two hours.

1.10 Delinquency Interventions and Facilitator Training	Failed Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

The program has a policy and procedures regarding delinquency interventions and facilitator training. A review of the program's contract of required services identified Thinking for a Change (T4C) as an evidenced based intervention curriculum. The program currently had two staff trained to facilitate T4C. Both facilitators have bachelor's-level degrees and over ten years of experience working with youth. An interview with the facility administrator reported the program provides T4C as an evidence-based intervention. The program completes a Residential Positive Achievement Change Tool (R-PACT) on each youth to determine criminogenic needs of the youth and based on the outcome, the decision is made on which group the youth is placed. The last annual compliance review occurred April 17-20, 2018. A review of the program's group sign–in sheets showed one T4C group started on January 16, 2018 and abruptly ended on April 12, 2018 at chapter three. There was no valid reason provided as to why group was abruptly ended. The program's activity schedule revealed youth did not spend at least sixty percent of their wake hours in structured, planned programing and/or activities. The program followed the groups schedule regarding mental health and substance abuse groups; however, there was not a delinquency interventions group started until the week of the annual compliance review on January 7, 2019. The program did not conduct a T4C group from April 13, 2018 to January 6, 2019. During the week of the annual compliance review, seven youth records were reviewed which indicated all seven youth were attending the T4C group started on January 7, 2019. All seven youth assessments identified delinquency intervention as a priority need. All seven youth performance plans included T4C group as a goal and identified it as a priority need. The T4C group started on January 7, 2019, was conducting groups twice a week. The program's activity schedule, along with group sign-in sheets, agendas, and logbooks supported groups were delivered, as designed, during the week of the annual compliance review.

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

The program maintains a written policy and procedures to address life skills training for youth. The program provides life skills training through Teen Relationships groups, Living in Balance, Skillstreaming the Adolescent, and Passport. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. A review of the program activity schedule confirmed a one-hour life skills training group is provided to the youth once a week by the therapist. All staff conducting groups received formal training and on-the-job training by a certified trainer to deliver the curriculum. A review of seven case management records and group sign-in sheets indicated services were delivered, as required. Reviewed documentation showed all seven youth were actively participating in Skillstreaming the Adolescent groups. An interview with the administration staff stated youth can practice skills in group role-play activities and interactions with staff and youth while at the program. All seven interviewed youth were able to explain the new skills or behavior they have been taught in life skills group such as coping skills, how to control their anger, and one reported not really learning anything yet. Interviewed youth also reported they were able to demonstrate the skills doing role play activities in groups and during treatment team meetings.

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

The program has a policy and procedures for the provision of restorative justice awareness to the youth. A review of the program's contract indicated Impact of Crime (IOC) curriculum is a required service to be provided to all youth in the program. The IOC curriculum is designed to assist youth to accept responsibility for harm they have caused by their past criminal actions. A review of training records verified the two staff facilitating IOC groups, during the annual compliance review period, were trained to facilitate IOC groups. Observation of an IOC group was conducted during the annual compliance review week. The facilitator followed the curriculum, had a laptop and a monitor available to present the lesson. All youth participated in the discussion and activities of the lesson presented. The program's FA also reported youth were exposed to the victim's perspective by watching the victim DVDs provided by the curriculum. The program's FA stated youth are allowed to participate and show acts of kindness by completing Christmas cards for a local nursing home in Okeechobee, Florida.

The program's current activity schedule showed there were two IOC groups in progress facilitated two times a week for one hour each group. A review of six months of IOC sign-in sheets determined the curriculum was not delivered as designed and groups scheduled were not followed and/or conducted. Documentation showed the program conducted six groups during the review period. Two groups started on May 9, 2018 and May 11, 2018 and were successfully completed and delivered the curriculum as designed. The third group started on July 2, 2018, the facilitator left, and another facilitator took over. On December 10, 2018, the group ended on chapter four, objective four, and no additional documents to show if the group was successfully completed. The fourth group started on September 3, 2018. Documentation

showed the group ended on November 19, 2018, on chapter three, objective three, and no evidence the group was successfully completed. The dates on the third and fourth groups sign-in sheets indicated groups were not presented with fidelity and did not follow the program's group schedule. The fifth and sixth groups started on September 4, 2018 and September 6, 2018 and were in progress at the time of the annual compliance review week. The sign-in sheets for both groups indicated the groups were presented correctly. The program could not provide documentation to support required internal fidelity monitoring of IOC was conducted once a month for all six groups. The program conducted an internal fidelity monitoring on January 7, 2019, during the week of the annual compliance review. A review of seven youth records confirmed five youth were currently participating in an IOC group. Two youth were participating in the IOC group which started on September 3, 2018. On November 19, 2018, the facilitator ended the group on chapter three and objective three. Therefore, the youth did not complete and receive the restorative justice awareness required by the identified needs. The intervention services were not delivered to both youth as designed.

1.13 Gender-Specific Programming	**Satisfactory Compliance**
The program provides delinquency intervention and gender-specific treatment services.	

A review of the program's contract of required services for gender-specific programming identified Young Men's Work (YMW) as the gender-specific curriculum provided to the youth. All youth in the program are provided Young Men's Work, which is an evidence-based gender-specific curriculum and includes exercises specifically for males regarding issues of violence, bullying, substance abuse, and issues related to teen fatherhood. A review of seven youth case management records confirmed youth were currently in or had completed this gender-specific group. Young Men's Work groups are included on the program's activity schedule one time a week for one hour. The facility administrator (FA) reported gender needs are addressed through Young Men's Work group and youth engagement in activities such as competitive football, basketball, and kickball. The FA also reported Teen Relationships and Skillstreaming the Adolescent groups are adjusted to address specific gender issues when necessary. All seven interviewed youth reported they participated in substance abuse, anger management, and teen relationships groups.

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

The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert, which may not have been previously entered prior to the youth's admission. The program has an alert board in master control, which identifies each youth's special alerts, escape risk, and/or gang affiliation. The board also identifies youth placed on any

type of mental health alert. The alert board has each youth's picture, arranged by cottage, and the alert associated with the youth. Reviewed documentation indicated the program's internal alert report is reviewed daily during shift briefings by the program's shift supervisory staff. An extra copy of the program's internal alert report is located in master control, near the door on a clip board, and is accessible to all staff. Seven youth records were reviewed for case management, medical, and mental health and substance abuse and all applicable alerts were accurately entered into JJIS. All internal and JJIS alerts were downgraded or discontinued by a medical staff, case manager, and/or licensed mental health staff. Five staff were interviewed and all reported they are informed of youth alerts during shift meetings, and they can review the program's alert board for youth alerts in master control. An interview with the facility administrator (FA) reported all internal alerts are entered into JJIS by their department managers, and medical alerts are updated and sent to the direct care staff daily. The alerts information is also reported to master control, where the controller will update the alert board for the program.

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

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

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

The program has a written policy and procedures to allow for youth feedback outlined in the grievance procedures. The five separate dormitories have been identified as Carver, Johnson, Adams, Robinson, and Marshall. The program has a youth advisory board where elected youth represent their respective dormitories. Youth are allowed to discuss issues and ideas on behalf of other youth in the program during the meeting with the facility administrator (FA) or designee and try to come to a resolution. A review of the youth advisory board meeting binder reflected an agenda, sign-in sheets, along with meeting minutes summarizing the subject areas were discussed. The meetings provide youth opportunities to identify issues impacting their residential community and make recommendations to improve conditions, enhancing the quality of life for both the youth and staff in the program. Further, program administration conducts quarterly interviews with randomly selected youth. The results of the interviews are sent to the corporate office and formally reviewed and discussed where by possible changes are made accordingly. Consequently, the program has systems in place for youth to provide constructive input into program operations. Seven youth were interviewed, and each reported the program does provide a process allowing youth to provide input regarding what happens at the program.

An interview with the FA indicated the youth complete and sign the Let's Talk form as a first attempt where youth will voice issues and concerns in the program. In addition, the youth advisory board has a formal process to promote constructive input by youth to the program. The youth meet once a month to discuss youth issues in their particular living cottage and present these findings to administration.

1.17 Advisory Board	Limited Compliance
The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.	

The program has an advisory board, which serves six programs located in Okeechobee County. The advisory boards were combined due to a limited amount of people living in this rural community and the number of boards local representatives were currently participating in. Reviewed documentation supported the program's community advisory board meets at least quarterly. The meeting minutes were documented with an agenda and sign-in sheets for June 22, 2018, September 20, 2018, and December 11, 2018, with the next quarter meeting scheduled for March 2019. The advisory board members currently consist of a member from law enforcement, interested community partners, a community business member, school board member, victim advocate/victim services member, and faith-based community member. There was clear documentation to support the program made attempts to schedule meeting dates and worked around community advisory board member's schedules by mailing a letter thirty-days in advance of the scheduled meeting to increase attendance. Reviewed community advisory board agendas and meeting minutes documented the program provides board members with information regarding program updates, community updates, and community service activities. The program did not have a parent/guardian whose child was previously involved in the juvenile justice system or a member from the judiciary. There was no documentation to demonstrate the facility administrator's (FA) recruiting efforts of a parent/guardian whose child was previously involved in the juvenile justice system or a member from the judiciary. An interview with the FA reported the community advisory board members offer suggestions on different activities in the community. The board members also offer donations to the program for different activities such as books, puzzles, and sports equipment. The FA reported board members also partner with local community organizations to host the program's annual Christmas party for the youth.

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

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

employees for exemplifying the TrueCore way, which is a positive culture, team work, and going above and beyond. Seven interviewed staff reported staff meetings are held monthly and shift briefings daily. Three interviewed staff reported the communication amongst the staff at the program is fair, one staff reported good, and three reported very good. The interviewed staff reported the monthly meetings to be valuable and informative. According to the interviewed staff, the topics discussed during the monthly meetings at the program included new procedures, staff attendance, drills, medical and mental health procedures, team work, youth supervision, staff positions during sight and sound supervision, staff positive performance, and any upcoming events dates for the youth. An interview with the facility administrator (FA) reported during monthly staff meetings the administration focus on activities and events to improve staff morale in the program.

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

The program conducts ninety-day performance evaluations for newly hired staff, and annual evaluations for all staff. Seven personnel records were reviewed, of which six contained an annual performance evaluation and one contained a ninety-day performance evaluation. The performance evaluations were specific to the applicable staff's job description. All seven reviewed performance evaluations found each staff's evaluation was based on the performance standards for their position. Six applicable staff performance evaluations included the effective delivery of the evidence-based curriculum delivered by the staff. The evaluations rated the staff's quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff's job-specific responsibilities. All seven interviewed staff reported receiving an evaluation every six-months and a ninety-day evaluation. An interview with the facility administrator (FA) reported staff are given a ninety-day performance evaluation and an annual performance evaluation by their cottage manager. The program's FA reported each staff annual evaluation is to determine how the staff performed throughout the year and used as a tool to identify staff who qualify for promotion from the company.

Standard 2: Assessment and Performance Plan

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

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

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

The program has a policy and procedures regarding youth orientation. A review of seven case management records showed documentation of orientation being conducted with each youth within twenty-four hours of admission into the program. The orientation included services available, daily schedule, expectations and responsibilities of the youth, written information on the program's behavior management system, information on how to access medical and mental health services, access to the Florida Abuse Hotline or the Department's Central Communications Center if the youth is over eighteen years of age, and items considered contraband. The youth orientation also included information on the performance plan process, dress code and hygiene requirements, procedures regarding visitation, mail, and use of the telephone, anticipated length of stay, community access, grievance procedures, emergency drills, physical design of the facility, and assignment to a living dorm. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet, including a copy of the youth handbook. During the annual compliance review week, a youth admission was observed. The case manager explained all the elements outlined in the program's policy, which validated the program's practice. A review of the program's logbooks and shift reports indicated youth orientations are documented either in the master control logbooks or the shift reports. Seven interviewed youth stated they received an orientation to the program within twenty-four hours of admission.

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Seven case management records were reviewed and four were applicable for written consent of youth over the age of eighteen before providing or

discussing information with the parent/guardian. Each youth record contained consent forms signed by the youth allowing the program to share with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.

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

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

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

The program has a policy and procedures addressing gang identification which includes notification to law enforcement. The program assesses each youth at intake for suspected gang involvement. Seven case management records were reviewed and three were applicable for youth gang involvement or association. The program notified the law enforcement gang liaison by email of the suspected gang members residing at the program. The program informed the educational provider and post-residential provider of the suspected gang youth. A review of the Department's Juvenile Justice Information System (JJIS) system indicated each youth's juvenile probation officer (JPO) was notified by the program of the youth's suspected gang member classification and the alert was entered into the Department's Juvenile Justice Information System (JJIS).

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

The program maintains a gang binder which contains information on youth who have been documented as gang members or associated with a gang. Seven case management records were reviewed and three were applicable for youth gang involvement or association. The three applicable youth records documented each youth was identified as a gang member or affiliated gang member. Each youth's performance plan included gang prevention and intervention strategies. The program utilizes Gang Resistance and Drug Education (GRADE) curriculum. The GRADE curriculum includes seven lessons and a final essay. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities. According to the program compliance manager, if youth are identified as gang members during the classification meeting, the youth are assigned gang intervention goals and attend gang prevention groups.

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

The program maintains a written policy and procedures outlining each youth's individualized needs shall be identified and prioritized through a comprehensive needs assessment process completed by a multidisciplinary intervention and treatment team staff. The youth's intervention and treatment team shall identify the youth's criminogenic risk and protective factors, prioritize the youth's criminogenic needs, and determine the youth's risk to re-offend. The Residential Positive Achievement Change Tool (R-PACT) Assessment shall be completed within thirty days of the youth's admission to the program. Seven youth case management records were

reviewed, and the program assessed each youth utilizing the R-PACT to identify criminogenic risk and protective factors and to prioritize the youth's criminogenic needs. Each reviewed R-PACT was completed in the Department's Juvenile Justice Information System (JJIS) within thirty days of each youth's admission date into the program. Reviewed documentation supported the program completed a R-PACT reassessment within ninety-days after the completion of the initial R-PACT assessment in six of the seven reviewed records. One was completed twelve days late. Reviewed records documented updates or reassessments were completed when deemed necessary, by the multidisciplinary treatment team to effectively manage each youth's progress. All reassessment documentation was maintained in each youth's case management record.

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

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

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

The program maintains a policy and procedures outlining the multidisciplinary treatment team, including the youth, shall meet and develop the performance plan with individualized delinquency intervention goals to be achieved before the youth is released from the program. Each youth's performance plan is based on the initial findings of the assessment of the youth and shall be completed within thirty days of the youth's admission. The developed performance plan facilitates the youth's successful reintegration into the community upon release form the program and to also facilitate the youth's rehabilitation. Seven youth case management records were reviewed and six documented the individualized performance plan was developed within thirty days of the youth's admission and after the initial assessment. One was completed six days late. Each reviewed performance plan was developed and signed by the treatment leader, youth, treatment staff, and education staff. The administrative representative participated and signed six of the seven performance plans and five living unit representatives documented their

participation and signature on the reviewed performance plans. One youth was in the custody of the Department and the Department of Children and Families (DCF); however, there was no documentation to support the DCF case manager participated or signed the applicable performance plan. Four youth were eighteen years of age and one youth was in the custody of DCF; therefore, the parent/guardian signature was not required. There was no documentation to support the two remaining applicable performance plans were signed by the parent/guardian. Each reviewed performance plan clearly documented the top three criminogenic needs and individualized goals based upon the prioritized needs reflecting the risk and protective factors identified in the Youth Needs Assessment Summary (YNAS) and R-PACT assessment. Reviewed documentation demonstrated the performance plans were completed with specific delinquency interventions with measurable outcomes, which will decrease criminogenic risk factors and promote strengths, skills, and support reducing the likelihood of the youth reoffending. The start date, projected completion date, status, frequency, youth's responsibilities to accomplish the intervention, and the program's responsibilities to enable the youth to complete the goal. In addition, court-ordered sanctions which can be reasonably initiated and/or completed while the youth is in the program were documented; mainly completing community service hours and/or letters of apology. Each performance plan identified the youth's responsibilities and timelines to accomplish the goals and the responsibilities of staff to enable the youth to complete the goals. All original signed performance plans were filed in each youth's case management record. Seven interviewed youth found each was able to verbalize their current goals they are working towards completing. Each validated they were provided a copy of their performance plan. Reviewed documentation supported within ten working days of the performance plan being completed, a transmittal letter and a copy of the plan was sent to the committing court, juvenile probation officer, applicable parent/guardian and DCF case manager. There were no signature pages returned to the program and filed with the original performance plan.

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

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

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

The program maintains a policy and procedures ensuring a formal performance review, requiring a meeting of the multidisciplinary treatment team, shall be conducted at least every thirty days. The treatment team assesses each youth's progress on their performance plan goals and overall behavior in the program and documents a summary, which is maintained in the Lauris case note system. The treatment team will also develop a performance summary within ninety calendar days following the completion and signing of the performance plan. Each summary includes the youth's status on each performance plan goal, youth's overall treatment progress based on their treatment plan, and the youth's academic status, including performance and behaviors in school. In addition, the youth's behavior, including the level of motivation and readiness for change, interactions with peers and staff, overall behavior adjustment, and the youth's adjustment to the program. Seven reviewed case management records indicated each had a performance summary completed within the required ninety-calendar-day timeframe. Reviewed performance transmittals supported each youth was provided the opportunity to review and add comments prior to signing the completed performance summary. Seven interviewed youth supported each was provided a copy of their performance plan and a copy of their performance summary. Two of the seven interviewed youth indicated they have been in the program for over six months and each was provided the opportunity to review and add comments to the completed performance summaries and were also provided a copy each time. Reviewed practice supported each completed performance summary was signed by the treatment team leader, staff member(s) participating in the preparation of the summary, facility administrator or designee, and the youth. Transmittal documentation supported each performance summary was sent to the applicable committing court, assigned juvenile probation officer (JPO), parent/guardian, and the Department of Children and Families (DCF) case worker within ten working days of completion. Reviewed documentation supported the original completed performance summary was filed in each applicable youth case management record. A review of three closed youth case management records supported the original release summary, along with justification for release and Pre-Release Notification (PRN), was sent to the assigned JPO. Two of the three summaries and PRNs were sent at least forty-five days prior to the planned release date. One reviewed youth record documented the summary and PRN was sent on November 29, 2018 and the youth was released December 21, 2018. There was no sexually violent predator program (SVPP) youth applicable for this review period. Transmittal documentation validated when the youth was released from the program the assigned JPO received the final performance summary, transition plan, and copies of the psychiatric reports completed while the youth was in the program. There were no applicable youth with charges requiring victim notification.

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

The program has a policy and procedures which addresses the encouragement of parent/guardian involvement in case management assessment, performance planning and development, progress reviews, and transition planning. Seven reviewed youth case management records indicated four youth were eighteen years of age and one youth was in the dual custody of the Department and the Department of Children and Families (DCF). Program practice is to provide all parents/guardians advanced notice of the scheduled formal treatment team meetings with date and times for the year. Each letter also indicated if they cannot attend in person, they may participate by conference call. The program had no scheduled formal treatment teams during the annual compliance review week; therefore, observations could not validate practice. An interview with the director of case management indicated all youth's parents/guardians are contacted by the case manager upon each youth's admission to the program, a welcome letter is mailed within forty-eight hours of admission, invited to participate in treatment team meetings, and encouraged to be involved with each youth through regular contact with program staff. Interviews with the superintendent indicated youth are encouraged to contract their parents/guardians weekly to encourage participating in weekly visitation. The program also conducts a family day once a quarter inviting the parents/guardians to come on-site and meet face-to-face with the youth's assigned treatment team members and to enjoy food and scheduled activities. During the last six months the program conducted family day events in September and December 2018. According to seven interviewed youth, parents/guardians participate in family therapy by telephone. Program staff indicated they want to move to Skype; however, the infrastructure issues with the internet and telephone lines does not allow usage. Each reviewed record contained a copy of the parent/guardian input form which was mailed along with the date of treatment team meeting to each parent/guardian. However, none of the parent/guardian input forms were returned as completed to the program.

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

The program has a policy and procedures addressing treatment team and its members. At a minimum, a multidisciplinary intervention and treatment team shall be comprised of the youth, parent/guardian, applicable Department of Children and Families (DCF) case manager, juvenile probation officer, program administrators, living unit representative, and others directly responsible for providing or overseeing provision of intervention and treatment services to the youth. The case manager shall request and encourage a representative of the education staff to participate as an intervention and treatment team member. At a minimum, the case manager shall obtain written input from the education staff for use when developing and modifying the youth's performance plan, preparing progress reports to the court, and engaging in transition planning. A review of seven youth case management records found each youth was assigned to a multidisciplinary treatment team based on their assigned cottage. The assigned therapist and case manager is documented on the admission card. Treatment team members included the case manager who serves as the treatment team leader, youth, administration representative, living unit representative, mental health treatment staff, education representative, juvenile probation officer (JPO), parent/guardian, and medical staff. Reviewed documentation supported

all required members participated by evidence of their signatures in case management and treatment planning; however, not consistently. Each reviewed youth performance plan was developed and signed by the treatment leader, youth, treatment staff, and education staff. The administrative representative participated and signed six of the seven performance plans and five living unit representatives documented their participation and signature on the reviewed performance plans. One youth was in the custody of the Department and the Department of Children and Families (DCF); however, there was no documentation to support the DCF case manager participated or signed the applicable performance plan. Reviewed documentation validated each assigned youth's JPO and parent/guardian were invited to participate in the treatment team in person or by telephone. The program had no scheduled formal treatment teams during the annual compliance review week; therefore, observations could not validate practice.

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

The program maintains a policy and procedures indicating when a youth has been identified with a mental health, substance abuse, or physical health need, the care plan shall be coordinated with the youth's performance plan through the multi-disciplinary intervention and treatment team process to ensure compatibility of goals, services, and service delivery. The youth's performance plan shall reference or incorporate the youth's treatment or care plan. When a youth has a current behavior support plan or case plan through the Agency for Persons with Disabilities (APD), the program shall coordinate the youth's performance plan with the youth's APD plan for related issues. A review of seven youth case managements records validated each had a completed academic plan which was incorporated in the performance plan. Applicable mental health and/or substance abuse plans were addressed in the performance plan. There were no applicable youth with an APD plan needing to be addressed and/or incorporated into the performance plan. One youth was in the custody of the Department and the Department of Children and Families (DCF) and a copy of the performance plan was sent to the DCF case worker; however, there was no response returned to the program to incorporate any revisions in the youth's performance plan. Reviewed documentation supported each performance plan was discussed during formal treatment team meetings and the progress or lack of was documented on the overall adjust and behavior section of the performance plan review form.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Limited Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT 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 progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT 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 progress.*	

The program maintains written policy and procedures outlining a formal performance review, requiring a meeting of the intervention and treatment team, shall be conducted at least every

thirty days. One biweekly performance review a month shall be informal, wherein the treatment team leader, including other team members' input when needed, meets with the youth to discuss progress and related issues. The treatment team shall document each formal and information performance review in the youth's case management record, including the youth's name, date of review, meeting attendees, any input/comments from the team members, and a brief synopsis of the youth's progress in the program. A review of seven youth case management records validated formal treatment team meetings were conducted approximately every twenty-eight days. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were invited and encouraged through advance notification to participate in each meeting. Formal treatment team meeting documentation included the youth's name and signature, date of review, attendees, comments by treatment team members, and a brief synopsis of the youth's progress in the program to include positive and negative behaviors. Documentation of one formal treatment team was missing in October 2018. The living unit representative did not document their signature to indicate participation in two of seven reviewed youth records. Four youth were eighteen years of age and one youth was in the custody of the Department and the Department of Children and Families (DCF). Two applicable youth parents/guardians did not document their participation in the treatment team meetings; however, supporting documentation validated the case manager sent a copy of the performance plan review to the parent/guardian for their review, signature, and return to the program. Seven interviewed youth indicated they are provided an opportunity to demonstrate skills acquired in the program. Demonstration is conducted through role play in groups and discussed during the formal treatment team meetings. All seven youth records had documentation the Residential Positive Achievement Change Tool (R-PACT) reassessment results were discussed during treatment team meetings. The program conducts formal treatment teams monthly on a bi-weekly basis and none were scheduled during the annual compliance review week. Therefore, the review team was unable to observe treatment team meeting. Informal treatment team meetings are also scheduled to be conducted on a bi-weekly basis and none were scheduled during the annual compliance review week. Reviewed documentation for the last six months found six of the seven reviewed youth records did not document an informal treatment team meeting was conducted bi-weekly as required. Two youth were missing informal treatment teams for September 2018, two youth were missing for October 2018, and one youth was missing for November 2018. All seven youth records contained documentation of the youth's input during treatment team meetings. All interviewed youth confirmed the treatment team meetings focused on performance plan goals, positive and negative behaviors, and treatment progress.

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

The program provides career education opportunities through the Washington County School System. The program offers the youth the opportunity to further their education. The program teaches personal accountability skills and behaviors, such as communication, interpersonal skills, and decision-making. The program offers Type 2 educational programming which provide an orientation to each youth with career choices based on personal abilities, aptitudes and interests which are appropriate for youth in all age groups and ability levels. The program provides vocational programming which includes an opportunity for the youth to receive SafeServ certification, Microsoft user certifications, and Building/Construction technology. The SafeServ certification is being taught by the school district's para-professionals as of November 16, 2018. The transitional educator assists youth with résumé writing, job application assistance, food handling, and basic life skills. An interview with the school principal indicated

career counseling is conducted by the transitional educator. A review of three closed records found all three records contained a completed job application, résumé, and a calendar of appointments including career resources, along with a vocational plan. Documentation supported each assigned juvenile probation officer (JPO) and parent/guardian was aware of the plan. An interview with the school principal and facility administrator indicated youth are provided with a career interest survey upon admission to determine possible appropriate career choices.

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

The program operates on a year-round basis providing educational services. Interviews with the school principal reported educational services are provided 250 days a year, with 300 minutes of instruction five days a week. During the annual compliance review week, youth were observed receiving the required minimum 300 minutes of daily instruction. Each youth has a separate educational portfolio, which is maintained throughout the duration of the youth's placement in the program. According to the school principal, educational staff attend and/or submit written input during formal treatment team meetings, transition conferences, and the exit conference for each youth. A review of seven active and three closed case management records documented youth received credit for participation in educational services. The program provides the basic core educational courses along with SafeServ certification, which teaches basic culinary safety and cleanliness. The program ensures youth are provided instruction with minimal interruption. A review of seven youth case management records contained evidence of youth receiving these educational accesses. The master control logbook entries and the school weekly attendance sheets further documented youth are attending school during the times indicated on the activity schedule. Seven interviewed youth reported there are no interruptions during educational instruction and one reported no major trouble in school at the program.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

The program has a policy and procedures in place regarding educational transition plans. A review of seven youth case management records revealed none of the youth were applicable for the education transition phase of the program. Each youth had an educational transition plans. Three youth closed records were also reviewed. All three applicable reviewed records indicated the individual transition plans were initiated during the youths' admission process and contained all requirements. Each youth's record contained documentation indicating the youth had been involved in the development of their transition plan. The plan addresses different services and interventions based on the youth's assessed educational needs and post-release education plans. Documentation showed services were provided during the youth's stay at the program and services were implemented once the youth was released. The education staff also provide recommended educational placement post-release and also specific monitoring responsibilities by individuals who are responsible for the reintegration and coordination of the provision of support services.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	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 policy and procedures in place regarding transition planning, releases, transfers, and Community Re-entry Team (CRT) meetings. A review of seven youth case management records revealed no youth was in the transitional phase of the program; therefore, three closed youth case management records were reviewed. Reviewed documentation showed all treatment team members were invited and encouraged to participate in the transition conference. Documentation supported each youth's transition conference was held at least sixty days prior to the youth's targeted release date and the youth, treatment team leader, facility administrator or designee, and other team members participated on each transition conference. All three reviewed closed youth records documented the exit conference was conducted and documented on the exit conference form. During the transition conference participants reviewed the transition activities outlined on each youth's performance plan during the transition conference. There were no applicable revisions to the performance plans reviewed. Documentation supported target completion dates and persons responsible for goal completion were identified at each completed conference. There was documentation in two of the three reviewed records to support the program received an invitation to the CRT meetings. A review of the release chronological forms in each record documented the CRT meeting date and time; however, the comment section was left blank. It was not clear as to whether the program staff participated in the meeting. The Department's Juvenile Justice Information System (JJIS) was reviewed to determine the knowledge of the meeting and participation by the program, youth, parent/guardian, and assigned juvenile probation officer (JPO). Reviewed documentation of the three closed records indicated the program and youth participated in two CRT meetings and the parent/guardian participated in one 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 maintains a policy and procedures ensuring the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program. Transition and release planning is an ongoing planning process which begins at the time of the youth's admission to the program. The transition process is continuously re-evaluated throughout the youth's stay and fully considers the youth's risks, protective factors, as well as identification of ongoing follow-up needs to be addressed upon the youth's release from the

program. The multidisciplinary treatment team complies assembled documents to assist the youth after release. Exit portfolios include such things as an identification card, Social Security card, birth certificate, all educational documentation, school transcripts, résumé, sample employment applications, and educational/vocational certificates earned in the program, along with a calendar of upcoming appointments. Three reviewed closed youth records found each youth had a completed exit portfolio with all required elements as outlined in their policy. In addition, each youth had a Plan for Success, which contained identified goals, contact person, location, and appointment dates. Upon release from the program each youth was provided a copy of their exit portfolio.

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

The program maintains a written policy and procedures pertaining to exit conference. The program conducts a conference at least fourteen days prior to the youth's targeted release date, wherein the youth, residential program staff, the youth's juvenile probation officer, parent/guardian, and other pertinent parties review the status of the youth's transitional activities and finalize plans for the youth's release and reentry into their home community. A review of three closed youth records documented a completed exit conference form outlining youth identifying information to include travel arrangements, residence address, post-residential supervision plans, the status of the transition plan, and a summary of youth progress and identification of ongoing strengths, abilities, needs, preferences and goals to be completed upon return to the community. The multidisciplinary treatment team document court ordered sanctions completed and yet to be completed, education plans, mental health and/or substance abuse follow-up plans, and any applicable healthcare needs. Additional information including societal and community-based needs were addressed. All three youth had a plan for continuation of education and/or employment and instructions for their post-release supervision. The date of admission and the date of termination documentation in the record correlated with the information in the Department's Juvenile Justice Information System (JJIS). A review of records in the Department's JJIS confirmed the admission date and date of termination matched the dates in the program's youth records. Each reviewed record also contained documentation to the parent/guardian and JPO, which confirmed the youth's release date and transportation arrangements for the youth's return to the community.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Limited 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 currently has an interim designated mental health clinician authority (DMHCA), who is a licensed mental health counselor (LMHC). The interim DMHCA's normal roll at the program is treatment director. A review of the Department of Health Medical Quality Assurance License search website revealed the interim DMHCA's license is clear and active in the State of Florida. The interim DMHCA was in place from April 6, 2018 until December 31, 2018, when a newly recruited and trained DMHCA took over; however, the new DMHCA abruptly resigned from the position on January 7, 2019. On January 7, 2019, the previous interim DMHCA was again given oversight of all clinical services and title of interim DMHCA. The program's recruitment officer indicated they have attempted to fill the DMHCA position since its initial vacancy and the program's human resource staff have participated in job fairs in May 2018, June 2018, July 2018, August 2018, and October 2018. The program's recruiter also posted the vacant position on the employment websites. The recruiter also placed advertisements in newspapers, posted the position on college websites, and on the local chamber of commerce website. The program recruiter has scheduled a job fair for January 16, 2019. An interview with the interim DMHCA reported being on-site weekly and work Monday through Friday, 9:00 a.m. to 5:00 p.m. The interim DMHCA is responsible for the quality of services provided at the facility including fidelity checks of groups, supervision of clinical staff, facilitating trainings, and making recommendations for youth presenting with suicidal ideations and/or in crisis. The interim DMHCA stated the program provides mental health overlay services and substance abuse treatment overlay services. The interim DMHCA reported the program provides these specialized services through group counseling, family, and individualized counseling with the youth. The interim DMHCA is currently overseeing three additional residential programs beside Okeechobee Youth Treatment Center, located on the same campus. It should be noted the interim DMHCA is carrying a caseload of sixteen youth from another program. Furthermore, the interim DMHCA is providing oversight for all case management and mental health staff at three programs on the Okeechobee campus and which included thirty-six staff in total.

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 licensed professional employed at the program and is acting as the interim designated mental health clinician authority (DMHCA). A review of the Department of

Health Medical Quality Assurance License website revealed the DMHCA license is clear and active in the State of Florida and expires March 31, 2019. The program also had another licensed professional employed at the program as the DMHCA in the six months prior to the annual compliance review; however, the staff resigned from the position abruptly as of January 7, 2019, by text message. A review of the Department of Health license verification website indicated the former DMHCA's license was clear and active in the State of Florida and expires on March 31, 2019. The program has a contract with a licensed psychiatrist to provide psychiatric services to the youth at the program. A review of the license verification website revealed the psychiatrist license is clear and active in the State of Florida and expires January 31, 2021. When the current psychiatrist is on vacation or leave there is a back-up psychiatrist which provides services to the youth. A review of the license verification website confirmed the back-up psychiatrist has a clear and active license in the State of Florida and it expires on January 31, 2020.

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

The program's organizational chart indicates the program is to have one lead therapist and six therapists employed at the program. The program is licensed under Chapter 397, F.S. to provide outpatient substance abuse treatment and all non-licensed clinicians work under the direct supervision of a qualified professional. The program currently employees a lead therapist, and two clinicians. The program has been borrowing two additional therapists from nearby Okeechobee Youth Development Center (OYDC) and Okeechobee Intensive Halfway House (OIHH). OYDC is contracted to have four therapists and OIHH is contracted to have three therapists. The program has been borrowing therapists from the other programs to ensure services are provided to the youth at the program; however, the program's they are borrowing staff from are then left shorthanded and the program still has not met their contractual requirements of having seven therapists on staff. An interview with the director of treatment services reported the program continues to utilize therapists from other programs on the same campus and has not been fully staffed for the entire review period. The program also has a non-licensed clinician who is responsible to conduct clinical and non-clinical groups for all the Okeechobee campus programs. In the past six months prior to the annual compliance review, there were three additional non-licensed clinicians who provided services to the youth at the program. A review of the employment records for all nine utilized clinicians revealed seven hold a master's-level degree in an appropriate field of study, one holds a doctor of philosophy (PhD) in human services, and one holds a bachelor's-level degree in an appropriate field of study. Seven of the nine clinicians with a master's-level degree or PhD received training and experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services to include the completion of five Assessment of Suicide Risks (ASR) under the direct supervision of a licensed professional. The eighth clinician started training of the ASRs but did not complete the training prior to resigning from the position. The ninth clinician holds a bachelor's-level degree in an appropriate field of study and has received the fifty-two hours of pre-service training, which includes a minimum of sixteen hours of documented clinical training in their duties and responsibilities. The ninth clinician only conducts mental health and substance abuse clinical and non-clinical groups; therefore, did not require training in ASRs. The program's policy indicates all non-licensed staff who provide clinical services to the youth at

the program are to receive weekly supervision by a licensed professional for a minimum of one hour. The program documents all clinical supervision on a program form which includes all required elements of Department mental health and substance abuse (MHSA) form 019. The program maintains all clinical supervision documentation in a binder which has sign-in sheets denoting the week of the supervision with the signatures of all clinicians who participated in the session; and attached to the sign-in sheet is documentation of the information discussed during the session. In the past six months prior to the annual compliance review, there were nine non-licensed clinicians who required direct supervision. For the nine non-licensed clinicians, direct supervision by a licensed professional was missed from one week up to ten weeks. In the last instance, the clinician had three additional weeks of supervision; however, there was no documentation of what was discussed during each session.

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 has a policy and procedures in place outlining the program's process for mental health and substance abuse admission screening for all youth. All youth are administered the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) at the time of admission to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The program also completed the Reynolds Adolescent Depression Scale - Second Edition, Adolescent Psychopathology Scale™ Short Form, Trauma Symptom Checklist for Young Children™, Trauma Symptom Inventory™, Substance Abuse Subtle Screening Inventory and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessments upon admission and throughout treatment as indicated by the therapist. A review of seven individualized mental health and substance abuse records showed each was administered the MAYSI-2 on the day of admission. Reviewed documentation confirmed all available information inclusive of the commitment packet, reports, and records of suicide risk, mental health, and/or substance abuse issues was reviewed by the mental health staff upon intake. A review of training records indicated all case management and mental health staff at the program are trained in MAYSI-2 administration as part of the clinical in-service training plan. Each of the seven reviewed MAYSI-2s were scored and completed using the Department's Juvenile Justice Information System (JJIS) as required. Six of the seven reviewed MAYSI-2s indicated further assessment was required based on the screening results. The program's practice is to conduct further evaluation using the Department's Assessment of Suicide Risk (ASR) on each youth admitted regardless of the MAYSI-2 results. Two reviewed MAYSI-2's documented a youth required further assessment due to suicide risk and an ASR was conducted within twenty-four hours as required. An interview with the facility administrator (FA) indicated upon each youth's admission to the program the staff completes a MAYSI-2 and the ASR to assess any suicide risks the youth may have.

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 has a policy and procedures in place indicating all youth who enter the program shall receive a new mental health and substance abuse assessment within thirty days of their admission. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida statute, to provide outpatient substance abuse treatment to the youth in the program, and the license expires April 7, 2019. A review of seven youth individualized mental health and substance abuse records revealed each youth had a new mental health and substance abuse evaluation completed within thirty days of their admission. All evaluations were completed by a non-licensed clinician. Six of the seven records contained evaluations reviewed and approved by a licensed qualified professional within ten calendar days after the completion of the evaluation. The seventh record contained an evaluation reviewed and approved by the licensed professional thirteen days after the completion of the evaluation, which made it late by three days. All seven reviewed evaluations contained each youth's demographic information, reason for the evaluation, relevant background information, behavioral observations, mental status examinations, interview or procedures administered, discussion of findings, diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, recommendations, patterns of alcohol and drug abuse, impact of alcohol and drugs on major life areas, risk factors of continued alcohol and drug use, and clinical impressions. All seven reviewed records contained a signed consent for substance abuse services and release of substance abuse information.

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

The program has a policy and procedures in place outlining the program's mental health and substance abuse services. A review of seven youth individualized mental health and substance abuse records revealed all seven youth were assigned to a multidisciplinary treatment team on the day of their admission, which was indicated by their cottage assignment and admission card. The program conducts mental health and substance abuse treatment teams at the same time as case management treatment teams. The teams consist of all required parties outlined in Florida Administrative Code 63N-1. A review of the seven records confirmed each youth had a signed consent to receive substance abuse services and release substance abuse information, and a properly executed Authority for Evaluations and Treatment (AET). All seven reviewed records confirmed each youth was receiving mental health and substance abuse services from the program staff, and the program has a current Chapter 397 license, which expires April 7, 2019. A review of the seven youth's individual progress notes and group sign-in sheets reflected mental health groups had no more than ten youth in a group and the substance abuse groups did not have more than fifteen youth in a group. Observations of groups also confirmed they had the appropriate amount of youth participating. A review of the non-clinicians training records

reflected they received proper training in mental health and substance abuse services, as well as group facilitator training. All seven reviewed records contained documentation each youth was receiving substance abuse groups, mental health groups, individualized sessions, psychiatric services, medication management, family sessions and supportive sessions; however, there were five of the seven records where the youth did not receive services as outlined in their individualized mental health and substance abuse treatment plans. Three of the six records indicated each youth was to receive monthly family sessions; however, a review of each youth's progress notes indicated each youth was missing at least one family session. The three youth records combined should have had eleven family sessions; however, the progress notes indicated there were eight sessions provided to those three-applicable youth. There was a fourth youth whose records indicated they had a family session August 18, 2018, but the note documenting the session was not entered into the providers case note system until November 2, 2018. There was no documentation to support the therapists had attempted to contact each youth's parents/guardians for family sessions. Three of the six applicable records indicated each youth was to receive monthly individualized sessions with their assigned therapist; however, the progress notes indicated each youth was missing one or more individualized sessions. The three youth records combined for a total of fifteen required individualized sessions; however, the progress notes indicate there were ten sessions provided to those three-applicable youth. Additionally, a review of the six months of progress notes for all seven youth revealed each youth's progress notes were missing information to validate services were correctly provided to the youth. There were seven family session notes where there was no therapist name documented as to who provided the session. There were five individualized sessions where there was no therapist name documented as to who provided the session. There were ten group session notes where there was no therapist name documented as to who provided the groups. The program administration stated when a therapist no longer works for the program/provider their name is removed from the providers Lauris case note system.

During the annual compliance review, the team was not able to observe a multidisciplinary treatment team meeting because the program was on a bi-weekly schedule and none were scheduled during the annual compliance review week. Interviews with seven youth indicated each youth is currently attending group treatment at the program. The youth indicated they were attending groups such as Impact of Crime, substance abuse groups, mental health groups, anger management groups, skills, and restorative justice groups.

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

The program maintains a written policy and procedures outlining responsibilities and required elements of mental health and substance abuse treatment services and planning. A review of seven youth individualized mental health and substance abuse (MHSA) records revealed each youth had an initial MHSA treatment plan. All treatment plans were developed when treatment

was provided on an expedited basis or within seven days of the onset of treatment. All initial MHSA treatment plans were developed on a program form which contains all elements of the Department MHSA form 015. Three of the seven reviewed initial treatment plans were applicable for psychiatric needs and those needs along with each youth's medication and frequency of monitoring by the psychiatrist was documented in the plans. All seven initial treatment plans were signed by a licensed professional within ten days of completion. Five of the seven reviewed initial treatment plans were signed by all treatment team members who participated in the development of the plan. The sixth initial treatment plan was signed by the director of case management, living unit representative and facility administrator six days after the development of the plan. The seventh initial treatment plan was not signed by a living unit representative. All seven reviewed youth individualized mental health and substance abuse records contained a completed individualized treatment plan within thirty days of admission. All individualized treatment plans were developed on a program form which included all elements of the Department form MHSA 016. Six of the seven individualized treatment plans were reviewed and signed by a licensed professional within ten days of completion. The seventh individualized plan was signed by the licensed professional two days late. Five of the seven individualized treatment plans were signed by all treatment team members. The sixth plan was not signed by a living unit representative or a member of the administrative team. The seventh plan was signed by the director of case management, living unit representative and the case manager two days after the plan was developed with the youth, therapist and other treatment team members. Four of the seven individualized treatment plans were applicable for psychiatric services and medication monitoring and the information was found in all applicable plans.

All seven reviewed youth individualized MHSA records contained individualized treatment plan reviews, which were completed on a program form with all elements of the Department MHSA form 017. Six of the seven reviewed records contained treatment plan reviews completed every thirty days for a total of thirty-seven total treatment team reviews. The seventh record indicated the time between the youth's September 2018 and October 2018 treatment team review was conducted late by four days. Two of the thirty-seven required treatment plan reviews were not signed by the licensed professional within ten days of completion. One was signed late by two days and one was signed late by three days. The seven records required thirty-seven treatment team reviews and not all required treatment team members participate in the treatment team reviews. All thirty-seven treatment team reviews had the youth, therapist, and other's responsible for the youth's treatment present at each review. The youth's parent/guardian, as well as the assigned juvenile probation officer (JPO), was invited to each treatment team review; however, they were not always present. There were eleven treatment team review meetings where a representative from the program's administrative team did not participate in the youth's treatment review, which was indicated by the lack of the appropriate person's signature on the reviewed treatment plans. There were nine treatment team review meetings where a representative from the youth's living unit did not participate in the youth treatment review, which was indicated by the lack of the appropriate person's signature on the treatment plan reviews. There were three treatment team review meetings where a representative from education did not provide written input or did not participated in the youth's treatment review, which was indicated by the lack of signature by the participating education staff or by the lack of notation on the treatment plan review the team was provided with written information by education.

Three closed records were reviewed to verify the program's mental health and substance abuse discharge process. All three records contained a completed mental health substance abuse discharge summary. There was documentation in all three records the mental health and substance abuse discharge plan was discussed with the youth, parent/guardian and the JPO

during the exit conference. All three closed records contained documentation to support the MH/SA discharge plan was provided to the youth, parent/guardian and the JPO upon the youth's discharge. All three MHSA discharge plans contained information needed for each youth to maintain the improvements they made in behavioral, emotional and socials skills while participating in the program's treatment services. None of the three reviewed discharged records revealed the youth was at risk of suicide when being discharged from the program.

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

The program is contracted to provide mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). The program has forty-eight MHOS slots for youth diagnosed with mild to moderate mental health disorders, who may have a co-occurring substance abuse diagnosis. The program has thirty-two SAOS slots for youth diagnosed with a substance abuse related disorders. The program provides the youth with mental health groups five days a week, Monday through Friday. The program provides the youth with substance abuse groups three days a week, Saturday through Monday. The program provides the substance abuse groups to include Pathways, anger management for substance abuse and mental health clients, Towards No Drugs, and Living in Balance. The program provides the mental health groups to include Thinking, Feeling and Behaving, Teen Relationships, Young Men's Work, strategies for anger management, Skills Streaming, and Passport. The program also provides each youth with monthly individualized treatment and family treatment, as described in each youth's individualized treatment plan. The program's contract requires the program to have a licensed psychologist available to provide services as needed, and the program currently uses the services of the regional psychologist when necessary. The program's contract also requires the program to have a certified behavioral analyst (CBA) provides services when necessary. The program contracts with a CBA who provides services to the youth at the program. An interview with the CBA confirmed they provide services to youth at the program who are referred to them by the management team and the CBA stated they are on-site one day a week to work with the youth assigned to them. The CBA stated they currently are working with two youth at the program. The CBA indicated they perform behavioral contracting with the youth to change the youth's behavior. The CBA indicated they get to understand the youth and their struggles, set up a behavioral contract with the youth, and when the youth accomplish their goals and abide by their contract they receive a positive reward. The rewards given to the youth are mostly food-based rewards. The CBA indicated they conduct functional behavioral assessments on the youth and then come up with strategies to work with the youth and help the staff work with the youth to improve the youth's behavior. The program's contract indicates they are to have seven therapists and the program's organizational chart indicates one of those therapists is designated as a lead therapist. The therapists are responsible for providing all clinical treatment services to the youth at the program. The program currently employees one lead therapist, and two additional therapists. A review of the program's three therapists and two borrowed therapist's youth case load assignment list indicates one of the clinicians has seventeen youth assigned to them, where all other clinicians are under or at the sixteen required youth. During the debriefing process, the program advised no clinician at the program has a case load over sixteen; however, the program did not provide the review team with any documentation to support the case load assignment sheet was wrong or with a new assignment sheet indicating a correction to the clinicians' youth case load assignments.

An interview with the interim designated mental health clinician authority (DMHCA) indicated the program offers substance abuse and mental health overlay services. The interim DMHCA also stated the program provides these services through group counseling, and individual sessions with the youth. The interim DMHCA indicated they ensure each youth receives the services outlined in the contract by using trackers and group sign-in sheets to verify the youth are receiving the services outlined in the contract. Furthermore, the interim DMHCA indicated they provide weekly supervision and regular coaching sessions with staff to address training needs, issues arising with the program youth, and professional development. An interview with the facility administrator indicated the program provides MHOS to the youth at the program, which includes daily therapeutic groups along with monthly individual and family therapy.

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.	

The program has a contract with a licensed psychiatrist who is board certified in psychiatry, as well as child and adolescent psychiatry to provide services to the youth at the program. A review of the Department of Health Medical Quality Assurance License website revealed the psychiatrists license is clear and active in the State of Florida and expires on January 31, 2021. A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatrist services to the youth at the program, as well as be on-call for emergencies and consultation twenty-four hours a day, seven days a week. An interview with the psychiatrist confirmed they are on-site weekly and available by telephone twenty-four hours a day, seven days a week. A review of the sign-in sheets for the psychiatrist for the six months prior to the annual review reveal the psychiatrist was on-site every week, except for two weeks. The sign-in sheets indicated the psychiatrist was on-site two times the week prior to the weeks they missed. The psychiatrist has a back-up psychiatrist to cover while they are on vacation or leave; however, the back-up did not cover for the psychiatrist during those two weeks. A review of the Department of Health Medical Quality Assurance License website revealed the back-up psychiatrists license is clear and active in the State of Florida and expires on January 31, 2020. A review of seven youth individualized mental health and substance abuse records revealed six youth received an initial diagnostic psychiatric interview with fourteen days of their admission. The seventh youth received an initial psychiatric interview within thirty days of admission, which follows the program's policy since the youth was not admitted to the program on medication. All initial psychiatric interviews documented the youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), documented diagnosis, and treatment recommendations.

Four of the initial psychiatric interviews resulted in the youth being prescribed medications. All four applicable records had the explanation for the need of the medication related to the youth's diagnosis, target symptoms, treatment goals, potential side effects, and risks and benefits of taking the medication documented in the psychiatric interview. All four interviews contained the frequency of the medication monitoring. All four initial psychiatric evaluations were completed on the Department's form entitled Clinical Psychotropic Progress Note (CPPN) and it clearly identified the evaluations as the initial diagnostic psychiatric interview. All four applicable records contained a fully completed page three of the CPPN. The four applicable records required twenty-one medication management reviews with the psychiatrist every thirty days. Each of the records had one of their sessions completed later than the required thirty-day

timeframe. Two of the four applicable records had their November session completed thirty-one days after their October session. The third record had their October session completed thirty-eight days after their September session. The fourth record had their September session completed thirty-six days after their August session. An interview with the psychiatrist revealed the psychiatrist provides initial psychiatric evaluations for every youth who enters the facility and provides medication management for all youth on psychotropic medications at least once a month, or more frequently as deemed necessary. The psychiatrist also indicated they meet with the program's treatment team and clinical coordinator every week to review the youth in the program in need of psychiatric services. The psychiatrist did not have any concerns about the psychiatric services provided at the program.

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

The program has a policy and procedures in place addressing the program's suicide prevention plan. The policy and procedures were last reviewed by the prior facility administrator (FA) on August 17, 2018. The current FA has yet to review and sign the plan because they were appointed to the position on the first day of the annual compliance review. The suicide plan was also signed by the program's prior designated mental health clinician authority (DMHCA) on January 3, 2019. The interim DMHCA also signed the plan on September 4, 2018, during their first tenure as interim DMHCA and their second term as interim DMHCA started the day before the annual compliance review. The program's suicide prevention plan includes the following elements: identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response and a review process. The program's plan follows Florida Administrative Code, 63N-1. An interview with the program's FA indicated all staff receive a minimum of six hours of training in suicide precautions and prevention, which also includes mock suicide drills conducted quarterly on each shift. The FA also indicated the program reviews suicide drills during the monthly all staff meeting.

3.11 Suicide Prevention Services (Critical)	Limited 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 program's written plan detailed suicide prevention procedures and included all required elements as outlined in Florida Administrative Code 63N-1. The program's practice is to conduct and Assessment of Suicide Risk (ASR) for all youth on the day of admission. Each reviewed record contained an ASR

completed on the day of admission. A review of seven individualized mental health and substance abuse records showed none were applicable for suicide prevention services. Three additional records were requested and reviewed. Each of the three records indicated the youth was placed on suicide precautions due to staff observations. Two of the three reviewed suicide precaution observation logs were completed correctly. One reviewed log documented a signature of the facility administrator; however, did not document the time or date. Each of the three reviewed records documented mental health staff provided supportive services while the youth was on suicide precautions. Each reviewed record documented the youth was referred and assessed using the Department's ASR the same day. One of the three reviewed ASRs clearly documented all appropriate signatures. Two reviewed ASRs did not contain the licensed mental health clinical staff signature on the section of the ASR indicating the youth's transition to standard supervision. Each of the three reviewed records were applicable for the completion of a Follow-up ASR and contained all required elements. Each of the three reviewed records documented a conference was held with the program's administration and the licensed mental health clinician prior to changing a youth's supervision level. Each of the three reviewed records documented a mental status examination (MSE) was completed prior to stepping each youth to standard supervision. All three records documented parent/guardian notification was made regarding each ASR and follow-up ASR recommendation. A review of the Department's Juvenile Justice Information System (JJIS) showed suicide alerts were initiated and downgraded as required. The placement on precautionary observation did not limit youth activity in each reviewed record. Each of the three reviewed ASRs and follow-up ASRs were completed within twenty-four hours as required. Each reviewed ASR and follow-up ASR was administered by a licensed mental health clinician or a master's level therapist working under the direct supervision of the licensed staff.

During the review of admission screenings throughout the annual compliance review, it was discovered two youth were applicable for suicide services based on the result of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). One of the two applicable records indicated the MAYSI-2 was completed at 11:25 a.m. by a non-licensed clinician. The youth's MAYSI-2 indicated the need for further assessment due to suicide risk. A review of the youth's record did not reflect the youth was placed on suicide precautions. The youth's ASR was completed at 2:31 p.m. and the youth was stepped to standard supervision. The second reviewed records indicated a MAYSI-2 was completed at 11:45 a.m. and also indicated the youth was a suicide risk. A review of the youth's record did not reflect the second youth was placed on suicide precautions. The second youth's ASR was completed at 4:11 p.m. and the youth was stepped to standard supervision. An interview with the program's director of treatment services did not offer any explanation as to why the youth were not assessed immediately and/or placed on precautionary observation after the MAYSI-2 indicated a suicide risk. The program did not place either youth on suicide precautions as indicated by program's comprehensive plan for mental health and substance abuse services.

The program does not utilize secure observation. The program utilizes New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Raulerson Hospital in Okeechobee, Florida for Marchman Act. Seven interviewed staff each indicated when a youth expresses suicidal thoughts staff notify the mental health search the youth and their room, place the youth on constant sight and sound, and document supervision.

3.12 Suicide Precaution Observation Logs (Critical)	Failed 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.	

A review of seven youth individualized mental health and substance abuse records revealed two youth were applicable for suicide services upon their admission to the program. A review of the two applicable records revealed the program did not place the youth on precautionary observations (PO) and did not start PO logs for either youth. One of the two youth had a second instance of suicide precautions; the record indicated two PO logs and one close supervision log were used while the youth was on elevated status. In reviewing the three applicable logs, there were seven gaps in supervision denoted on the logs. The gaps ranged from three minutes to twenty-two minutes of missed supervision. Two additional youth records were reviewed for suicide prevention services to ensure an appropriate sample of youth were reviewed for suicide services. The two additional youth records contained ten PO logs and three close supervision logs. There were twenty-four instances on the logs where there were gaps in supervision and the youth was not observed at either thirty-minute intervals or five-minute intervals. The gaps range from one minute to two hours of missed supervision. One of the youth's suicide risk supervision level was increased from constant supervision to one-to-one supervision and the staff did not use the appropriate supervision log. There was no indication in the reviewed supervision logs the youth was elevated to one-to-one supervision because the program does not use the appropriate one to one supervision log and did not indicate the increased level on the logs used. An interview with the interim designated mental health clinician authority (DMHCA) indicated the program does not currently use a one-to-one supervision form; however, they would like the program to start to use the correct forms to show the proper supervision statuses for youth on suicide precautions. Additionally, on one of the three reviewed close supervision logs there was no date or time documented as to when the youth was placed on close supervision. Another one of the close supervision logs did not have a time when the youth was placed on close supervision. The third close supervision log did not have the youth's date of birth, juvenile justice information system identification number, race, sex, program name, provider name, indication of step down to suicide precautions checked, date and time of step-down and the log was not signed by a supervisor. When reviewing the ten PO logs for the two youth one log lacked the time the supervisor reviewed the log on second shift. Two additional PO logs lacked the date and time the supervisor reviewed to log on second shift. One PO log did not have the alert system box checked on the form. One PO log did not document observations in sequential order. Observations were documented for 1:30 a.m., 2:00 a.m., 1:10 a.m., 1:18 a.m., 1:27 a.m., 1:37 a.m., 1:49 a.m., 1:53 a.m. and then 2:02 a.m. Three youth who were placed on PO were interviewed about staff always staying with them while they were on PO, and all youth indicated staff were with them always and they were never left alone.

3.13 Suicide Prevention Training (Critical)	Limited 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 has a policy and procedures outlining staff training in suicide prevention. The policy indicates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, along with participation in mock suicide

and emergency drills. A review of seven in-service training records and seven pre-services training records revealed all fourteen staff received the required six hours of suicide training. A review of the program's mock suicide drills confirmed they are conducting drills at a minimum of quarterly on each shift. The mock suicide drills conducted since the last annual compliance review were reviewed to ensure all staff who have direct contact with youth participated in at least one quarterly drill semi-annually. There were thirty-three staff who were hired since the last annual compliance review which should have participated in the two drills semi-annually. There were eighteen staff who participated in at least one mock suicide drill, six staff who participated in two mock suicide drills, and there were nine staff who did not participate in a suicide drill since the last annual review. It should be noted the program reviews all mock suicide drills at their morning management meetings, which occur Monday through Friday, shift briefing with oncoming staff, and monthly all staff meetings. By reviewing the drill scenarios at these meetings, it provides staff with the necessary training to respond to an incident of suicide attempt or serious self-injury.

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 has a policy and procedures in place addressing the program's crisis intervention plan. The program's mental health crisis intervention plan was last reviewed and signed by the prior facility administrator on August 17, 2018. The current facility administrator has yet to review and sign the plan because they were appointed to the position on the first day of the annual compliance review. The crisis intervention plan was also signed by the program's prior designated mental health clinician authority (DMHCA) on January 3, 2019. The interim DMHCA has yet to sign the plan as their term as interim DMHCA started the day before the annual compliance review. The program's mental health crisis intervention plan addresses notification and alert system, means of referral, to include youth self-referral, communication, supervision, documentation and review of the crisis, which follows Florida Administrative Code, 63N-1.

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

The program has a policy and procedures in place for the completion of a crisis assessment if a youth is in psychological distress. A review of seven individualized mental health and substance

abuse records revealed none of the youth were applicable for a crisis assessment. The program was able to provide three additional youth records for completion of crisis assessments. All three youth crisis assessments were completed on the Department Mental Health and Substance Abuse (MHSA) form 023. All three crisis assessments contained the reason for the assessment, mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up. All three youth were maintained on standard supervision after the completion of the crisis assessments. All three crisis assessments were completed by a non-licensed clinician and were reviewed by a licensed professional within an hour of completion. All three records contained documentation to support the youth's parents were notified of the crisis and completion of the assessment; however, one record did not have the section filled out for parent/guardian notification but the notes within the crisis assessment indicated the youth's guardian was contacted by the youth's case manager. Two of the three records contained documentation the youth's juvenile probation officer (JPO) was notified of the youth's crisis and the completion of the crisis assessment. The third record had the youth's JPOs name documented on the form; however, there was no indication of the date and time the JPO was contacted or if they were contacted all. Since none of the youth were placed on any other type of supervision besides standard supervision after the completion of the crisis assessments, there was no need for the clinician to enter a mental health or suicide alert into the Department's Juvenile Justice Information System (JJIS).

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 has an emergency mental health and substance abuse service plan, which outlines the care for youth in imminent danger to themselves or others due to mental health or substance abuse emergencies. The program's emergency mental health and substance abuse service plan was last reviewed and signed by the prior facility administrator on August 17, 2018. The current facility administrator has yet to review and sign the plan because they were appointed to the position on the first day of the annual compliance review. The plan was also signed by the program's prior designated mental health clinician authority (DMHCA) on January 3, 2019. The interim DMHCA also signed the plan on September 4, 2018, during their first tenure as interim DMHCA and their second term as interim DMHCA started the day before the annual compliance review. The emergency plan indicates youth with mental health emergencies will be transported to New Horizons of the Treasure Coast and Okeechobee for crisis stabilization placement. The plan further indicates youth with substance abuse emergencies will be transported to Lawnwood Regional Medical Center for treatment. The program's plan contains the following elements: procedures for immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and substance abuse evaluation and treatment, documentation, training requirements, and a review process, which meets all elements of Florida Administrative Code, 63N-1. A review of seven pre-service and seven in-service staff training records indicated all staff received training on the program's emergency mental health and substance abuse services.

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 the review period; therefore, the indicator rates as non-applicable.

Standard 4: Health Services

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

The program maintains a policy and procedures identifying the authority responsible for the provision of healthcare services. The program's designated health authority (DHA) is responsible for the delivery of health services, supervision of personnel, and liaison services within the program. The program's DHA resigned for personal reasons on December 27, 2018. The program has a provisional agreement with an alternate licensed medical doctor currently providing DHA services. There has been no lapse in DHA services at the program since the last annual compliance review. An interview with the program's health services administrator (HSA) reported the program is currently working on recruitment and contract negotiations with a new permanent DHA. The former DHA held an unrestricted license and met all requirements for unsupervised and independent practice in the State of Florida. The interim DHA signed a temporary amendment to provide medical coverage for the program on January 8, 2019. The DHA is scheduled to be on-site for two hours each week. The DHA is on call twenty-four hours a day, seven days a week when not at the program. The current DHA holds an unrestricted osteopathic physician license in the State of Florida with an education concentration in internal medicine. The current DHA's license expires January 31, 2021. In the absence of the DHA, services are provided by an alternate licensed medical doctor, and the assigned DHA will perform administrative duties. The program does not utilize a physician's assistant or an advanced registered nurse practitioner. The DHA and/or designee is on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. There were no instances where there were more than nine days passed between on-site visits. Documentation showed the DHA and/or designee is on-site each Friday. Reviewed documentation reflected during DHA illnesses coverage was arranged and provided. A review of sign-in/out logs confirmed weekly visits for the past six months. There were two instances in the last six months where the DHA was on-site less than two hours. An interview with the current DHA verified his roles and responsibilities at the program. Copies of all medical licenses for professionals providing care to youth at the program were obtained and verified during the annual compliance review. Each held a free and clear medical doctor or registered nursing license in the State of Florida. The program has an agreement with and utilizes the services of an optometrist when needed. The optometrist's license was clear and active in the State of Florida with an expiration date of February 28, 2019. The program does not currently have an active dentist agreement. The dentist agreement expired on October 7, 2018. An interview with the program's health services administrator reported the program is working on contract negotiations with a replacement dentist and take youth in need of dental care to the Okeechobee County Health Department.

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 (FOPs) for all health-related procedures and protocols utilized. Reviewed documentation showed the designated health authority (DHA) and facility administrator (FA) signed and dated all respective treatment protocols and FOPs as required. The program's medical FOPs showed and effective date of July 9, 2018. Each was

signed by the FA on August 17, 2018, the corporate officer on July 9, 2018, the previous DHA on July 9, 2018, and the fill-in DHA on August 30, 2018. The psychiatric FOPs were each signed by the psychiatrist on August 11, 2018. Documentation supported the program's nursing staff reviewed, signed, and dated a cover page on which all FOPs, treatment protocols, and other procedures are listed. There were no instances where new policies or changes in policies made during the year required review. A review of the program's health-related policies, procedures, and protocols ensured the program properly outlined the program's healthcare services. There were two new medical staff since the last annual compliance review. A copy of the comprehensive clinical orientation to the Department's healthcare policies and procedures was given by a registered nurse for both new staff. A review of pre-service training and on the job training documents supported each required orientation was completed in its entirety.

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 policy and procedures to ensure parents/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to youth at the program. Seven individual healthcare records (IHCRs) were reviewed for the presence of the Department's Authority for Evaluation and Treatment (AET) form. Two youth were over the age of eighteen. Both records contained a copy of the AET in place prior to the youth turning eighteen years old and also contained a Release of Information Authorization Form for 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 five records 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 nurse 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 program nurse 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 eighteen years of age or older.

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

The program maintains a policy and procedures 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. Seven individual healthcare records (IHCRs) were reviewed for parental notification. Two youth were over the age of eighteen. One youth signed their own parental consents and the other youth record contained a Release of Information Authorization Form for eighteen years of age or older requesting the parent/guardian receive notifications. Each reviewed record contained documentation of parental notification for over the counter medications beyond those covered by the AET. One reviewed youth healthcare record was applicable for vaccinations and/or immunizations not consented for on the AET. Three records were applicable for significant changes to existing

medication not including psychotropic medications. One record was applicable for discontinuation of medication prescribed prior to youth entering the Department's custody. Four records were applicable for changes in a condition and/or medication for a chronic condition. Three records were applicable for off-site emergency care notification made by phone and in writing. Three youth records were applicable for non-routine dental procedures. Five youth records were applicable for new medication and verbal parent/guardian notification of the changes were reflected in the progress notes. Each of the five records applicable for new medications contained written notifications sent regardless of telephone notifications and a copy maintained in the record. Each was documented on the Department's Parental Notification of Health-Related Care Form. Five of five applicable reviewed records documented a staff member witnessing a telephone call attempt and/or conversation to the parent/guardian to obtain treatment consent. Each of the five applicable reviewed records contained a copy of the mailed parental notification. There were no records applicable for youth being in the care of the Florida Department of Children and Families. An interview with the program nurse reported whenever there is a change in a youth's medical condition a parent/guardian is notified immediately by telephone for verbal consents and/or notifications. The program nurse added parents/guardians are notified of any care given outside of what is consented on the AET. The program nurse reported in the case of medical emergencies the parent/guardian, designated health authority, health services administrator, and facility administrator are notified of the event following the determination a youth is safe.

4.05 Notification – Clinical Psychotropic Progress Note	**Satisfactory Compliance**
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

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. Two of the seven reviewed individual healthcare records (IHCRs) were applicable for a psychotropic medication being initially prescribed, discontinued, and/or a significant dosage adjustment being made. An additional record was reviewed for a sample size of three. Each applicable record contained documentation of the program obtaining consent prior to administering psychotropic medications. Two records were applicable for significant changes or discontinuation of psychotropic medication. Verbal consent was obtained and documented on the CPPN in three applicable records where the initiation and/or the continuation of psychotropic medication took place. Each of the three records documented a staff member witnessed all telephone call conversations on the third page of the CPPN. Review documentation showed each CPPN was sent to the parent/guardian with a corresponding cover letter. 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 third record reviewed was applicable for being in DCF care and contained documentation of the CPPN being mailed to the DCF worker and the parent/guardian. The reviewed record for the youth in DCF care also contained a court order for treatment. An interview with the program's nurse reported the psychiatrist obtains a verbal witnessed consent when prescribing or adjusting psychotropic medications. The nurse reported the consent is documented on the third page of the CPPN and then mailed by certified mail to the guardian for signature and return.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

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. Seven 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 Authority for Evaluation and Treatment 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 HS 022. One record was applicable for a consent to be obtained for a missing vaccination/immunization. The reviewed record documented the receipt of consent and the administration of the vaccine within thirty days of admission. The program utilizes the Okeechobee County Health Department for administration of vaccinations/immunizations. An interview with the program's nursing staff confirmed each youth's vaccination/immunization record not documented in the youth's IHCR upon admission, will be obtained through the Florida Shots system. The nursing staff indicated the program's practice is to review each youth's immunization record upon admission.

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

The program maintains a policy and procedures to ensure youth receive routine healthcare screenings and evaluations upon admission. An interview with the program's nurse reported all newly admitted youth are seen immediately when they arrive. 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. A review of seven youth individual healthcare records 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.

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

The program maintains a policy and procedures to ensure all staff are made aware when medical issues exist which may affect the security and safety of the youth in the program and which may necessitate the need for emergency medical services. Seven staff were interviewed regarding the program's practice for sharing alerts. One staff reported alerts are available in master control and one staff reported alerts are discussed in shift briefing. The remaining five staff reported alerts are discussed in shift briefing in addition to being posted in master control.

Six of the seven reviewed youth records were applicable for medical alerts. A review of the Department's Juvenile Justice Information System (JJIS) validated the alerts were updated and/or removed as required. An interview with the superintendent reported all internal alerts are entered into JJIS by the department managers. It was also reported the information is shared with all departments during the morning management meeting. The superintendent added the alert information is provided to master control and the alert boards are updated by master control staff. The program also maintains a separate medical alert sheet sent out daily. The superintendent reported the program holds a classification meeting for newly admitted youth prior to youth group and room assignment. The classification meeting includes alert sharing and updates regarding the physical health of each youth at the program. An interview with the program nurse reported the medical records clerk and the health services administrator (HSA) update medical alerts. It was further reported if the medical clerk updates the alert the HSA and/or registered nurse verify the alert.

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

The program maintains a policy and procedures to ensure all youth admitted to the program are oriented upon admission to the program's healthcare systems. The program's medical orientation and admission health education is provided by the healthcare staff, in writing and during an individual session with the youth on the day of admission. Seven individual healthcare records (IHCRs) were reviewed for orientation to healthcare services. Each of the seven records documented a healthcare orientation was conducted on the day of admission. Each reviewed record documented the signature of a registered nurse and the youth on a health education packet. Each youth received orientation on how to notify staff about medical alert issues, extreme shortness of breath, and/or faintness while exercising, and their right to refuse care. Each youth was also oriented on what to do in the case of a sexual assault or attempted sexual assault, the non-disciplinary role of the healthcare providers, and situations in which the healthcare staff shall notify security and/or program administration. The additional healthcare topics discussed during admission included how to access sick call, what constitutes an emergency, how medications are administered, notifying staff about allergies, how to notify staff of chest pain, and how to notify staff if youth are having side effects from medication.

4.10 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 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. Seven individual healthcare records (IHCRs) were reviewed for DHA admission notification. Five of the youth records documented the DHA notification was made by telephone, and two reflected the notification took place in person on the day of admission. Five of the seven records were applicable for a known or suspected chronic condition. None of the reviewed records reflected the youth was in need of an emergency response. An interview with the program nurse reported

the registered nurse (RN) completes the Department's Facility Entry Physical Health Screening (FEPHS) form and notifies the DHA on the day of admission of any youth with chronic conditions.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

The program maintains a policy and procedures to ensure a rescreening and the completion of a new Facility Entry Physical Health Screening (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 seven youth individual healthcare records (IHRCs) found none were applicable for a change in physical custody occurring. Three additional applicable IHRCs were reviewed. Reviewed documentation supported all three youth received a healthcare admission rescreening utilizing the Department's FEPHS form. Each FEPHS form was completed by a registered nurse (RN). An interview with the program nurse reported when youth return to the program the RN immediately completes the FEPHS.

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

The program maintains a policy and procedures outlining the completion and/or update of the Department's Health-Related History (HRH) Form upon admission. A review of seven individual healthcare records (IHCR) documented each youth received a completed HRH within seven days of admission, and prior to the Comprehensive Physical Assessment (CPA). Each was completed on the day of admission. All seven 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 nurse reported the program practice is for the RN to complete the HRH at the time of admission for all youth.

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

The program maintains a policy and procedures to ensure all admitted youth receive a current comprehensive physical assessment (CPA) prior to any participation in sports, exercise, or any other strenuous activity. A review of seven youth individual healthcare records (IHCRs) documented the program used the Department's standardized CPA form. Each reviewed CPA showed it was completed by the designated health authority (DHA) and/or designee within the required timeframe. Each of the seven reviewed CPAs had documentation of an "O" for each completed portion. Each reviewed record did not contain an "X" on portions of the form requiring comment; however, comments were clearly noted on each CPA justifying the deferment reason in each instance. There were no instances where any of the youth refused part of the examination. Two youth records were applicable for having the Department's

Problem List updated and each documented an update as required. An interview with the program nurse reported the CPA is completed within seven days of intake and annually for all youth.

4.14 Female-Specific Screening/Examination	Non-Applicable
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

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

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

The program maintains a policy and procedures ensuring all youth admitted to the program are thoroughly screened upon admission to determine if a youth has an acute illness or a chronic condition requiring immediate evaluation and treatment. 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 seven youth individual healthcare records (IHCR) validated each youth had at least one verified tuberculin skin test (TST) documented within the last year. 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 tuberculosis (TB) screening. Seven reviewed IHCRs found the results of the TST were documented on the youth's Comprehensive Physical Assessment (CPA) and on the Department's Infectious and Communicable Disease (ICD) form. Each reviewed record contained documentation of a Tier I TB screening completed on the day of admission. An interview with the program nurse reported youth are assessed at the time of admission with the FEPHS. The nurse also reported purified protein derivatives (PPDs) are administered annually, and if deemed applicable, at the time of admission for all youth.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

The program maintains a policy and procedures outlining admission screening and medical evaluations for sexually transmitted infections (STIs). The policy further outlines the role of the designated health authority (DHA) and/or designee to review the admission screening tool and evaluation and to order testing for STIs when indicated. A review of seven youth individual healthcare records (IHCRs) found each youth was identified as sexually active and was clinically screened and evaluated for STIs. Three youth were referred to the DHA for needing further evaluation and the referrals were documented in the IHCR progress notes. Testing was ordered and performed for each youth on the day of admission. Test results were filed in the lab section of the IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or requiring a rescreening due to presenting symptoms. An interview with the program nurse 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.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

The program maintains a 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 seven youth individual healthcare records (IHCRs) validated each youth was offered the opportunity to receive counseling and testing for HIV of which four consented and three did not consent to testing. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's HIV Antibody Test Youth Consent form. The program's designated health authority carries a medical doctor license and is authorized to provide pre-counseling, testing, and post-counseling. Each of the four records applicable for HIV testing contained results placed in a sealed envelope marked personal and "Confidential" and the youth's name, Department identification number, date of birth, and date of testing. Seven youth were interviewed regarding their ability to ask for an HIV test. Each of the seven-interviewed youth acknowledged the availability of HIV testing at the program. An interview with the program nurse reported if a youth consents to HIV testing they are pre-counseled by the designated health authority (DHA). HIV testing is completed by a registered nurse and post-HIV counseling is 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.

4.18 Sick Call Process – Requests/Complaints	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 maintains a policy and procedures to ensure sick call care is available to all youth. The policy outlines sick call care to be provided by licensed healthcare professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program offers youth the opportunity to make sick call requests seven days a week. Sick calls are scheduled to be conducted two times daily Monday through Friday and one time daily on weekends. All scheduled sick calls are conducted by the licensed registered nursing staff. The program's cafeteria and each of the five program cottages have sick call forms and a deposit box for the forms accessible to all youth. The program practice is to check the boxes two times a day. A review of seven youth individual healthcare records (IHCRs) reflected six youth completed a sick call request form at least once during their stay. In each instance the registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There was one reviewed applicable IHCR showing the youth presented with a similar sick call complaint three or more times within a two-week period. Documentation showed the youth was subsequently referred to the DHA. The program's dental sick call is also incorporated into the healthcare sick call process. An interview with the program nurse reported all sick call referrals are documented on the sick call log and in the IHCR chronological notes. The program nurse also reported youth have the availability for sick call services outside of scheduled sick call hours when needed. The

program nurse additionally reported sick calls are only conducted by RN's in the clinic to ensure youth privacy. Seven program staff were interviewed regarding who conducts sick call. Each of the seven-staff reported sick call is conducted by the program's nurse.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

The program maintains a policy and procedures to ensure a system is in place to respond to the complaints of a youth illness or injury of a non-emergent nature. The program offers sick call care, including dental complaints, to all youth. 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. Seven staff were interviewed regarding who conducts sick call at the program and each reported the nursing staff conduct sick call. One interviewed staff reported the doctor also conducts sick call. An observation of sick call during the annual compliance review showed the youth was escorted to the nurse's station by the Protective Action Response (PAR) certified youth care worker. The youth provided verbal and initialed consent for regional monitor to observe the sick call process. All aspects of the sick call process where thorough and informative. The program's registered nurse (RN) identified themselves and why the youth was there, asked the youth to initial the sick call form, and saw the youth in a private area with no other youth present. The nurse was knowledgeable of the youth's condition, offered medication included on the AET, and informed the youth of an appointment already scheduled for off-site care. The youth was educated on the over the counter (OTC) medication provided, the youth's allergies were confirmed, and the MAR was updated. Seven youth were interviewed regarding how quickly they see a nurse after submitting a sick call. One youth reported immediately, five youth reported within one day, and the last youth reported never submitting a sick call request.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program's policy, procedures, or contract states they do not use restricted housing, to include confinement, seclusion, room restriction, or secure observation; therefore, this indicator rates as non-applicable.

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

The program maintains a policy and procedures to ensure there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth. The program requires each encounter to be documented on the Department's First Aid/Emergency Care Log form HS 009. 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. A review of seven youth individual healthcare records (IHCRs) found four youth requiring episodic and/or first aid care at the program. All treatment services were provided by nursing staff. Each of the reviewed nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) format. Nursing staff also maintained an episodic/first aid/emergency care log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). The program maintains five automated external defibrillators (AED) and twelve first aid kits. The program's AEDs were located in master control, the administrative building, in the medical office, the gymnasium, and in the maintenance office. The program's first aid kits were located in each of the five living units, one in the main medical department, one in the maintenance office, one in the gymnasium, one in the cafeteria, one in the vocational classroom, one in the administrative building, and one in the medical room outside of the cafeteria. The first aid kits were observed to be fully stocked and no items were expired. The first aid kits are inventoried weekly and perpetually by medical staff and observed documentation validated the practice. In addition, the program maintained two first aid kits for the program's transport vans and one epinephrine auto injector, located in the medical clinic in a locked box. The program's AED and suicide response kits were checked monthly by nursing staff according to the program's policy. An interview with the program nurse reported the treating nurse documents episodic care in the nurse chronological note. When non-healthcare staff perform episodic care, the event is documented on the Non-Healthcare Staff On-Site Care Form HS049. The nurse further reported the program uses a health services provider tracker to track youth who are sent off-site for first aid or emergency care. Seven youth were interviewed regarding the ability to see a dentist and/or doctor while at the program. Each of the seven youth reported they can see a dentist if they have tooth pain and seven youth reported they can see a doctor if needed.

4.22 Emergency Care	**Satisfactory Compliance**
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

The program maintains a policy and procedures to ensure there is a written plan to provide twenty-four-hour emergency medical, mental health and dental care to youth, as needed, in response to unexpected illnesses, accidents or conditions requiring immediate attention. The program posts the name, addresses and telephone numbers of contracted emergency healthcare providers, on-call healthcare providers, the poison control center, and emergency medical services (EMS). All staff with direct contact with youth or provide supervision to youth are trained in sick call complaints which are actually emergency complaints and proper emergency on-site emergency notification procedures and care. The program policy is to ensure all phones within the facility have access to outside lines with unimpeded access to the emergency use of 9-1-1. A review of all six-nursing staff training records showed each maintained current certification in cardiopulmonary resuscitation (CPR) and use of the automated external defibrillator (AED). The program conducts monthly mock medical drills on each shift. Reviewed drills supported an annual calendar is maintained and followed prescribing the drill type conducted. Seven times a year CPR and AED usage are included as part of the drill. Observations during the program tour found postings throughout the program informing staff of their right and responsibility to call 9-1-1. Lists of emergency telephone numbers were

posted in the medical clinic and in the supervisor's office inaccessible to youth. A review of mock medical drill sign-in sheets showed only two of the seven reviewed staff had documented participation in a medical drill within the last six months. A review of shift briefing reports, monthly all staff meeting minutes, and morning management meeting minutes for the past six months supported the program practice of reviewing and discussing drills with all program staff. The five staff identified as not personally participating in a mock medical drill did sign-in for two all staff meetings where meeting minutes indicated drills where reviewed. The program's five AEDs were verified. Each AED was operational when turned on, and none of the batteries or pads where expired. A review of monthly emergency equipment inventories verified the AEDs are inspected monthly. Seven staff were interviewed regarding their ability to call 9-1-1 in an emergency. Two staff stated they are allowed to call 9-1-1 when needed and five staff reported they would contact master control and the master control staff would call 9-1-1. The program provided monthly all staff meeting minutes and sign-in sheets for the last six months. The meeting minutes showed the program conducted trainings on staff member's ability to call 9-1-1 on September 25, 2018 and July 24, 2018. An interview with the campus wide superintendent reported the medical drills are completed one time a month on each shift. An interview with the program nurse reported the medical staff have a drill calendar and conducts a drill one time a month on each shift.

4.23 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 policy and procedures for the provisions of off-site emergent and non-emergent referrals for medical care and treatment. A review of seven Individual healthcare records (IHCRs) showed five were applicable for receipt of off-site care. Three of the five were applicable for parental notification and two youth were over the age of eighteen. Each of the five records contained a Summary of Off-Site Care form and applicable follow-up and discharge paperwork in the IHCR. Each of the five reviewed applicable records showed the designated health authority (DHA) and/or designee reviewed off-site care findings, instructions and information. Four of the reviewed records were applicable for youth requiring follow-up care and each contained evidence of timely follow-up care occurring. An interview with the program nurse reported the program calls the DHA after all off-site visits are completed and the registered nurse receives telephone orders from the provider. All off-site care orders are reviewed by the DHA during the next on-site visit. The nurse also reported the DHA documents the review on the off-site care form and nursing staff track any follow-up appointments by use of the transportation appointment calendar.

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

The program maintains a 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, with the exception of allergies, hearing/speech/visual impairment, developmental disability, or mental retardation. 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. A review of seven individual healthcare records (IHCRs) indicated four youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening form. There was one youth prescribed psychotropic medications subsequent to admission and a second youth admitted on psychotropic medications. Three of seven reviewed youth IHCRs documented the youth was classified with a medical grade of two through five. There were no youth diagnosed with a communicable disease or currently undergoing treatment for physical health conditions 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 and chronic condition. Reviewed records supported each youth received periodic evaluations as required. There was no indication of lapses in care or missed periodic evaluations. The designated health authority (DHA) diagnosed each chronic condition with a prescribed medication treatment plan. Approximately every sixty days the DHA conducts a periodic examination of the youth, and if applicable, continues the youth on the specialized treatment plan and/or modifies the plan. The Department's Problem List was updated for each applicable youth as required. An interview with the campus wide superintendent reported the program has a formalized procedure for discussing important medical issues for youth at the program. The medical staff participate in the morning management meeting and a quarterly meeting. It was reported the program's quarterly meeting includes participation of the DHA, pharmacist, psychologist, mental health staff, and the facility administrator. An interview with the program nurse and the DHA reported youth with chronic conditions are seen by the DHA every sixty days or sooner, if needed.

4.25 Medication Management – Verification	**Satisfactory Compliance**
A youth's medication regimen shall be ascertained upon admission to the facility.	

The program maintains a written policy and procedures to ensure youth's medications are verified upon arrival. A review of seven youth individual healthcare records (IHCRs) indicated one youth was admitted into the program on prescribed medications. Two additional applicable youth IHCRs were reviewed for a sample size of three. Reviewed nursing admission notes and Facility Entry Physical Health Screenings 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.

4.26 Medication Management – Orders/Prescriptions	**Satisfactory Compliance**
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

The program maintains a 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 contracts with 1st Choice Pharmacy. The program may obtain emergency prescriptions from a local pharmacy, when necessary. A review of seven youth individual healthcare records (IHCRs) validated six were applicable for prescribed medication while attending the program.

Each documented a current and valid prescription order. One of the records was applicable for a youth being admitted on medications. Each of the applicable reviewed IHCRs indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the doctor's order sheet clearly documented the medication and dosage. Five reviewed records were applicable for over the counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) being administered. Each of the five were administered in accordance with approved protocols or according to the practitioner's order. An interview with the program nurse reported all medications are verified with the youth's parent/guardian and the pharmacy. The verification is then documented by the registered nurse in the chronological section of the IHCR.

4.27 Medication Management – Storage	**Satisfactory Compliance**
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

The program maintains a policy and procedures to ensure all chemical products, medications, 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. The program policy states all unused and expired medications are returned to the pharmacy for proper disposal, credit and/or replacement and all medication shall be inaccessible to youth. Observations found all medications securely stored in the medical clinic inaccessible to youth. All controlled medications were stored in a separate, secure box located in a locked medication cart. The key to the cart was maintained in mounted lock box on the wall of the medical clinic. The mounted box was accessible by a digital code. Oral medications were not stored with injectable or topical medications. The program maintains a locked refrigerator for medications requiring refrigeration. The program utilizes a pharmaceutical disposal solution for the disposal of all over-the-counter (OTC), non-controlled, and controlled medications. An interview with the lead nurse reported OTC and non-controlled prescription medications can be destroyed utilizing the solution with the presence of two medical staff. The lead nurse also reported the controlled medications requiring disposal are maintained and tracked on a controlled inventory log. The controlled medications are disposed of with the pharmacy consultant witness on-site during the monthly consultation visits. The program nurse reported the program keeps a perpetual and a weekly inventory of all medication. A review of medication inventory logs supported the practice.

4.28 Medication Management – Medication and Sharps Inventory	**Satisfactory Compliance**
All medications and sharps shall be inventoried as per department requirements.	

The program maintains a 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. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. Reviewed documentation supported the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator, health services administrator, designated mental health clinician authority, and consultant pharmacists. Agenda and minutes are maintained highlighting risk reduction measures, notable trends medication treatment errors, medication errors, mock emergency drills, youth chronic conditions

and youth psychotropic medications. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. The program maintains written procedures for the disposal of narcotics and other controlled substances. All disposed medications are documented on the Consultant Pharmacist Monthly Inspection form and on the applicable Controlled Medication Inventory Record in the disposition of remaining doses box. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three over-the-counter (OTC) medications were reviewed, and the inventories were accurate. Three sharps were inventoried, and inventories were accurate. The program had ten youth prescribed a controlled medication during the annual compliance review. Three controlled medications were inventoried, and each was accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. Reviewed documentation and nursing interviews confirm all OTC medications are inventoried at least weekly. The program's practice is for OTC medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substances with a shift-to-shift inventory conducted by two registered nurses (RNs). Sharps are counted through a perpetual inventory and are verified weekly.

4.29 Medication Management – Controlled Medications	**Satisfactory Compliance**
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program maintains a 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. The program policy states all unused and expired medications are returned to the pharmacy for proper disposal, credit and/or replacement and all medication shall be inaccessible to youth. The program maintains a Modified Institutional Class II Type B permit with an expiration date of February 28, 2019. The program maintains a Community Pharmacy Schedule II and 3:1 Pharmacy Technician Ratio Approved certification with 1st Choice Pharmacy with an expiration date of February 28, 2019. 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. 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. Shift-to-shift inventories are conducted by two registered nurses, or a registered nurse and a shift supervisor. The program had ten youth prescribed a controlled medication during the annual compliance review. Three controlled medications were randomly selected, and inventories were accurate. An interview with the program nurse reported all controlled medications are stored behind a double lock in the medication cart. The nurse reported the consultant pharmacist is on-site monthly for inspection and attends quarterly meetings at the program.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

The program maintains a policy and procedures to ensure all medications are provided pursuant to a physician order written in the youth's individual healthcare record (IHCR). A review of seven youth IHCRs found one youth was prescribed medication prior to admission. An additional to IHCRs were reviewed for a sample size of three. The program utilizes a pre-printed 1st Choice Pharmacy Medication Administration Record (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. One of the reviewed records showed the youth was taking prescribed medications upon admission and the initial MAR matched the medication listed. An additional two applicable youth MARs were reviewed, and each matched the medication listed. The reviewed youth IHCRs supported the MAR documented the youth received the medication as ordered. The MAR clearly indicates 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 three reviewed MARs. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. Refusals were clearly documented on the MAR and nursing staff complete the Department's Refusal of Treatment form when a youth refused a medication dosage. A review of the Department's Central Communications Center showed one substantiated incident regarding a medical error since the last annual compliance review. As a result of the incident, the program's regional director of nursing completed a program specific training on October 5, 2018. The training sign-in sheet documented the training included the facility operating procedures (FOPs) on medication administration.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

The program maintains a policy and procedures to ensure all oral prescription medications are administered, according to instructions. The policy further states all staff administering medications will have knowledge or be informed of the common side effects and precautions of prescribed medications. Healthcare staff at the program administering medications are to ensure the five rights of medication administration are verified for every youth. A review of five youth individual healthcare records (IHCRs) validated each youth was prescribed medications. No youth required parenteral medication at the time of the annual compliance review; however, procedures are in place for only the licensed registered nurse (RN) to administer the medication. Seven IHCRs were reviewed and six were applicable for having medication administered while at the program. Each of the reviewed Medication Administration Records (MARs) validated the youth received the medication as ordered and at the scheduled timeframes. Refusal of medications were clearly documented on the MAR and the Refusal of Treatment form was also completed and filed in the youth's IHCR. On-site observations showed the medical clinic was clean and organized. An observation of medication administration was conducted during the annual compliance review and showed the program nurse verified the five rights of medication administration for each youth. A review of the Department's Central Communications Center showed one substantiated incident regarding a medical error since the last annual compliance review. As a result of the incident, the program's regional director of

nursing completed a program specific training on October 5, 2018. The training sign-in sheet documented the training included the facility operating procedures (FOPs) on medication administration. Seven youth were interviewed regarding who administers medication at the program. Four youth reported the nurse administers medications and three youth reported not taking medication at the program. Seven staff were interviewed regarding who administers medication at the program. Each of the seven staff reported the nurse administers medication and one staff reported the doctor also administers medication. Three staff additionally reported the supervisory staff can administer over the counter (OTC) medication at the program.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program maintains a policy and procedures outlining the provisions for the self-administration of medications by non-licensed staff members. Non-licensed staff provide self-administration only when there is no licensed healthcare staff on-site. The program's health services administrator (HSA) provided medication administration and allergic emergencies to include the use of epinephrine auto injector in August and November 2018 to all program supervisory staff. The HSA maintains a list of trained and approved non-medical staff authorized to assist in self-administration of youth medications. The list is updated monthly and included nine supervisory and administrative staff. The list was observed posted in the medical clinic and is updated monthly. Seven program staff were interviewed regarding which staff members administer medication and each reported the program's nursing staff administer medications. Three staff also reported the supervisory staff assist in the self-administration of over the counter medications. Seven youth were interviewed regarding who administers medication at the program. Four youth reported the nurse administers medications and three youth reported not taking medication at the program.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

The program maintains a policy and procedures to provide psychiatric services to youth at the program with a Diagnostic and Statistical Manual, Fifth Edition (DSM-5) mental disorder, to include psychiatric evaluations, psychiatric consultations and medication management. The program's policy states all psychotropic medications will be provided pursuant to a physician order written in the individual healthcare record. The policy additionally states the program will not have standing orders for and/or use psychotropic, tranquilizing, or stimulating medications for the purposes of program management and control. A review of seven youth healthcare records validated two youth were prescribed psychotropic medications. An additional record was reviewed for a sample size of three. Each reviewed psychiatric evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN). The three youth records required a combined number of seventeen thirty-day monthly medication management appointments. Three of the applicable seventeen appointments occurred beyond the thirty-day timeframe. One youth record noted a medication management appointment conducted ten days late, and the remaining two contained a medication management appointment occurring one

day late. None of the reviewed applicable records showed a lapse in the administration of psychotropic medications. The program did not have standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. Reviewed documentation showed the psychiatrist does not provide the program with pro re nata (PRN) orders for psychotropic medications. All program staff administering medications are to have knowledge or be informed of the common side effects and precautions of prescribed medications. A review of the three individual healthcare record's (IHCR's) Medication Administration Record (MAR) each documented daily side effect monitoring conducted by the registered nurse. Each reviewed IHCR was applicable for youth requiring monthly monitoring of Tardive Dyskinesia. In addition, the psychiatrist conducted the Abnormal Involuntary Movement Scale (AIMS) on each applicable youth. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist who maintains professional liability insurance. A review of the liability insurance showed an expiration date of July 31, 2019. An interview with the health services administrator and weekly sign-in sheets supported the psychiatrist is scheduled to be on-site two hours each week. The program's practice is to refer all youth to the psychiatrist for an initial psychiatric evaluation within fourteen days of admission.

4.34 Infection Control – Surveillance, Screening, and Management	**Satisfactory Compliance**
The facility 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 program maintains an infection control plan is combined with the program's exposure control plan. The infection control plan includes common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outlines outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist agents, chemical exposures, and methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms. The plan documented signature of the facility administrator (FA) on August 17, 2018, the corporate officer on July 9, 2018, the previous designated health authority (DHA) on July 9, 2018, and the fill-in DHA on August 30, 2018. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for hepatitis B immunizations during orientation. Staff are provided access to protective equipment on-site. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste. The program documents a transport log for monthly medical waste pick-up through Stericycle, Inc. The program maintains a current operating permit through the Department of Health for biomedical waste state laboratory/clinic with an expiration date of September 30, 2019. The program had no instances in which the Okeechobee County Health Department, Center for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified of any infectious disease.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

The program maintains a policy and procedures to establish and make accessible for all staff, a uniform procedure to eliminate or limit occupational exposure to bloodborne pathogens through training, education, and standard precautions. The plan is also intended to provide guidelines for appropriate treatment and counseling should a staff member be exposed to blood or blood products. The program's health services administrator (HSA) provides staff training through orientation and ongoing in-service trainings regarding infection control. The program's nursing staff provide each youth an orientation to the program's healthcare services. A review of the program's youth orientation documentation packet showed all youth receive education in infection control practices, standard precautions, basic personal hygiene, and hand washing. A review of seven youth individual healthcare records validated each youth received training on infection control to include hand washing techniques, respiratory etiquette, universal precautions, prevention of transmission of communicable diseases, vaccinations, and the Center for Disease Control and Prevention (CDC) guidelines for infection control. The program's control of infectious and communicable diseases plans included staff training during the pre-service phase and annual in-service training. A review of seven staff pre-service training records and seven in-service training records found twelve staff received the required training. One staff did not receive annual training for infection control education and blood-borne pathogens since the last annual compliance review. Another staff member's pre-service training record was missing infection control education. An interview with the program nurse reported the campus wide training department and HSA conduct infection control training for staff. The nurse also attested the nursing staff provide infection control training to youth upon admission and annually thereafter.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The program maintains an exposure control plan combined with an infection control plan in order to provide a safe environment for youth, staff and visitors. The program's plan showed documentation of an annual review as required. The plan documented signature of the facility administrator (FA) on August 17, 2018, the corporate officer on July 9, 2018, the previous designated health authority (DHA) on July 9, 2018, and the fill-in DHA on August 30, 2018. The program reported 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 exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The exposure control plan included a comprehensive process for needle stick post-exposure evaluation and the plan is available to all staff. There were no documented instances of staff having experienced an occupational exposure since the last annual compliance review. An interview with the campus wide superintendent reported the exposure control plan is located in master control, the FA's office, and in the medical clinic. A review of seven staff pre-service training records and seven in-service training records found twelve staff received the required training. One staff did not receive annual training for infection control education and another

staff member's pre-service training record was missing infection control education. An interview with a program nurse reported the HSA is responsible for providing training to all staff on the program's exposure control plan.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

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

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

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

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

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 to ensure youth are supervised and the appropriate staff to youth ratio is maintained. The program promotes safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observe behavior of youth and change inappropriate behavior, and consistently apply the program's positive performance system. The program conducts formal and informal head counts throughout the day. A review of the program logbooks for the past six months verified head counts and movements are conducted and documented by master control. Observation of staff supervision for four days during the annual compliance review included movement from classroom to classroom, from classroom to cottages, from classroom to cafeteria, and from medical to cottages. During the observations, staff were actively supervising youth and strategically situated to visibly see youth and respond to any emergency situation. According to the program's contract, staff to youth ratio of one to eight during awake hours was observed to be in compliance. Prior to any movement, staff inform master control, by way of two-way radio, of the count. Once the count is confirmed, youth are moved to the designated area. Random interview with direct care staff indicated they knew what to do when the count cannot be reconciled.

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) employed at the program.*	

The program has a written policy and procedures addressing the implementation and training of the program's behavioral management system (BMS) approved by the facility administrator on August 17, 2018. The program has a clearly written BMS which is a multi-level system designed to enhance the youth treatment, increase healthy, pro-social behavior using reinforcing and decreasing unhealthy behaviors through natural consequences. A review of seven staff training records for pre-service training and seven for in-service training indicated one staff was not trained on the BMS for pre-service training and three staff were not trained on the BMS for in-service training. The program has three listed volunteers during the annual compliance review period. There was no documentation to verify they were trained in the BMS. According to the regional compliance manager, there is no agreement with the schoolboard related to the BMS; however, training records verified teachers were trained in the implementation of the BMS on April 20, 2018. Review of the youth handbook indicated the BMS is included. A review of seven youth records indicated each received an orientation informing the youth of the BMS to include youth expectations, responsibilities, and consequences. According to the programs' regional

compliance manager, the BMS has not changed since the last annual compliance review. Observation of the youth dorms indicated the BMS is posted to include youth who have earned weekly incentives. Observation during school of staff and youth interaction for adhering to the BMS indicated staff addressed a ratio of four to one, positive to negative consequences, when redirecting the youth as indicated in the program's policy. An interview with the facility administrator indicated the BMS used in the program is based on successful completion of treatment plan goals, performance plan goals, daily performance, compliance with scheduled activities, participation in groups, increasing social skills, and self-management. The facility administrator also indicated rewards are monitored through the BMS which allows youth to earn daily, weekly, and monthly incentives. The youth also have a chance to earn other incentives from the good citizen award each week. The program ensures the rewards outnumber the consequences at a minimum of four to one by posting the daily tracker each day on the units for youth to review. Seven staff were interviewed and was able to explain the program's BMS and knew the rewards provided to youth. Seven staff were interviewed and asked if things can be taken away from youth as a consequence. Six stated no and one stated yes. Seven youth were interviewed and knew the consequences used in the program and was able to discuss the rewards used in the program.

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

The program has a written policy and procedures to ensure staff are provided feedback regarding the implementation of the behavioral management system (BMS). Review of the BMS indicated it is not used solely to increase a youth's length of stay, deny basic rights, or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program includes a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions and youth are given an opportunity to explain their behavior. Special treatment team meetings are held for those youth whose behavior need immediate intervention. The program does not utilize room restriction for major infractions. A random review of seven staff program descriptions indicated BMS implementation is addressed as a part of the staff daily functions. An interview with the facility administrator indicated the BMS is monitored to ensure it is fairly and consistent among staff by ensuring all staff who have direct contact with youth have access to the youth handbook which describes the positive performance system, program rules and progressive disciplinary system for youth. The update of the youth handbook as necessary when changes or modifications are made to the system. Ensure all staff who have direct contact with youth are trained in the implementation of the positive performance system. Provide ongoing training to the positive performance system as needed and appropriate, during monthly all-staff meetings. Seven youth were interviewed and knew the consequences used in the program and was able to decribe the rewards used in the program. Seven staff were interviewed and stated youth are informed of the consequences and are able to explain their behavior. Seven staff were interviewed and asked to explain how

supervisors provide feedback to staff regarding the implementation of the BMS. Three staff stated feedback is given during meetings, briefings, and throughout the day. Four staff stated supervisors do not provide feedback.

5.04 Ten-Minute Checks (Critical)	Limited 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 policy and procedures in place for staff to conduct and document ten-minute checks. The program has a total of forty-three recording video cameras with each being operable and capable of recording thirty-days of video footage. Staff are required to document room check every ten-minutes when youth are in their sleeping quarters. Staff ensure skin, or a body part is seen to confirm the youth's presence and are not allowed to enter a youth's room. Staff will document the actual time of the room check and initial on the ten-minute check log sheets verifying who completed the room check. If a youth is not in his room, an "X" is marked in the box for the time of the room check. Supervisors are required to conduct three room checks and visibly see flesh of each youth in their room. Supervisors then document, in red, on the ten-minute log sheets to include the time of the check and initials. The living units consist of six cottages (Adams, Carver, Johnson, Koger, Marshall, and Robinson) with camera surveillance. A review of ten-minute check logs from ten different days along with the corresponding video footage from each cottage indicated checks were not consistently conducted within the timeframe or documented as required. On Robinson cottage on December 29, 2018, staff did not conduct ten-minute checks from 4:00 a.m. to 4:56 a.m. as documented on the log sheet. The staff completed and documented checks from 5:10 a.m. to 5:40 a.m. within the ten-minute timeframe but did not conduct the ten-minute check at 5:50 a.m. as documented on the log sheet. The staff conducted a ten-minute check at 6:14 a.m. and the next check was completed at 6:48 a.m., which was not within the ten-minute timeframe. Also, the staff did not document the 6:00 a.m., 6:14 a.m., 6:48 a.m., 7:09 a.m., and 7:11 a.m. checks on the ten-minute log sheet. On Adams cottage on December 30, 2018, a review of ten-minutes checks from 3:00 a.m. to 4:30 a.m. indicated staff did not conduct ten-minute checks from 3:07 a.m. to 4:19 a.m. as documented on the log sheet. It is to be noted, prior to the annual compliance review, the program was on an outcome based corrective action plan (OBCAP) for failure to conduct ten-minute checks as required. Seven staff were interviewed and each stated room checks are conducted every ten-minutes when youth are placed in their rooms for sleeping or non-disciplinary 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 practicable after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a written policy and procedures to track the daily census. The program tracks daily census information to include the daily count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by a physical count and a random head counts when requested by master control. Random review of the facility log books for the past six months contained documentation of youth counts at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. The program maintains an approved escape response plan signed by the facility administrator on August 17, 2018 and the designated safety and security coordinator on August 21, 2018 to ensure appropriate levels of supervision is maintained to provide adequate safety and security which is necessary to prevent escapes. The program's escape response plan is reviewed with staff to ensure the procedures are followed in the event of a youth escape. Observation of youth count during the annual compliance review indicated prior to any youth movement, master control is contacted to inform of the number of youth being moved and to what location. Random interview with staff indicated when the count is not reconciled, master control is contacted, and all movement stops until the count is corrected. Seven staff were interviewed and was able to explain when youth counts are conducted and what happens when there is a discrepancy, including emergency counts.

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

The program has a written policy and procedures for logbook documentation. Master control maintains a bound logbook with numbered pages. The logbook documents emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Central Communications Center (CCC), Florida Abuse Hotline, and supervisors are able to leave special instructions pertaining to supervision of youth. Each entry is made in ink with no erasures or white-out. A review of logbooks for the past six months indicated errors are not consistently struck threw with a single line, are not initialed

by the staff correcting the error, staff not constantly documenting youth attending school, or document searches of common areas prior to and after youth use. The program conducts staff briefings prior to the beginning of each shift and is documented on the daily shift report. Incoming staff are briefed on the previous shift and sign the shift report to acknowledge information has been shared. A review of the program shift reports indicated information is shared with incoming staff prior to the beginning of the shift. Random interview with seven staff verified this practice.

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

The program has a written policy and procedures for assignment, inventory, tracking, and storage of facility keys. The program has a daily key log to track keys. The log indicates the name of staff and what type of key they are to be assigned according to their position. Facility keys are kept in mater control in a locked key box. Keys are bound on a tamper resistant color-coded ring which includes a brass colored tag with the initials of the staff positions and a tracking number. When staff arrive to work, they gain access to the facility by way of master control. Staff will submit their personal keys and receive a facility key. Master control staff initial the key log of staff name receiving the keys before and at the end of each shift. Personal keys are placed in the key box next to the corresponding staff's name. Medical staff have a separate key box located in master control. Only medical staff have access to the key box. When medical staff report to work, they enter master control, obtain the facility key, and deposit their personal keys in the medical key box. Damaged keys are turned over to maintenance staff to have the key replaced. The program also has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff signs an acknowledgment form indicating a key identification number and the number of keys issued. The warehouse clerk competes a bi-annual key check of all facility keys. A review of the key checklist verified this practice. A random check of six staff indicated none had personal keys on their person. Interview with master control staff indicated there were no lost keys reported in the past six months. If any keys are lost, staff indicated all program movement is stopped and a search is conducted. If the keys have not been found within two hours, a Central Communications Center (CCC) report is reported. Seven staff were interviewed and was able to explain the program's key control process including how keys are assigned, reconciled, the process for missing or lost keys, damaged keys, and restricted keys.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. 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 youth.* *The program shall document the confiscation of any 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.*	

The program has a written policy and procedures which identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. Review of the program's policy, youth handbook, and visitor contraband list verified a list of unauthorized items not permuted to include personal cellular telephones or devices capable of taking photos and/ or audio/ video recordings. The program conducts search of rooms on each of the two shifts and document on a daily search report any contraband found. A review of the facility logbooks for the past six months indicated perimeter searches are documented in the logbook, however searches of common areas prior to and after youth use are not consistently documented as required by the program's policy. A random review of daily search reports verified this practice. A review of Central Communications Center (CCC) for the past six months indicated illegal contraband was confiscated on two separate occasions. In each instance the contraband was discarded as required.

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

The program has a written policy and procedures to ensure searches and full body visual searches are conducted according to Florida Administrative Code. Youth are searched at the time of admission, after off campus activity, and visitation. Searches are conducted by two staff of the same sex as the youth being searched and are conducted in a private area. Parents/ guardians are notified of searches during visitation by way of the parent intake letter which is sent at the time of the youth's admission. Youth are searched after school, after transport, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off campus, suspected of contraband, or a security risk are searched prior to returning to the general population. Parents/ guardians are notified of searches during visitation by way of the parent intake letter which is sent at the time of youth admission. Observation of searches was conducted of a new admission, after school, and during transport indicated searched are conducted by a same sex staff, conducted in a manor

not to degrade the youth, and based on the Protective Action Response (PAR) training manual and reflect trauma informed practices. Seven staff were interviewed and knew how youth searches are conducted. Seven youth were interviewed and indicated searches are conducted when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after wok detail.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *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 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 to ensure vehicles used to transport youth are properly maintained. The program has two operable vans to transport youth. Each vehicle received an annual safety inspection. Both observed vehicles are equipped with a fire extinguisher and first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each passenger. Annual vehicle inspections are conducted by the program's in-house mechanic who is automotive service excellence (ASE) certified until June 30, 2022. Review of the annual safety inspections for both vehicles verified this practice.

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

The program has a written policy and procedures to ensure the safe secure transportation of youth and staff. The program has two operable vehicles to transport youth. Inspection of both vehicles verified an up-to-date fire extinguisher, first aid kit, seatbelt cutter and window punch. First aid kits remain in the mater control area until ready for use. Rear passenger doors are unbaled to be open from the inside. The program maintains a list of staff who have eligible driver's license which is updated monthly and signed by the facility administrator. The program also provides a ratio of one staff to five youth during transport. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Observation of a transport verified, the ratio of staff to youth was in compliance, youth were not attached to any part of the vehicle, and youth and staff wore seatbelts. Seven staff were interviewed and asked what type of communication device staff are provided with during transport, six stated a two-way radio. One also stated a two-way radio and a cellular telephone. Staff are not allowed to transport youth in their personal vehicles. Seven staff were interviewed, and each verified staff are not allowed to transport youth in their personal vehicles. Observation of twenty staff vehicles indicated one was unlocked. The staff member was notified by master control to have the vehicle secured.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a written policy and procedures to ensure safety and security of the facility is maintained. The policy addressed who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. Weekly safety and security audits are conducted by the facility administrator (FA) and documented on the safety and security audit inspection form. Any deficiencies are addressed on the form and a work order submitted to the appropriate staff for corrections. Deficiencies are also discussed during the morning managers meeting. Review of the safety and security inspections forms for the past six months indicated only one inspection was completed for the month of November 2018. During this time, the facility administrator (FA) resigned from the position. Supervisors also conduct perimeter checks and are documented on the program's safety perimeter check inspection and in the facility logbook. Checks are conducted on each shift. A review of the safety perimeter check inspection forms verified checks are conducted as required. An interview with the FA indicated deficiencies are identified by the youth care workers (YCW) of by walk-through conducted weekly. Work orders are then written and forwarded to the FA for review and approval. Maintenance staff then receive the work orders and add to the maintenance tracker which is reviewed at all morning meetings by the management team.

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

The program has a written policy and procedures for tool management. The policy addresses storing and inventory of tools as well as class type. The program maintenance tools are kept in the carpenter's shop located off-site and a daily tool inventory is kept on each tool when the shop is in use. Tools are organized in a locked cabinet with a list of each tool located on the outside. All tools are classified as A list tools by the program. Mechanic tools are kept in the mechanic shop under lock and key. Each tool is labeled and inventoried daily. An inventory of each tool is listed on the outside of the storage cabinet. Review of the inventory list for both carpenter and mechanic tools verified there were no missing tools. Observation of areas for carpenter and mechanic tools indicated it was clean, neat, and maintenance staff indicated youth are not allowed to utilize tools. Kitchen tools and knives are stored in a locked cabinet inside the kitchen with limited access to kitchen staff. Review of daily inventory log indicated kitchen tools were not inventoried since November 17, 2018. Class B tools are stored on each cottage in a designated locked closet. An inventory list is posted on the inside of the door indicating the tools being stored. There is a vocational woodshop program located on the campus which is operated by the Washington School District where power tools are maintained and owned by the school district and utilized by the youth. Observation of tools in the vocational class indicated tools are placed on a shadow board and stored in a locked closet accessible only by school district staff; however, the school district does not maintain an inventory list or sign in and out logs for these tools.

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 for youth tool handling and supervision. A storage closet which includes a broom, mop, mop bucket, plunger and dust pan is designated for each of the cottages. Youth are not allowed to handle tools unless a risk assessment has been completed and determining the youth is not at risk. Review of seven youth case management records verified risk assessments are completed and identify if a youth is eligible to handle tools. A review of seven staff in-service training records indicated six staff were trained in the use of tools and one was not. The program also has a vocational program operated by Washington County school system were youth utilize class A tools. A review of seven youth enrolled in the vocation program indicated each had an up-to-date risk assessment indicating they are eligible to handle tools. Seven youth were interviewed and indicated they only use mops and brooms. Seven staff were interviewed and stated youth are only allowed to use mops and brooms.

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

The program has a written policy and procedure establishing guidelines for outside contractors prior to beginning any work in the facility. When a contractor arrives on campus, they sign the contractors sign-in log, are provided a visitor's contraband list outlining unauthorized items, and review and sign the contractor guidelines. If any unauthorized items are needed by the contractor while in the facility, approval is obtained by the facility administrator (FA) or designee. A review of the contractors' sign-in sheet and contractor's guidelines along with the corresponding work invoices verified the contractors were on-site on the same date the documents were signed. Interview with the interim physical plant manager indicated when contractors are on-site, youth are not allowed in the vicinity of the work area. While the work is being performed, a maintenance staff is assigned to the contractor to ensure the work is being competed and all tools are accounted for.

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's Continuity of Operations Plan (COOP) which addresses fire, safety, and evacuation emergency drill are to be conducted monthly, at random times, and under varied conditions. Drills are documented on the program's facility drill form which indicates the type of drill, date and time of the drill, participants, a brief scenario, and recommendations. A review of the program's facility drill forms from the past six months verified drills were performed on both shifts and included all staff on duty. The forms also included debriefing documentation and feedback on how the drills were performed. Observation of the program during the annual compliance review indicated egress plans are posted throughout the facility and in each cottage. Seven youth were interviewed, and each indicated they have been instructed on what to do in the case of an emergency and drills are conducted at least monthly.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program has a Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a wide range of potential emergency situations. Email documentation was reviewed confirming the plan was submitted to and approved by the Department on May 18, 2018. Review of the plan indicated alternative housing if the program has to be vacated due to an emergency or disaster. Interview with facility administrator (FA) indicated a copy of the COOP is maintained in the medical office, master control, and in the administration office.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous and toxic materials. Toxics are stored off-site in the locked facility maintenance shed. A list of staff who are authorized to use chemicals are posted on the outside of the storage door. All caustic materials are stored according to type and use. A Safety Data Sheet (SDS) binder is located inside the storage area with a picture of each material and a number corresponding to the SDS for each chemical. A perpetual chemical inventory list is maintained, and the chemicals are checked daily. A review of the inventory list verified this practice. The program also has a chemical daily usage log used to track all toxic when in use by authorized staff. The form identifies the chemical number, description, amount used, amount remaining, date chemical is used and initial of staff. Observation of the storage area indicated it is clearly marked hazardous chemicals and securely locked. Items were neatly stored on metal shelving and numbered according to the SDS. Flammable items are stored in a metal cabinet clearly marked as flammable items. Chemicals used to clean the cottages are stored in a locked closet located on each cottage. An inventory sheet is maintained in each closet and documents the daily use. The program has a gasoline pump located by the physical plant building used to fill the program vehicles and equipment. The use of the gasoline pump has been discontinued and is currently empty according to the maintenance staff. The tank has not been filled since November 12, 2018 and gasoline is purchased at the local gasoline station with a purchase credit card. Maintenance maintains gasoline in two five-gallon gas containers and three two and a half gallon containers. There is approximately seven gallons on-site during the annual compliance review.

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

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, and toxic items and materials. Authorized staff maintain control over all flammable, poisonous, toxic items off-site with limited access. When needed, authorized staff will obtain a supply of chemicals from the warehouse manager used to clean the cottages and are stored in a closet on each cottage designated for this purpose. A sign out chemical log is maintained within each closet. Review of the logs verified staff sign out chemicals when in use. Youth are not allowed to possess flammable, poisonous, toxic and caustic items. When necessary, staff will spray the chemical and youth will wipe it up. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waist. Seven youth were interviewed and asked do they handle any chemicals. Four youth stated paint, two of the four youth also stated floor wax, and three youth stated they do not handle chemicals. The staff spray the chemical and youth wipe it up.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance mechanic, 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 written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials are kept in the locked storage shed located off campus and are disposed of according to the Safety Data Sheet (SDS). The program's maintenance staff dispose of unused flammable, poisonous, toxic material in Okeechobee County during Amnesty Day which is a day set by the county for disposal of such materials. Signed documentation from the county is received indicating what materials are being disposed. Review of documentation verified chemicals listed on the disposal log was disposed on January 27, 2018. According to the interim physical plant manager, disposal is scheduled for the month of January 2019. Used kitchen grease and waist is stored in a large container outside the kitchen area and is disposed of quarterly. Review of the invoice verified the grease trap was serviced on October 15, 2018. All chemical spills are reported to master control immediately and the shift supervisor. An evacuation of the affected area is conducted and a determination by the facility administrator (FA) whether to contact outside assistance to contain the spill. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional.

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

The program has a written policy and procedures in place to provides a variety of recreation and leisure activities for youth in the program to promote cognitive skills development, creativity,

teamwork, healthy competition, mental stimulation, and physical fitness. According to the program contract, the program is required to have two recreational therapists in order to expose youth to a variety of recreation and leisure choices, constructive use of leisure time, and social and cognitive skill development. Additionally, the recreational therapists will ensure the therapeutic activity provided is incorporated into each youth's individualized performance treatment plan. The educational requirements state the candidate will preferably have a bachelor's-level degree of science in recreation and sports management with a track in recreational therapy. The program has no certified staff for both positions which has been vacant since August 18, 2018. The program has designated a staff to conduct recreational activities; however, the staff was not certified or possess the credentials as a recreational therapist. The program has made efforts to recruit for the positions through career fairs, Career Source, and the employer's referrals system. However, there was no documentation to support if any candidates have been interviewed from August 18, 2018 to January 7, 2019, or if any candidates have been offered the recreational therapist position. A potential candidate was interviewed during the annual compliance review week and additional interviews have been scheduled for the following week. An indoor and outdoor recreation schedule of the days and times of activities is posted in each cottage which identifies individual and team recreational activities. Recreation is also listed on the daily program schedule. A review of the program's activity schedule and logbooks verified a variety of activities are provided to the youth including leisure and recreational. During the absence of the recreation therapist, the program's direct care staff conducted extra activities by playing football and basketball with the youth. The program's direct care staff did not have the credentials of a recreation therapist. A review of seven youth individual performance plans revealed six plans did not contain a wellness/recreational goal incorporated into the performance plan. Seven youth were interviewed and stated physical activities and leisure activities provided for at least one hour to include football, basketball, and kickball.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program has a written policy and procedures for youth to have visitation and communication with family members in order to re-establish family and community relationships. Youth are informed of visitation upon admission during the orientation process. The program encourages visitation from the parents/guardians by forwarding a welcome letter, upon the youth's admission, notifying the days and time of visitation, who is allowed to visit, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in the youth's case management records and updated as needed. A review of seven youth case management records verified each record contained an approved correspondence, visitation and telephone log. Visitation is held in the cafeteria on Saturdays from 1:00 p.m. to 4:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate in the regularly scheduled visitation day. A review of the facility logbooks for the past six months verified visitation and special visitation are conducted as required. Youth are also provided

weekly telephone calls, writing material and a self-addressed stamped envelope to talk and send letters to approved family members. Youth can have unimpeded access with the courts, attorneys, the assigned juvenile probation officer, and/or the Department of Children and Families case worker. Observation of the cottages indicated the visitation and telephone schedules were visibly posted in the youth's living area. Seven youth were interviewed, and each indicated they are given the opportunity to communicate with family members by mail, telephone, and/ or visitation.

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

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

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

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

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

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

Program Name: Okeechobee Youth Treatment Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): January 8-11, 2019

MQI Program Code: 1325
Contract Number: 10188
Number of Beds: 80
Lead Reviewer Code: 125

Overall Rating Summary

Overall Rating Summary
This program has received an overall program compliance rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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

Limited Ratings	Failed Ratings
1.07 Pre-Service/Certification Requirements*	1.10 Delinquency Interventions and Facilitator Training
1.17 Advisory Board	1.12 Restorative Justice Awareness for Youth
2.15 Treatment Team Meetings (Formal and Informal Reviews)	3.03 Non-Licensed MH/SA Clinical Staff
3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	3.12 Suicide Precaution Observation Logs*
3.06 MH/SA Treatment	5.21 Recreation and Leisure Activities
3.07 Treatment and Discharge Planning*	
3.08 Specialized Treatment Services*	
3.11 Suicide Prevention Services*	
3.13 Suicide Prevention Training*	
5.04 Ten-Minute Checks*	
5.13 Tool Inventory and Management	