STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Okeechobee Youth Treatment Center Re-Review

TrueCore Behavioral Solutions, LLC

(Contract Provider)

[Street Address]

Okeechobee, Florida 34972

Review Date(s): June 18-21, 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)
Keith Bennis, Office of Program Accountability, Regional Monitor (Standard 5)
Christine Calvert, Office of Program Accountability, Regional Monitor (Standard 3)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 5 and Interviews)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 4)
Maryann Sanders, Office of Program Accountability, Regional Deputy Supervisor (Standard 2)

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
RE-REVIEW ADDENDUM

Program Name: Okeechobee Youth Treatment Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): June 18-21, 2019

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings		Original Review 01/11/19	Re-Review 06/21/19
Standard 1 - Management Accountability			
1.01	* Initial Background Screening	Satisfactory	Satisfactory
1.02	Five-Year Rescreening	Satisfactory	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory	Satisfactory
1.04	* Management Response to Allegations	Satisfactory	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory	Satisfactory
1.07	* Pre-Service/Certification Requirements	Limited	Satisfactory
1.08	In-Service Training	Satisfactory	Satisfactory
1.09	Grievance Process	Satisfactory	Failed
1.1	Delinquency Intervention and Facilitator Training	Failed	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory	Satisfactory
1.12	Restorative Justice Awareness for Youth	Failed	Limited
1.13	Gender-Specific Programming	Satisfactory	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Satisfactory	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory	Satisfactory
1.16	Youth Input	Satisfactory	Satisfactory
1.17	Advisory Board	Limited	Satisfactory
1.18	Program Planning	Satisfactory	Satisfactory
1.19	Staff Performance	Satisfactory	Limited

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

Standard 2: Youth Management
Residential Rating Profile

Indicator Ratings		Original Review 01/11/19	Re-Review 06/21/19
Standard 2 - Assessment and Performance Plan			
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory	Satisfactory
2.02	Youth Orientation	Satisfactory	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory	Failed
2.10	Performance Plan Revisions	Satisfactory	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory	Failed
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory	Satisfactory
2.13	Members of Treatment Team	Satisfactory	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Limited	Satisfactory
2.16	Career Education	Satisfactory	Satisfactory
2.17	Educational Access	Satisfactory	Satisfactory
2.18	Education Transitions Plan	Satisfactory	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory	Satisfactory
2.20	Exit Portfolio	Satisfactory	Satisfactory
2.21	Exit Conference	Satisfactory	Satisfactory

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

Indicator Ratings			
		Original Review 01/11/19	Re-Review 06/21/19
Standard 3 - Mental Health and Substance Abuse Services			
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Limited	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Failed	Limited
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Limited	Satisfactory
3.07	* Treatment and Discharge Planning	Limited	Satisfactory
3.08	* Specialized Treatment Services	Limited	Satisfactory
3.09	* Psychiatric Services	Satisfactory	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory	Satisfactory
3.11	* Suicide Prevention Services	Limited	Satisfactory
3.12	* Suicide Precaution Observation Logs	Failed	Satisfactory
3.13	* Suicide Prevention Training	Limited	Satisfactory
3.14	* Mental Health Crisis Intervention Services	Satisfactory	Satisfactory
3.15	* Crisis Assessments	Satisfactory	Satisfactory
3.16	* Emergency Mental Health and Substance Abuse Services	Satisfactory	Satisfactory
3.17	* Baker and Marchman Acts	Non-Applicable	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings		Original Review 01/11/19	Re-Review 06/21/19
	Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory	Satisfactory
4.02	Facility Operating Procedures	Satisfactory	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory	Satisfactory
4.04	Parental Notification	Satisfactory	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory	Satisfactory
4.06	Immunizations	Satisfactory	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory	Satisfactory
4.08	Medical Alerts	Satisfactory	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory	Satisfactory
4.12	Health Related History	Satisfactory	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory	Satisfactory
4.17	HIV Testing	Satisfactory	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory	Satisfactory
4.20	Room Restriction/Controlled Observation	Non-Applicable	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory	Satisfactory
4.22	Emergency Care	Satisfactory	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory	Satisfactory
4.25	Medication Management - Verification	Satisfactory	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory	Satisfactory
4.27	Medication Management - Storage	Satisfactory	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory	Satisfactory
4.35	Infection Control - Education	Satisfactory	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable	Non-Applicable

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings			
		Original Review 01/11/19	Re-Review 06/21/19
	Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory	Satisfactory
5.04	*Ten Minute Checks	Limited	Failed
5.05	Census, Counts, and Tracking	Satisfactory	Satisfactory
5.06	Logbook entries and Shift Report Review	Satisfactory	Satisfactory
5.07	Key Control	Satisfactory	Limited
5.08	Contraband Procedure	Satisfactory	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory	Satisfactory
5.11	Transportation of Youth	Satisfactory	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory	Satisfactory
5.13	Tool Inventory and Mangement	Limited	Limited
5.14	Youth Tool Handling and Supervision	Satisfactory	Satisfactory
5.15	Outside Contractors	Satisfactory	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory	Satisfactory
5.21	Recreation and Leisure Activities	Failed	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable	Non-Applicable
5.23	Visitation and Communication	Satisfactory	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable	Non-Applicable
5.25	Controlled Observation	Non-Applicable	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable	Non-Applicable

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Summary

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 re-review, the program had twenty-six vacant positions; which included two case managers, one group facilitator, one transitional service manager, four therapists, one recreational therapist, one shift supervisor, fourteen youth care worker-I (YCW) positions, and two YCW-II positions. 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 re-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)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 fifteen newly hired staff, one contracted 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 nine employee records revealed each employee passed both portions of the pre-employment assessment tool. There was documentation in all nine 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance** rating for this indicator. 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 three staff and two contracted staff applicable for a five-year rescreening during this annual compliance re-review period. Each staff's re-screening was completed and submitted to the Department's Background Screening Unit/Clearinghouse prior to their anniversary date. There were no volunteers who required five-year re-screenings since the last annual compliance review.

1.03 Provision of an Abuse-Free Environment (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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. However, the telephones for direct connection to the Florida Abuse Hotline were not working in all the five cottages due to internet issue during the re-review week. Documentation supported the service company had been contacted and in the process of fixing the Florida Abuse Hotline telephone. The program's facility administrator (FA) reported youth are brought to a case manager office or a therapist office upon requesting an abuse call and the youth will pick up the telephone and place the call. The program's normal practice when the telephones are working 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 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 nine 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 were three reviewed abuse allegations reported to the Florida Abuse Hotline and CCC during the annual compliance re-review period and the investigation remained ongoing in two of three during the annual compliance re-review.

Nine interviewed youth reported never being stopped from reporting abuse to the Florida Abuse Hotline or CCC. Eight of the nine youth reported staff are respectful when speaking with them and one reported sometimes. Seven youth reported never hearing staff use curse words when speaking to youth, one reported once, and one reported occasionally. All nine-interviewed youth

reported feeling safe in the program. None of the nine-interviewed staff reported ever seeing a co-worker deny a youth an abuse call. All nine 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. Seven of the nine interviewed staff reported they had never observed a co-worker using profanity when speaking to youth and two 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)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 three allegations of abuse involving staff members within the last six months. Reviewed documentation found management took immediate action regarding the staff-involved incident by initiating an internal investigation regarding staff on each allegation of abuse. Documentation indicated two of the three abuse allegations were under investigation and ongoing at the time of the annual re-review. Documentation supported staff were removed from direct contact with youth. The third abuse allegation documentation showed the staff member was re-trained and received a written corrective action base on the outcome of the investigation.

1.05 Incident Reporting (CCC) (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures regarding response to incidents, which is in accordance with Florida Administrative Code. The program had twenty-five reportable incidents during this annual compliance re-review period. A review of five incident reports found all five were reported to the Department's Central Communications Center (CCC) within two hours of the incident or becoming aware of the incident. Four of the five applicable incidents were documented in the program's facility logbook and the non-applicable incident was anonymously reported. In reviewing the program's internal incident reports and grievance reports, there were no incidents which should have been reported to the CCC and 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY 18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures regarding the utilization of physical intervention techniques in accordance with Florida Administrative Code. The program had two 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 two 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. Both 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 1.51. 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)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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. Nine staff training records were reviewed for pre-service certification. Eight of the nine 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 November 5, 2018 and completed 100.5 hours of training by June 15, 2019. There was no documentation to show the staff was in the process of completing the remaining pre-service training hours. Documentation showed the staff was provided youth supervision 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures regarding in-service training for all staff. Nine staff training records were reviewed for in-service. Nine of the nine reviewed staff training records documented each staff member exceeded the twenty-four hours of annual in-service training requirements. However, in two staff training records documentation showed all the mandatory training were not completed. All nine-staff had current certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). Eight of the nine staff completed training in professionalism, ethics, and seven staff completed the six hours of suicide prevention training. In one record, there was no documentation of professional and ethics and the two hours SkillPro suicide prevention trainings. The other record was missing four hours instructor led for suicide prevention training, infection and exposure control, and safe use of tools. According to an interview with the program staff, the two-staff members were scheduled for the required training on several occasions; however, both staff did not attend. One of the three applicable staff exceeded the eight hours of management/supervisory training. One supervisor staff did not complete four of the eight hours of management and supervisory training required. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Failed Compliance rating** for this indicator. 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 time frames of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are also provided with the opportunity to file an alternative informal request by utilizing a Let's Talk form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and Let's Talk forms were readily available to youth, as observed during the facility tour. Reviewed documentation showed the program twenty Let's Talk forms submitted by youth since the last annual compliance review. The program did not maintain copies of the grievances since the last annual compliance review. According to the program staff, grievances forms completed after January 11, 2019, were unable to be located. The Department's review team was unable to review the program's grievance process during the annual re-review period. Nine pre-service staff training records and nine in-service training records were reviewed. All eighteen training records documented each staff received the required training on the program's grievance process and procedures. During the annual compliance re-review, nine youth and nine staff were interviewed. The nine youth were able to explain portion of the grievance process to include submission of a completed grievance form into the secured grievance box. All nine interviewed youth reported being able to request assistance in completing a grievance form, if needed. All nine 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. The grievances are reviewed in the morning meeting with the management team and addressed with the youth within seventy-two hours.

1.10 Delinquency Interventions and Facilitator Training

The program originally received a **Failed Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 one staff trained to facilitate T4C. The facilitator had a bachelor's-level degree 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. A review of the program's activity schedule confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. The T4C groups are held twice a week, for one hour each. A review of nine youth records confirmed all nine youth were either currently in or had completed the T4C group and had goals in performance plan to address the delinquency needs.

1.11 Life Skills Training Provided to Youth

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 groups are 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 nine case management records and group sign-in sheets indicated services were delivered, as required. Reviewed documentation showed all nine youth were actively participating in Skillstreaming the Adolescent groups. An interview with nine program staff stated youth can practice skills in group role-play activities and interactions with staff and youth while at the program. All nine 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 make better decisions, and how to have one-on-one communication with a person. 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

The program originally received a **Failed Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Limited Compliance rating** for this indicator. The program has a policy and procedures for the provision of restorative justice awareness to the youth. A review of the program's contract indicated Impact of Crime (IOC) curriculum is a required service to be provided to all youth in the program. The program provides restorative justice activities through the IOC curriculum, which is a program with demonstrated effectiveness, as outlined in the Department's Sourcebook of Delinquency Interventions. The program's current activity schedule showed there were five IOC groups in progress, facilitated two times a week for one hour for each group. Documentation showed group schedules were not followed in three of the five IOC groups. There was one month gap of service delivery for three of the five groups. Four of the nine youth case management records review showed a gap in IOC services.

1.13 Gender-Specific Programming

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 nine 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 football, basketball, and kickball. The program staff also reported Teen Relationships and Skillstreaming the Adolescent groups are adjusted to address specific gender issues when necessary. All nine interviewed youth reported they participated in substance abuse, anger management, and teen relationships groups.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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, 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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. Nine 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. Nine 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 staff, where the staff will update the alert board for the program.

1.15 Youth Records (Healthcare and Management)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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."

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains individual healthcare, mental health and substance abuse, and case management records for each youth. Nine 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 Koger. 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. Nine 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

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a community advisory board, which serves six programs located in Okeechobee County. The advisory board meets quarterly and were combined due to a limited amount of people living in this rural community. Reviewed documentation supported the program's community advisory board meets at least quarterly. The reviewed meeting minutes, sign-in sheets, and agendas showed meetings occurred in December 2018, March 2019, and June 2019. The next community advisory board meeting is scheduled for September 18, 2019. The advisory board members currently consist of a member from law enforcement, interested community partners, a community business member, school board member, victim advocate/victim services member, a parent/guardian whose child was previously involved in the juvenile justice system, a member from the judiciary, and a faith-based community member. A review of community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and community service activities. The board rotates meeting locations between Okeechobee Juvenile Offender Correctional Center, Okeechobee Youth Development Center, and Okeechobee Girls Academy each quarter and serves as the board for Okeechobee Youth Treatment Center and Okeechobee Intensive Halfway House as well. A telephone call was made during the annual compliance re-review to the local sheriff who serves as a board member and indicated they send an officer to participate in the scheduled meetings and also confirmed the program's regular invitations to events and meetings.

1.18 Program Planning

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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. Nine interviewed staff reported staff meetings are held monthly and shift briefings daily. Five interviewed staff reported the communication amongst the staff at the program is good, two staff reported fair, one reported very poor, and one 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 security alerts, staff attendance, drills, 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Limited Compliance rating** for this indicator. The program conducts ninety-day performance evaluations for newly hired staff, and annual

evaluations for all staff. Nine personnel records were reviewed, of which five were applicable for an annual performance evaluation and four were applicable for a ninety-day performance evaluation. The five applicable records which required an annual performance evaluation contained the evaluation. The four applicable records which required a ninety-day performance evaluation did not contain the evaluation. The performance evaluations were specific to the applicable staff's job description in five of the nine records and four were not completed. The five-reviewed performance evaluations found each staff's evaluation was based on the performance standards for their position. 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 nine-interviewed staff reported receiving an annual evaluation and/or a ninety-day evaluation. An interview with the facility administrator (FA) reported staff are given an annual performance evaluation by their supervisor. The program's FA reported each staff evaluation is to determine how the staff performed throughout the year, and to identify areas the staff are excelling or need improvement. The program is required to ensure all contractually required positions are being maintained and performed as outlined in the contract. The program's staff vacancy list was updated during this annual compliance re-review and reported twenty-six staff vacancies. Vacancies included two case managers, one group facilitator, one transitional service manager, four therapists, one recreational therapist, one shift supervisor, fourteen youth care worker-I (YCW) positions, and two YCW-II positions.

Standard 2: Assessment and Performance Plan

2.01 Initial contacts to Parent/Guardian and Court Notification

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing initial contact to parents/guardians and the committing court upon each youth's admission. Nine reviewed case management records found each parent/guardian or the Department of Children and Families (DCF) worker was notified by telephone and in writing of the youth's admission within twenty-four hours of arrival to the program. Each of the nine reviewed records confirmed youth were provided a telephone call to the parent/guardian or DCF worker at the time of admission. Additionally, each record documented an admission letter and an input questionnaire sent to the parent/guardian or DCF worker when applicable within forty-eight hours of each youth's admission. Nine case management records were reviewed, and each record documented the program's practice of sending a notification letter to the committing court(s). The written notification was mailed to the committing court within twenty-four hours of each youth's admission to the program and a copy was sent to each assigned juvenile probation officer. None of the reviewed records documented the youth were assigned to a post-residential counselor at the time of admission.

2.02 Youth Orientation

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing youth orientation. A review of nine case management records supported each youth was provided an orientation within twenty-four hours of admission. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet and information on the program's daily schedule, expectations and youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) number, contraband, dress code and hygiene procedures, community access, grievance procedures, emergency procedures and assigned living units. The orientation packet provided to each youth included a map of the facility and designated areas which are not accessible to youth. The reviewed records also validated each youth received a copy of the youth handbook which outlined the program rules governing conduct and positive/negative consequences for behavior. Review of program logbooks reflected each admission is documented. Nine interviewed youth reported their orientation included program rules, procedures, schedules and all other pertinent information. Each interviewed youth confirmed the orientation was conducted on the day they were admitted to the program.

2.03 Written Consent of Youth Eighteen or Older

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Nine 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 reviewed record contained the required signed consent of each youth. Two youth were eighteen years old at the time of admission to the program and the consent was sign on the date of admission. Two youth turned eighteen years old subsequent to admission and each signed a consent on or within one week of their birthday but prior to sharing information.

2.04 Classification Factors, Procedures, and Reassessment for Activities

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procures addressing the classification process. The policy

outlines the effective delivery of treatment services based on determination of each youth's individual needs and risk factors. The program's policy also addresses when reassessments are warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and behavioral concerns. A review of nine case management records found each youth had a completed admission classification for the purpose of assigning youth to a living/sleeping area and staff advisor. Each reviewed admission classification form was completed on the date of admission for each youth. During an interview, the program's facility administrator reported a classification meeting is conducted at each youth's admission and all classification factors are taken into consideration when deciding where to place the youth. Nine admission classification forms were reviewed and six were applicable for having an alert entered into the Department's Juvenile Justice Information System (JJIS). Documentation confirmed the appropriate alerts were entered for applicable youth. The program has an internal alert system. All program alerts are maintained and updated as needed on an alert board which is accessible to all staff. In addition, alerts are reviewed at each shift's briefing and at monthly all-staff meetings.

The program's policy and procedures address reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other actives which involve the use of tools, and a youth's participation in any off-campus activities. Nine reviewed case management records indicated each youth was applicable for reassessment prior to participation in activities, work projects, consideration for an increase in privileges or freedom of movement. Each reviewed record documented the completion of a reassessment which included review of the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. Documentation confirmed reassessment results were discussed at treatment team meetings. It is the program's practice to complete a reassessment each month for each youth and documentation supported this was completed in each of the nine youth case management records reviewed.

2.05 Gang Identification: Notification of Law Enforcement

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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).

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing gang identification which includes notification to law enforcement. The program assesses each youth at admission for suspected gang involvement. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS). Nine case management records were reviewed, and three were applicable for gang involvement or association. Documentation validated the program notified the local law enforcement's gang liaison by electronic mail of two youth admitted to the program who were identified as a gang associate or

gang member. The program notified the gang liaison of the third youth's gang affiliation during the annual compliance review. The law enforcement gang liaison notifies the local law enforcement in each youth's home county if identified as a gang member or gang associate post-admission. The gang information is also shared with the educational staff at the program, the youth's juvenile probation officer (JPO), and the post-residential services counselor, if applicable. The program has identified each case manager as a gang liaison.

2.06 Gang Identification: Prevention and Intervention Activities

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a gang binder to include information on youth documented as gang members or associated with a gang. Nine youth case management records were reviewed for participation in gang prevention and intervention activities and three were applicable. Documentation supported each of the three applicable youth were documented in the gang binder as associated with or a member of a gang and each had a performance plan which included gang prevention and intervention strategies. Each individual performance plan (IPP) documented gang interventions; however, the interventions for two of the three applicable youth were added to the IPP sixty to ninety days after admission. The program utilizes Impact of Crime (IOC), Arise Foundation, and 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.

2.07 R-PACT Assessment and Reassessments

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. A review of nine case management records found eight contained a Residential Positive Achievement Change Tool (R-PACT) assessment completed within thirty days of the youth's admission to the program. The R-PACT for one youth was completed five days late. Each R-PACT was completed in the Department's Juvenile Justice Information System (JJIS) and was used to identify criminogenic risk and protective factors and prioritized the youth's criminogenic needs. A copy of the R-PACT assessment overview report was maintained in each youth's case management record. Nine reviewed case management records found eight were applicable for a R-PACT Reassessment. One youth was not in the program for over ninety-days; therefore, a R-PACT Reassessment was not required. Documentation supported seven of the eight R-PACT Reassessments were completed within ninety-days of the initial R-PACT Assessment. One R-PACT Reassessment was twenty-four days late. Each R-PACT Reassessment was maintained in the youth's case management record. There were no other updates or reassessments deemed necessary by the intervention and treatment team.

2.08 Youth Needs Assessment Summary (YNAS)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. Nine case management records were reviewed, and seven contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of the youth's admission to the program. One YNAS was completed nineteen days late and one was completed fifteen days late. Reviewed documentation supported each YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in each youth's case management record.

2.09 Performance Plan Development, Goals and Transmittal (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Failed Compliance rating** for this indicator. The program has a policy and procedures addressing performance plan development. The treatment team, including the youth, meet and develop the individual performance plan (IPP), based on the findings of the initial assessment of each youth within thirty days of the youth's admission. Nine youth case management records were reviewed, and five documented the IPP was developed within thirty days of the youth's admission. One IPP was twelve days late, one was seventy-eight days late, one was five days late, one was six days late, and one was fifteen days late. The treatment team members who participated in the development of the IPP for each youth included the case management representative, youth, administration representative, living unit representative, mental health treatment staff, and education staff for six of the nine youth and was verified by each member's signature and date on the IPP. Two youth under the supervision of the Department of Children and Families (DCF) had no documentation to support the DCF caseworker provided input in the development of the IPP. One youth had no documentation to reflect any member of the treatment provided input in the development of the IPP, as the plan was not signed and there were no corresponding case notes. The reviewed performance plans for each of the nine youth were developed after the initial assessment.

The IPP is a document developed by the treatment team, including the youth, which stipulates goals the youth must achieve prior to release from the program. The goals are measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include delinquency interventions, targeted

court-ordered sanctions, and identified transition activities. Nine youth IPPs were reviewed and each included individualized goals based on prioritization needs. All goals included specific interventions which were measurable, included youth and staff responsibilities to complete the goals, and included projected target dates for completion. A review of nine youth disposition court orders indicated four were applicable for additional court ordered sanctions besides court fees and documentation validated these sanctions were included in the youth's IPP. All nine reviewed records indicated each youth was enrolled in education and career programing. Each of the nine reviewed IPPs addressed the top three criminogenic needs of the youth and documented transition activities. Nine interviewed youth reflected each was familiar with their IPP goals and were able to explain the treatment process. Each interviewed youth confirmed they received a copy of their initial IPP and were aware of their current goals. Additionally, one youth observed at a treatment team meeting during the annual compliance review was able to identify and discuss their IPP goals.

The individualized performance plans are signed by each youth and treatment team leader, as well as all parties with significant responsibility in goal completion. Within ten working days of completion of the IPP, the program sends a transmittal letter, and a copy of the IPP to the committing court, each youth's juvenile probation officer (JPO), and each parent/guardian. Nine youth case management records were reviewed, and seven indicated a transmittal letter and a copy of the performance plan was sent within ten working days to the committing judge, JPO, parent/guardian, and Department of Children and Families (DCF) worker when applicable. One transmittal was sent six days late and one was not sent. All nine IPPs were signed by the youth, treatment team leader, and all significant parties responsible for the goal completion; however, one IPP was signed by all parties seventy-seven days after it was created with a note stating, "lost original". The program mailed all nine IPPs to the parents/guardians or DCF worker to sign and return to the program; however, only one was returned. Interviews with nine youth confirmed each received a copy of their IPP.

2.10 Performance Plan Revisions

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing performance plan revisions. Nine youth case management records were reviewed, and seven were applicable for a revision to the individual performance plan (IPP). Documentation supported each IPP was revised based on the Residential Positive Achievement Change Tool (R-PACT) Reassessment results, newly

acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and/or completing a goal. Documentation found IPPs were updated with recommendations from the treatment team. Three closed youth case management records were review and documentation found each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

2.11 Performance Summaries and Transmittals

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Failed Compliance rating** for this indicator. The program has a policy and procedures addressing performance plan summaries and transmittals. Nine case management records were reviewed, and seven were applicable for requiring a performance summary. Documentation validated two performance summaries were completed every ninety-days following the signing of the initial performance plan. Five performance

summaries were completed late with two summaries ten days late, one was twenty-three days late, one was six days late, and one was twenty-four days late. All performance summaries included the youth's overall progress on the treatment plan, academic status, behavior, level of readiness to change, interactions with peers and staff, the status of each goal, and significant positive or negative events. Each reviewed performance summary was signed by each youth and included comments, and each original performance summary was filed in the youth's case management record. Each of the seven reviewed case management records contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and the parent/guardian or Department of Children and Families worker when applicable.

Three closed youth case management records were reviewed for completion of a release summary. Documentation supported a release summary was completed and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least ninety-days prior to the youth's planned release in two of the three records. One release summary and PRN was forwarded to the JPO twenty-one days late. Each of the three-applicable closed case management records contained the signed PRN. No youth were applicable for the sexually violent predator program (SVPP) and victim notification.

2.12 Parent/Guardian Involvement in Case Management Services

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures which addresses encouraging parent/guardian involvement in case management services. Each parent/guardian is contacted by telephone by

the case manager upon each youth's admission to the program, and a welcome letter is mailed within forty-eight hours of admission. The welcome letter includes a calendar of all treatment team meetings and parents/guardians are encouraged to participate in person or on the telephone. Parents/guardians are involved in the assessment process, the development of the youth's performance plan, and progress reviews. One treatment team meeting was observed during the annual compliance review which confirmed the program's practice of the parent/guardian providing input by telephone. The program also hosts family days one a quarter and weekly visitation. Nine interviewed youth reported their parent/guardian is involved in their case management process and treatment team meetings. Each youth reported all participation is conducted over the telephone. During an interview, the program's facility administrator stated each youth's parent/guardian is contacted by the assigned case manager upon admission and is consistently updated on the youth's progress or lack thereof during the entire stay in the program. In addition, parents/guardians are invited to all special events including quarterly family days.

2.13 Members of Treatment Team

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing treatment team and its members. At a minimum, treatment team includes the youth, representative from the program's administration, living unit representative, education, and others responsible for providing or overseeing the provision of intervention and treatment services. At admission, each youth is assigned to a treatment team. Nine youth case management records were reviewed, and each documented youth participated in an initial treatment team meeting. Documentation reflected attendance of all required members of treatment team inclusive of each youth's case manager, a representative from administration, a living unit representative, educational staff, mental health staff, the assigned juvenile probation officer (JPO), and the youth's parent/guardian or Department of Children and Families worker when applicable.

2.14 Incorporation of Other Plans into Performance Plans

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. Each youth's performance plan shall reference or incorporate the youth's treatment or care plan. Nine youth case management records were reviewed. Each had separate academic, mental health and/or substance abuse, and wellness plans which were incorporated into the individual performance plan for all nine youth. The goals included the responsibility of the program staff in assisting the youth to successfully complete the goal(s). Two youth were under the supervision of the Department for Children and Families (DCF); however, neither had a separate DCF plan. An Agency for Persons with Disabilities (APD) behavior support plan was not applicable for any the nine youth records reviewed.

2.15 Treatment Team Meetings (Formal and Informal Reviews)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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 reviews 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures addressing formal and informal treatment team meetings. Nine case management records were reviewed and each documented formal treatment team reviews were conducted at least once every thirty days and informal treatment team reviews were conducted at least once within thirty-days for eight of the nine youth. One youth did not have an informal treatment team meeting during the month of February 2019. The program utilized a performance plan review form which included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions. Reviewed documentation confirmed formal treatment team meeting attendees consisted of the youth, case management staff who act as the treatment team leader, clinical staff, education, and a program administration representative for eight of the nine youth. One youth was missing the program administration representative and a mental health/substance abuse representative for the months of March 2019 and April 2019 and missing the program administration representative and living unit representative for the month of May 2019. Each youth's juvenile probation officer (JPO), parent(s)/guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and Residential Positive Achievement Change Tool (R-PACT) Reassessment results. All staff gave relevant input on the youth and agreed on how to proceed to formal treatment team. An observation of one formal treatment team meeting conducted during the annual compliance review reflected the youth was present and was allowed to demonstrate skills acquired at the program. The youth exhibited verbal skills by reading a prepared document highlighting the progress made while in the program. The youth's progress on performance goals, stages of change, education, behavior, and treatment progress were also discussed. Observed attendees included the treatment team leader/case manager, the youth, a representative from administration, education staff, medical staff, living unit representative, and clinical staff. Attempts were made to contact the assigned JPO and parent/guardian on the telephone; however, neither was available.

2.16 Career Education

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program provides career education opportunities through the Washington County School District and 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 provides 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. In an interview, the program's lead teacher stated the program's vocational programming includes Building Construction Technology, which is aligned with the National Center for Construction Education and Research (NCCER) program standards and Workplace Essentials which provides students subject area knowledge as well as hands-on opportunities. The NCCER components include Core Curricula and Electrical and Construction Technology. The Building Technology instructor is also certified in Occupational Safety and Health Administration (OHSA) Safety which allows students the opportunity to complete training to obtain OSHA certification cards. The program also offers a Computer Science and Information Technology course which focuses on data programming, network management, hardware and software design, and web programming. This course combines hands-on instruction with lecture components. The lead teacher stated youth also receive training in the ServeSafe program which covers all areas including necessary information and exams to certify students to receive ServeSafe certificates which are required in the food service industry. All youth are assigned an elective period within the school day during which they select a career discovery course to complete. Youth are given a variety of career related courses to choose from within the Plato courseware. The program had twenty youth enrolled in the career discovery course during the 2018-2019 school year. An interview with the facility administrator validated the career education courses offered at the program.

2.17 Educational Access

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program operates on a year-round basis providing educational services. An interview with the program's lead teacher explained 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 their placement in the program. According to the lead teacher, 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 nine 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 career education programming. The program ensures youth are provided instruction with minimal interruption and a review of program logbooks and observation during the annual compliance review validated this practice. 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. Nine interviewed youth reported there are no interruptions during educational instruction.

2.18 Education Transition Plan

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a policy and procedures in place regarding educational transition plans. A review of three closed youth case management records supported each education transition

plan was initiated during the youths' admission process and documented all required elements. Each youth's record contained documentation supporting the youth was involved in the development of their transition plan. Each reviewed plan addressed services and interventions based on the youth's assessed educational needs and post-release education plan. Documentation reflected services were provided during the youth's stay at the program and services were implemented once the youth was released. The education staff also provided recommended educational placement post-release and 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)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. Three closed case management records were reviewed for transition planning conference and community re-entry team meeting. Reviewed documentation validated two transition conferences were conducted at least sixty days prior to the youth's release date. One transition conference was conducted three days late. All pertinent parties were invited to attend the transition conference through advanced notice and encouraged to provide written input if unable to attend. Reviewed documentation in all three transition conferences supported the youth, case manager who also acted as the treatment team leader, the program director or designee, educational staff, mental health staff, and medical staff participated in person, and the parent/guardian and the assigned juvenile probation officer (JPO) participated by phone or documented attempted telephone contact with the parent/guardian. The transition activities and target dates were reviewed, and all required signatures were obtained. A copy of the transition plan and conference were electronically send to the JPO for all three youth and each closed record contained an electronically signed copy of the form. A copy of the transition plan and

conference were mailed to each parent/guardian; however, none were returned with a signature. Each transition conference included a discussion of all transition activities including persons responsible for completing the activities and targeted completion dates.
Each of the three reviewed closed records contained documentation supporting a community re-entry team (CRT) meeting was conducted. Each reviewed record documented the youth and case manager's participation in the CRT meeting.

2.20 Exit Portfolio

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program assembles an exit portfolio for each youth to assist the youth upon reintegration back into the community. A review of three closed case management records found the exit portfolios were discussed and signed by each youth during the transition conferences. Each youth's exit portfolio included a copy of the transition plan, calendar with dates/times/locations of follow-up appointments in the community, social security card, birth certificate, State of Florida Identification card, vocational certificates, school transcripts, résumé, and a sample job application. Reviewed documentation confirmed educational staff forwarded information to the receiving school board when applicable and program staff sent a copy to the juvenile probation officer (JPO) for each youth. Youth were provided with completed forms and clear instructions on how to obtain relevant information when applicable. All responsible staff were identified during the transition conference to assist the youth in obtaining the required information to successfully complete their goals.

2.21 Exit Conference

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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 juvenile probation officer (JPO), which confirmed the youth's release date and transportation arrangements for the youth's return to the community.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. Three closed case management records were reviewed for completion of the exit conference at least fourteen days prior to each youth's release. Reviewed documentation found two exit conferences were conducted at least fourteen days prior to the youth's release. One was conducted three days late. Reviewed documentation in all three exit conferences supported the youth, case manager who also acted as the treatment team leader, the program director or designee, educational staff, mental health staff, and medical staff participated in person, and the parent/guardian and the assigned juvenile probation officer (JPO) participated by phone or documented attempted telephone contact with the parent/guardian. The transition activities and target dates were reviewed, and all required signatures were obtained. A copy of the exit conference was electronically sent to the JPO for all three youth and each closed record contained an electronically signed copy of the form. A copy of the exit conference was mailed to each parent; however, none were returned with a signature. The date of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS) for each of the reviewed records.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program's designated mental health clinician authority (DMHCA) position was vacant for more than a year prior to the hiring of a DMHCA on April 22, 2019. The campus-wide director of treatment services was previously assuming the responsibilities of the position and continues to assist on-site as needed. The DMHCA is currently completing on the job training and assumed the roles and responsibilities of the DMHCA on June 3, 2019. A review of the DMHCA license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is a licensed clinical social worker (LCSW). The DMHCA is on-call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health and substance abuse services at the program. A review of the DMHCA's job description and an on-site interview verified the role and responsibilities of the position. The current DMHCA reported being on-site Monday through Friday for a minimum of forty hours and providing clinical services only at Okeechobee Youth Treatment Center. The current DMHCA is carrying a caseload of thirteen youth as of June 7, 2019. The DMHCA explained the necessity to carry a caseload could not be avoided due to the program having four current therapist vacancies. The program has an operating capacity of eighty youth and does not utilize a clinical coordinator.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has one full-time licensed clinical social worker (LCSW) serving as the designated mental health clinician authority (DMHCA). The DMHCA is supervised by the campus-wide director of treatment services whom is a licensed mental health counselor (LMHC). The program maintains an agreement for professional services with a State of Florida board-certified licensed psychiatrist who is scheduled to be on-site weekly. The program has an agreement with a certified behavior analyst and a psychologist who offer services as needed. Reviewed documentation found each licensed clinician maintained a clear and active license in the State of Florida. The reviewed records demonstrated each staff worked within the scope of their licensure, experience, and training. The program's DMHCA and psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week. The program is licensed through the Department of Children and Families (DCF) in accordance with Chapter 397, Florida Statutes, to provide substance abuse services for outpatient treatment.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff

The program originally received a **Failed Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Limited Compliance rating** for this indicator. The program has one full time group facilitator, a designated mental health clinician authority (DMHCA), one lead therapist position, and six therapist positions. The group facilitator and seven therapist positions are all non-licensed positions. The program reported four therapist vacancies at the time of the annual compliance review. The program is situated on a large campus comprised of three additional programs. A review of youth interviews and youth records reflected the program shares staff with the neighboring programs shared under the same contract number. A review of case notes showed in the last six months six master's level non-licensed therapists, the campus-wide director of treatment services, two licensed staff, and three group facilitators have provided treatment planning, assessment, crisis and suicide intervention, and therapy services to youth at the program. The program has been utilizing three borrowed master's level therapists from programs on the same campus to assist in group facilitation. Additionally, clinical staff have been receiving clinical supervision, and treatment planning assistance from clinical directors on the same campus under a shared contract number.

The program's regional staff submitted the following statement regarding retention and recruitment during the annual compliance review. "TrueCore is addressing both retention and recruiting at all levels. TrueCore has added a chief administration officer with a primary function of overseeing the filling of professional positions. A new vice president of human resources and a recruiting manager have also been put in place. In addition, we continue to utilize the corporate recruiter for clinical positions on a global level as well as a local general recruiter participating in job fairs. Retention has been a primary focus of the program as well. A retention meeting was held in March, the outcome of the meeting was to increase therapist and clinical director salaries for current employees. They also will be offered compensation for taking on cases outside of their normal eight-hour workday. Both of those strategies have been put into place. The program is also offering retention bonuses to be paid out after one year of employment. TrueCore is conducting a comprehensive wage analysis to ensure our current staff are being compensated within the industry standard as well as to attract a larger pool of clinical applicants. The program also is offering relocation funds and sign on bonuses and retention bonuses as well as continued housing opportunities for clinical director positions. TrueCore also added a Locum Tenens Provider, Maxim, to recruit full time clinicians".

The program's contract limits therapist caseload to sixteen youth; however, review of clinical supervision notes found documentation stating the program's lead therapist was assigned twenty-four youth and one non-licensed therapist were assigned seventeen youth as of May 15, 2019. The program's DMHCA reported carrying a caseload of thirteen youth as of June 7, 2019 due to staff vacancies. The program provided a therapist case load assignment list during the annual review showing sixty-eight youth were shared amongst five clinical staff and within caseload limits; however, one of the assigned therapist has resigned effective June 22, 2019,

and the program's lead therapist was promoted to another position within the organization the day after the annual compliance review.

A review of weekly clinical supervision for nine non-licensed staff providing services to program youth over the past six months was conducted. Documentation supported each staff received the required face-to-face weekly supervision, with the exception of one group facilitator. The group facilitator was missing four weeks of clinical supervision for the month of January 2019. The reviewed documentation found the clinical supervision logs included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. Each reviewed direct supervision log included all information as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. A review of the training records for the non-licensed staff validated completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation included the administration of five Assessments of Suicide Risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form.

3.04 Mental Health and Substance Abuse Admission Screening

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures to ensure each youth's mental health

and substance abuse needs are identified through a comprehensive screening process, including suicide prevention. 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 policy is to also complete a records review form for each newly admitted youth outlining the review of all available information inclusive of the commitment packet, reports, and records of suicide risk, mental health, and/or substance abuse issues by the mental health staff upon intake. Nine youth mental health and substance abuse records were reviewed, and each was applicable for the completion of a MAYSI-2. Each of the nine records contained a completed records review form and a completed MAYSI-2 administered on the day of admission in a confidential manner by trained staff. Eight of the nine reviewed MAYSI-2s reflected the screening was completed on the Department's Juvenile Justice Information System (JJIS) as required. One reviewed MAYSI-2 documented the assessment and scoring in JJIS were completed by two different staff. The program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results; therefore, no additional referrals are generated during the intake process. There were no instances where a staff member believed the youth was in need of further evaluation contrary to the MAYSI-2 results in the nine reviewed records. There were no instances where the MAYSI-2 information indicated the need for a crisis intervention or emergency service in the nine reviewed records. In addition to completion of the MAYSI-2, the program's suicide risk screening process includes an initial evaluation of each youth during intake utilizing the Suicide Probability Scale (SPS) and the Department's Assessment of Suicide Risk (ASR). An ASR was completed in each of the nine reviewed records. Six of nine reviewed MAYSI-2 results indicated the need for further assessment and the need for further evaluation was clearly documented on the MAYSI-2. An interview with the facility administrator (FA) confirmed all youth are assessed for suicide risk upon admission utilizing the MAYSI-2. The FA further explained, youth with an indicator for suicide are placed on suicide precautions and immediately assessed using the ASR.

3.05 Mental Health and Substance Abuse Assessment/Evaluation

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. The program’s practice is to complete a new comprehensive mental health and substance abuse evaluation regardless of identified needs for each new admission. The master’s level non-licensed therapist is responsible for completion of the evaluation and to provide a provisional diagnosis. The program’s designated mental health clinician authority (DMHCA) is responsible for reviewing each comprehensive mental health and substance abuse bio-psychosocial evaluation and indicates a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review. 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 nine mental health and substance abuse records showed each was applicable for a new comprehensive mental health and substance abuse evaluation. Eight of the nine reviewed records contained an evaluation completed within thirty days of admission as required and one record did not contain a new or updated evaluation. The one record contained an evaluation completed by another program four months prior to admission. Six of the reviewed records documented the non-licensed staff completed the evaluation, and each of the evaluations were signed by the licensed staff within ten calendar days as required. The remaining two completed evaluations were conducted by a licensed mental health clinician. Each of the eight completed comprehensive mental health and substance abuse evaluations documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, and recommendations. Six completed comprehensive evaluations documented accurate original referral reasons indicated on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) and two documented incorrect information. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. Each of the nine reviewed records contained a signed consent obtained for substance abuse services. Eight of the nine evaluations were completed and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use.

3.06 Mental Health and Substance Abuse Treatment

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. Each youth's mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. The primary therapist develops the youth's individualized treatment plan based on identified needs, and treatment is provided by staff trained to perform the services provided. A review of nine youth mental health and substance abuse records documented each youth was assigned to a treatment team upon arrival to the program. Each youth record contained an admission card and an initial mental health and substance abuse treatment plan created the day of arrival.

Reviewed documentation supported each youth was assigned to a treatment team comprised of representatives from administration, education, medical, mental health, and substance abuse departments, in addition to the youth and parent/guardian. A review of case notes for each of the nine youth for the past six months supported mental health and substance abuse groups were being provided daily as scheduled. A review of prescribed services for nine youth for a six-month period showed three youth missed a total of four individual sessions, and one youth was missing one family session. A review of mental health and substance abuse group sign-in sheets supported groups were provided daily to youth as scheduled. The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents. The program's group facilitators and masters level therapists facilitate mental health and substance abuse groups. Nine youth were interviewed regarding participation in groups at the program. Each of the nine-youth reported participating in mental health and/or substance abuse groups in addition to restorative justice groups, life skills groups, and gender specific groups. Nine program staff were interviewed regarding mental health and substance abuse groups at the program. Each of the nine-interviewed staff reported therapists facilitate groups. An interview with the facility administrator and the designated mental health clinician authority confirmed the program offers mental health overlay or substance abuse overlay services for all youth.

3.07 Treatment and Discharge Planning

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures outlining responsibilities and required elements of mental health and substance abuse treatment services and planning. Nine mental health and substance abuse records were reviewed for an initial treatment plan. Each record contained an initial mental health substance abuse treatment plan documenting development on the day of admission. Each reviewed initial plan included signatures of the master's level non-licensed therapist, treatment team members who participated in the development of the plan, and the youth. Each plan was signed by a licensed clinician within ten days as required. Each reviewed plan also documented the plan was mailed to the parent/guardian. Each initial treatment plan was documented on the program's form and contained all elements outlined in the Department's initial Mental Health/ Substance Abuse Treatment Plan form. Three of the nine reviewed records were applicable for the youth being prescribed psychotropic medication. Each of the four applicable records documented the frequency of medication management and details regarding the prescribed medication. A review of nine youth mental health and substance abuse records found eight contained a completed individualized mental health and substance abuse treatment plan which was developed within thirty days of the youth's admission. One youth

record contained a plan created at the youth's previous residential setting. Each of the eight completed individualized plans was documented on the program's form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy. Each reviewed plan was signed by the clinical staff person creating the plan. Six of the eight completed plans documented signature of all treatment team members who participated in the development of the plan. One plan did not contain a case manager signature, and another documented signature of the youth and medical staff two days after the plan was created. Six of the eight completed plans documented signature by the licensed staff within ten days of completion as required. One documented signature by the licensed staff three days late and the other was signed one day late. Five of the eight completed plans documented the parent/guardian participated in plan development by telephone and three did not. Each of the eight completed plans included provisions for psychiatric services. A review of nine youth mental health and substance abuse records found individualized treatment plan reviews were completed every thirty days as required for eight records. One record showed the review was not yet due, because thirty days had not passed since the development of the individualized treatment plan. Each of the eight applicable records contained plan reviews documented on the program's form containing all elements of the Department's Individualized Mental Health/ Substance Abuse Treatment Plan Review form. Three closed records were reviewed for the completion of a mental health and substance abuse discharge summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/ Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth being released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

3.08 Specialized Treatment Services (Critical)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program provides 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 substance abuse related disorders. The program provides the youth with group therapy services seven days a week. The program's substance abuse treatment curricula include Pathways, anger management for substance abuse and mental health clients, Towards No Drugs, and Living in Balance. The program provides mental health groups using Thinking, Feeling and Behaving, Teen Relationships, Young Men's Work, strategies for anger management, Skills Streaming, and Passport curriculums. The program also provides each youth with monthly individualized treatment and family treatment, as prescribed by 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, and the program utilizes the services of a certified behavioral analyst (CBA) when necessary. An interview with

the program's designated mental health clinician authority (DMHCA) indicated the program offers substance abuse and mental health overlay services. The DMHCA confirmed the program's offerings of group counseling, family counseling, and individual sessions with youth. The campus wide director of treatment services reported the program ensures each youth receives services outlined in the contract by using trackers and reviewing group sign-in sheets. An interview with the facility administrator indicated the program provides MHOS and SAOS treatment to youth at the program, which includes daily therapeutic groups along with monthly individual and family therapy.

3.09 Psychiatric Services (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains 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 license showed the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program does not utilize an advanced registered nurse practitioner (ARNP). A review of the program's contract with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave; however, no back-up coverage was provided since the last annual compliance review. A review of the back-up psychiatrist's license showed it was a clear and active MD licensure in the State of Florida with an expiration date of January 31, 2021. The program's policy and practice is to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission. A review of nine youth mental health and substance abuse records showed each youth received an initial diagnostic psychiatric interview within fourteen days of their admission. Three of the nine reviewed records were applicable for a youth being admitted on prescribed psychotropic medications and three were applicable for psychotropic medications prescribed subsequent to admission. Each reviewed initial psychiatric interview 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. Each of the six youth records applicable for the prescription of psychotropic medications supported the youth was seen a minimum of every thirty days as required. Four of the six reviewed records were applicable for a change to an existing psychotropic medication and page three of the Clinical Psychiatric Progress Note (CPPN) documenting consent was completed as required. Two of the six records applicable for the prescription of psychotropic medications were applicable for a consent for youth in foster care and all applicable consents and/or court orders were present. A review of treatment team meeting notes and sign-in sheets for the past six months documented the psychiatrist's participation in treatment planning. There were no documented lapses in psychiatrist services for the nine records reviewed; however, the psychiatrist was not on-site for three weeks in the past six months. An interview with the program's health services administrator explained the psychiatrist did provide on-site services two times for one week to ensure all youth were seen as required. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported participation in weekly treatment team meetings and weekly on-site visits. The psychiatrist reported the role of providing initial psychiatric evaluations for every youth entering the program, providing medication management for all youth on psychotropic medications, and meeting with treatment team members and/or designated mental health clinician authority every week to review youth concerns at the program.

3.10 Suicide Prevention Plan (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written suicide prevention plan. The suicide prevention plan was last updated and approved by the campus wide director of treatment services on September 4, 2018, the psychiatrist on August 31, 2018, and the designated mental health clinician authority on June 3, 2019. The plan outlines the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. An interview with the facility administrator indicated staff receive suicide prevention training during pre-service and in-service trainings. Additionally, the program conducts mock emergency mental health drills at least quarterly on each shift.

3.11 Suicide Prevention Services (Critical)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedure. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services. The program maintains nine complete suicide response kits located in master control, medical, the cafeteria, the school area, and each of the five cottages. Observations during the annual compliance review confirmed each kit contained the knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct and Assessment of Suicide Risk (ASR) for all youth on the day of admission. A review of nine youth mental health and substance abuse records found each youth was screened upon admission utilizing the program's form and containing all elements included in the Department's Assessment of Suicide Risk (ASR) form. Each of the nine reviewed completed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. Three additional records were requested and reviewed for provided suicide prevention services. Two of the applicable records documented the youth was placed on suicide precautions due to admission screening results and one was placed on suicide precautions due to self-reporting suicidal thoughts. Each of the three records

documented the youth was referred and assessed on the same day they were determined to be at risk and each was placed and maintained on constant supervision status. Each of the three records documented the authorization of precautionary observation status, the completion of a suicide precautions observation log, and support services provided by the program's mental health staff. Each of the three records documented the completion of a Follow-up ASR completed the day after the ASR was completed. Each Follow-up ASR was completed on the program's form and contained all elements on the Department's Follow-up Assessment of Suicide Risk form. Two of the three reviewed Follow-up ASRs clearly documented the time, date, and results of a conference held with the facility administrator and the licensed mental health staff prior to stepping the youth to close supervision. One reviewed record did not document the conference with the licensed clinical staff; however, the assessment was electronically signed twenty-two minutes later by the licensed staff member. Each of the three reviewed records clearly documented telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. Each reviewed ASR and Follow-up ASR was completed by a licensed mental health staff or a master's level therapist working under the direct supervision of the licensed staff. A review of all master's level non-licensed therapists providing services at the program for the past six months showed each received the required twenty hours of ASR training under the direct supervision of a licensed professional. Each of the three reviewed records documented the completion of a mental status examination prior to stepping the youth from close to standard supervision. A review of the Department's Juvenile Justice Information System (JJIS) documented alerts were initiated and removed as required. A review of the program's shift reports and logbooks documented clear updates regarding youth on precautionary observation status. 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. Nine interviewed staff each indicated when a youth expresses suicidal thoughts staff notify the mental health staff, search the youth and their room, place the youth on constant sight and sound, and document supervision.

3.12 Suicide Precaution Observation Logs (Critical)

The program originally received a **Failed Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO) status. A review of nine youth mental health and substance abuse records found none were applicable for placement on PO while at the program. Three applicable records were requested and reviewed for Suicide Precaution Observation Logs. Each of the three reviewed records contained a completed Department Suicide Precaution Observation Log form. All three reviewed logs contained real time supervision notes maintained by the direct care staff. Each documented supervision log was conducted within thirty-minute intervals as required. None of the reviewed records were applicable for a youth displaying warning behaviors while on PO. Each reviewed PO log documented signature of the shift supervisor and mental health staff, in addition to identifying safe housing requirements. An informal interview was conducted with three youth currently attending the program with a history of being placed on PO. Each youth reported staff was with them at all times while they were on suicide precautions.

3.13 Suicide Prevention Training (Critical)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures outlining staff training in suicide prevention. The policy dictates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, in addition to participation in mock suicide and emergency drills. A review of nine in-service training records and nine pre-service training records showed sixteen of the eighteen staff completed all required training. Two in-service staff completed only part of the required six hours of annual training in suicide prevention. A review of the program's mock suicide drills confirmed the program is exceeding the required quarterly drill on each shift. A review of drills for the past six months showed the program has completed eight mock drills. Six of the completed mock drills included the use of life saving measures. Each reviewed emergency drill clearly documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. The mock suicide drills conducted since the last annual compliance review were reviewed and reflected all staff who have direct contact with youth participated. The program's practice is to conduct mock suicide drills in conjunction with the mandatory all-staff meetings to meet this requirement. The program practice is to review all mock suicide drills during morning management meetings, which occur Monday through Friday, at all shift briefings with oncoming staff, and during monthly all staff meetings. By reviewing the drill scenarios at these meetings, staff are provided with the necessary training to respond to an incident of suicide attempt or serious self-injury.

3.14 Mental Health Crisis Intervention Services (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written crisis intervention plan. The plan was reviewed, approved, signed, and dated by the program's psychiatrist on August 31, 2018 and the designated mental health clinician authority on June 3, 2019. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process.

3.15 Crisis Assessments (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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).

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written crisis intervention plan, which includes provisions for the completion of crisis assessments. A review of nine youth mental health and substance abuse records found three instances requiring the completion of a crisis assessment. A review of the three applicable assessments found the program utilizes a program form containing all elements outlined in the Department's Crisis Assessment form. Each crisis assessment documented completion immediately following the determination a youth may be in crisis. All three assessments were completed by the master's level non-licensed mental health clinical staff working under the direct supervision of a licensed clinician. Two reviewed assessments documented electronic signature by the licensed staff within twenty-four hours as required and one documented review two days later. Reviewed documentation showed in each instance the youth posed a safety or security risk to harm self or others and were subsequently placed on precautionary observation. Each reviewed record also documented the completion of a mental status examination prior to transitioning the youth to standard supervision.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written emergency mental health and substance use services plan, which was last revised and approved by the campus wide director of treatment services on September 4, 2018, the psychiatrist on August 31, 2018, and the designated mental health clinician authority (DMHCA) on June 3, 2019. The plan included procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. An interview with the facility administrator and the DMHCA indicated there were no youth applicable for emergency mental health and/or substance abuse services since the last annual compliance review. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act to New Horizon's of the Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilizes the emergency services through Raulerson Medical Center in Okeechobee, Florida for substance abuse Marchman Act. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. Nine interviewed staff acknowledged the ability for all program staff to call 9-1-1 in the event of an emergency.

3.17 Baker and Marchman Acts (Critical)

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program did not utilize a Baker Act or Marchman Act procedure during the review period; therefore, the indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a policy and procedures identifying the authority responsible for the provision of healthcare services. The program has a medical clinic and a contracted designated health authority (DHA) 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 had a provisional agreement with one medical doctor to serve as the interim DHA and two licensed physicians to serve as backup. The interim physicians serving as the DHA signed a temporary amendment to provide medical coverage for the program on January 8, 2019 until May 28, 2019. The program has a new independent contractor agreement with a State of Florida licensed osteopathic physician. The current DHA holds an unrestricted osteopathic physician license in the State of Florida with an education and specialty training in family practice. The DHA is scheduled to be on-site for two hours each week and on call twenty-four hours a day, seven days a week when not at the program. Interview with the DHA validated this practice. The current DHA's license expires March 31, 2020 and maintains certificate of liability insurance with an expiration date of August 10, 2019. The program does not utilize a physician's assistant or an advanced registered nurse practitioner. Reviewed attendance logs for the last six months indicated the interim DHA and/or designee was on-site at least once a week, with a week defined as the seven-day period beginning on Sunday and ending on Saturday. However, there were ten separate visits whereby the DHA was not on-site for a minimum of two hours as required in contract. The program

identified this, and the regional health services administrator and the program's lead health services administrator discussed this with the interim DHA. There was no change and the interim DHA subsequently resigned. An interview with the current DHA verified her roles and responsibilities in the program. The program maintains an independent contractor agreement with a State of Florida licensed optometrist for services as needed. The optometrist's license was clear and active with an expiration date of February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed dentist to provide dental services to youth. The dentist license was clear and active with an expiration date of February 28, 2020 and maintains certificate of liability insurance with an expiration date of January 21, 2020.

4.02 Facility Operating Procedures

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains facility operating procedures (FOPs) for all health-related procedures and protocols utilized. Reviewed documentation supported the DHA signed all healthcare policies and procedures on August 30, 2018. In addition, the facility administrator documented a review on August 17, 2018, the corporate office documented a review on July 10, 2018, and the psychiatrist documented a review on August 31, 2018. The interim DHA reviewed and signed the healthcare policies and procedures on January 7, 2019 and the new DHA documented their review on June 10, 2019. Documentation supported the program's nursing staff reviewed, signed, and dated a cover page on which all healthcare policies and procedures in August and December 2018, and June 2019, and signed and dated a cover page for the nursing protocol manual July and December 2018, and June 2019. A review of the program's health-related policies, procedures, and protocols ensured the program properly outlined the program's healthcare services. There was one 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 the new staff. A review of pre-service training and on-the-job training documents supported the required orientation was completed as required.

4.03 Authority for Evaluation and Treatment

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring each youth maintains a signed and dated Authority for Evaluation and Treatment (AET) form in the healthcare record. The AET form is signed by the parent/legal guardian and serves as informed consent for non-invasive medical procedures or for minor ailments requiring over-the-counter medications which can be treatment by healthcare staff. The program 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. A review of nine youth healthcare records found four contained an AET and five youth records contained an original release of information form for youth eighteen years of age and older. All four reviewed AETs were copies and each copy was clearly labeled with the word "Copy" stamped. Each reviewed AET and/or release of information form was filed in each youth's healthcare record in the appropriate section. An interview with the program nurse 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of nine youth healthcare records validated the program sends a list of over-the-counter (OTC) medications approved by the designated health authority (DHA) to each parent/guardian, with a welcome letter and a request to return the signed consent form. Each reviewed youth healthcare record contained a welcome letter from the nursing department sent to the parent/guardian highlighting several forms requiring parental consent and signatures. The letter also instructs the parent/guardian of the youth having access to two on-site physicians; designated health authority and psychiatrist. Reviewed healthcare records supported four applicable parents/guardians were notified when significant changes to existing medication occurred. Five youth were eighteen years of age and four consented notifying the parent/guardian. Three applicable parents/guardians were notified when changes in condition and/or medication for youth identified with a chronic condition. There were four applicable reviewed healthcare records of youth requiring off-site emergency care and notification was made by telephone and subsequently in writing. There were five youth taken off-site for medical treatment and notification was made by telephone and followed-up in writing. Seven applicable youth received new medication and notification to the parent/guardian was documented in the nurses' chronological progress notes and written notifications were sent regardless of telephone notifications. Two youth were in the custody of the Department of Children and Families (DCF) with one having parental rights terminated and the other youth did not. The program notified the applicable youth's parent/guardian with applicable changes in medical care. 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 indicated 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.

4.05 Notification – Clinical Psychotropic Progress Note

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of nine youth healthcare records validated seven youth were prescribed psychotropic medications. According to program policy, no new psychotropic medication shall be initiated without parental consent to youth under the age of eighteen. All efforts to contact the parents/guardians are documented in the youth's healthcare record. Documentation must include the date and time of the attempted contact or contact made, telephone number called, name of the parent/guardian, name and dosage of medication, general description of the reason the medication was prescribed, risk of the medication, and name of the prescriber. Reviewed documentation supported this practice. Reviewed youth healthcare records supported four of the seven youth were under the age of eighteen and required parent/guardian consent. Three youth were eighteen years of age; however, one youth did consent to include their parent/guardian in notification for significant changes in psychotropic medication. Two youth were in the custody of the Department of Children and Families (DCF). The applicable four youth requiring parent/guardian and the two youth who were in the custody of DCF had court order documented a telephone consent and/or notification conducted by the psychiatrist and witnessed by the nurse. The parent/guardian and the DCF case worker received a written follow-up of a copy of the Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. An interview with the program's nurse reported for new medications, parental consent is required. 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. For discontinuation or adjustments, the notification may be mailed by regular mail.

4.06 Immunizations

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring an immunization history shall be obtained for each youth admitted and all applicable youth receive the proper immunizations. A review of nine youth healthcare records validated nursing staff review each youth's electronic commitment packet to determine whether it contains a complete history of immunizations. Nursing staff obtain a school printout of the youth or utilize the Florida Shots Florida Certification of Immunization to determine if the immunization history is missing or incomplete. Each reviewed healthcare record contained a Florida Certification of Immunization and a Department Immunization Tracking Record. Reviewed documentation supported the vaccinations were verified within thirty days of the youth's admission. In practice, they were verified when the registered nurse completed the admission screening process. No youth had a completed religious exemption from immunization form filed in the healthcare record. An interview with the program's nursing staff confirmed each youth's vaccination/immunization record not documented in the youth's healthcare 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 the guardian is required to complete the religious exemption from immunizations form provided to the county health department and provide a copy to the program.

4.07 Healthcare Admission Screening Form

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission to determine if the youth has an acute injury, illness, chronic medical condition, physical impairment, or developmental disability requiring medical or mental health evaluation and treatment and/or medication needs to be met. An interview with the program's nurse reported all newly admitted youth are seen immediately when they arrive. A review of nine youth healthcare records validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse on the youth's day of admission. Youth identified with a substance abuse diagnosis and receive a positive urinalysis for drugs during the admission screening process also receive a Detoxification Assessment to ensure there are no signs and symptoms of detoxification present. The assessment is completed at admission, and again twenty-four hours later, forty-eight hours later, and seventy-two hours later.

4.08 Medical Alerts

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all staff are made aware when medical or mental health issues exist which may affect the security and safety of the youth and may necessitate the need for emergency medical or mental health services. All communication regarding a youth's condition(s) or risks shall be made on a "need to know" basis and shall be

conducted in a manner which best preserves a youth's privacy, while still providing appropriate staff the information they need to properly and safely supervise the youth. A review of nine youth healthcare records as well as the program's internal alert system and the Department Juvenile Justice Information System (JJIS) validated youth identified with medical, dietary, physical limitations, or healthcare complications were updated accurately as required. The nursing staff ensure all alerts are verified, accurate, and up-to-date and placed on the medical alert roster. The alert roster includes the youth's medical grade, cottage assignment, medication allergy, special dietary restrictions and/or order, physical limitations, complications, and Vulnerability to Victimization and Sexual Aggressive Behavior (VSAB). The alerts are updated daily by nursing staff. A review of the JJIS validated the alerts were updated and/or removed as required. The program maintains copies of the internal alert system in the staff breakroom, master control, and paper copies are provided to staff at shift briefing during change of shift. Informal interviews with staff validated this practice. An interview with the program nurse reported the health services administrator (HSA) and the medical records clerk update medical alerts. The HSA verifies the alert internally and in JJIS.

4.09 Youth Orientation to Healthcare Services

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission. A review of nine youth healthcare records validated each youth received a healthcare orientation on the day of admission. Each youth receives a health education packet specifically designed for male adolescents. Youth and nursing staff sign the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, nursing staff conduct health education groups monthly covering a variety of topics utilizing a health education curriculum consistent with the Center for Disease Control and Prevention (CDC). On-going health education was documented in each reviewed healthcare record. Nursing staff also conduct monthly height, weight, body mass indices, and vital signs for each youth. Reviewed healthcare records validated this practice.

4.10 Designated Health Authority/Designee Admission Notification

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a policy and procedures ensuring after the healthcare staff review the youth's healthcare record and completes the screening and/or reviews the completed screening, the designated health authority (DHA) will be notified whenever possible telephonically, or verbally for all new admissions regardless of any identified medical conditions to provide a comprehensive overview. The program practice is for the designated health authority (DHA) to be notified by telephone of all admissions and when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone and an order is obtained to continue the youth on the prescribed medications. Nursing staff obtain the initial admission orders, initial applicable medication orders, applicable preliminary laboratory studies, applicable dietary orders, activity release or restriction, and specific treatment orders and instructions for youth with a health-related condition. Nursing staff document the notification(s) on the DHA Notification of Admission form. The nurse signs the form and the DHA signs the form at the next on-site visit. A review of nine youth healthcare records validated this practice.

4.11 Healthcare Admission Rescreening

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring a healthcare admission rescreening and the completion of a new Department Facility Entry Physical Health Screening

(FEPHS) form occurs anytime the youth returns to the program following a physical custody change. The rescreening process is to ensure the youth can be placed back into the general population and is not in need of immediate medical attention. A review of nine youth healthcare records found one applicable youth where a change in physical custody occurred three times. Two additional applicable healthcare records were reviewed where there was a change in custody one time. Reviewed documentation supported all youth received a healthcare admission rescreening utilizing the Department's FEPHS form. Each FEPHS form was completed by the registered nurse. An interview with the program nurse reported when there is a change in custody of the youth, upon return to the program the registered nurse (RN) completes a new FEPHS.

4.12 Health Related History

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring nursing staff shall review and update the Department's Health Related History (HRH) form at admission and prior to the Comprehensive Physical Assessment (CPA). Nursing staff ensure the HRH is updated annually and as needed. A review of nine youth healthcare records found a new HRH was completed for each youth on the day of admission. The nursing staff and the designated health authority (DHA) document their review of the HRH with the nurse signing the form and the DHA documented a review on the completed CPA. An interview with the registered nurse (RN) 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring each youth shall receive or have on file a current Comprehensive Physical Assessment (CPA). The designated health authority (DHA) reviews the applicable CPA the youth was admitted with while examining the youth and completes a new CPA. All youth will have a new CPA completed within seven days of admission and prior to the youth engaging in strenuous exercise or being subjected to extreme outdoor weather conditions including, but not limited to, high heat indices and frigid temperatures. A review of nine youth healthcare records validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority. All sections of the CPA were completed in full utilizing "O" or a "X". All five reviewed CPAs indicated the youth refused a portion of the examination and the youth documented their signature of refusal on the CPA. Reviewed documented practice validated the Department's Problem List was updated for each youth throughout their stay, when applicable. 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

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. This is an all-male program, therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. This is an all-male program, therefore, this indicator rates as non-applicable.

4.15 Tuberculosis Screening

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. All youth are thoroughly

screened upon admission in order to determine if a youth has an acute injury or illness, a chronic condition requiring immediate evaluation and treatment and/or identified medication needs. A review of nine youth healthcare records validated each youth had at least one verified tuberculin skin test (TST) documented within the last year to determine exposure to tuberculosis. The TST is conducted annually. 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 screening. All tier I tuberculosis screenings were conducted within twenty-four hours of each youth's admission. Interview with health services administrator indicated there were no applicable youth with symptoms suggestive of active tuberculosis or prescribed anti-tuberculosis medication. Reviewed documented practice found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and the Comprehensive Physical Assessment (CPA). 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluation for sexually transmitted infections (STI). The designated health authority or designee then decides based on the screening tool and medical evaluation to order testing for STIs. A review of nine youth healthcare records found seven youth were identified as sexually active; however, all nine youth were clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Each youth was referred to the designated health authority (DHA) for further evaluation. Testing was ordered and was performed for each youth within twenty-four hours. Test results were filed in the lab section of the healthcare record 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 required a rescreening due to symptoms present. An interview with the program nurse reported youth are screened for STIs at admission. If a youth is symptomatic, the youth will be rescreened by the DHA. All health education is documented in the healthcare record on the health education record form.

4.17 HIV Testing

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of nine youth healthcare records validated each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. The program's designated health authority is authorized to provide pre-counseling, testing, and post-counseling. Interview with the registered nurse validated this practice. Reviewed youth records validated five youth consented to receive testing and received pre-counseling, testing, and post-counseling. Each reviewed youth healthcare record supported the youth's health education record was updated. The results were placed in a sealed envelope marked 'Personal' and 'Confidential' with the youth name, date of pre-test counseling, date of test, and date of post-test counseling on the outside of the envelope. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not include HIV status as part of the internal alert system. Nine youth were interviewed regarding their ability to ask for an HIV test. Each of the nine-interviewed youth reported they can request to receive an HIV test at the program any time.

4.18 Sick Call Process - Requests/Complaints

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints or illness or injury of a non-emergent nature treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. The program maintains an independent contractor agreement with a State of Florida licensed optometrist for services as needed. The optometrist's license was clear and active with an expiration date of February 28, 2021. The program maintains an independent contractor agreement with a State of Florida licensed dentist to provide dental services to youth. The dentist license was clear and active with an expiration date of February 28, 2020 and maintains certificate of liability insurance with an expiration date of January 21, 2020. The program offers youth the opportunity to sick call seven days a week, two times daily conducted by the licensed nursing staff. Sick call is scheduled Monday through Friday from 7:00 a.m. to 7:30 a.m. and 5:30 to 6:00 p.m. Saturday and Sunday sick call is scheduled from 7:30 a.m. to 8:30 a.m. and 12:00 p.m. to 12:50 p.m. A review of nine youth healthcare records validated five youth completed a sick call request form at least one time during their stay. The registered nurse documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. However, program procedures outlined the healthcare staff will automatically refer the youth to the designated health authority or dentist for an evaluation and treatment. The dental sick call is incorporated into the healthcare sick call process. When a licensed healthcare staff is not on-site, all sick call request forms shall be turned into the shift supervisor for review. The shift supervisor is required to review the sick call complaint promptly but no longer than two hours after the request was submitted. The shift supervisor will determine if the sick call requires immediate attention. Licensed healthcare staff are on-call and are available for consultation to determine if the sick call requires immediate attention and/or for instructions. The program currently has three trained shift supervisors each receiving medical technician training delivered by the regional health services administrator. Eight of the nine-interviewed staff reported sick call is conducted by the program's nurse and

one reported by the doctor. Nine youth were interviewed regarding how quickly they see a nurse after submitting a sick call. Eight youth reported within one day and one youth reported never submitting a sick call request.

4.19 Sick Call Process - Visits/Encounters

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all youth shall be able to make sick call requests and have their complaints treatment appropriately through the sick call system. The program maintains designated health authority (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. A review of nine youth healthcare records found each youth submitted a sick call request form during their stay. Sick call is completed by the registered nursing staff when they are on-site. Procedures are in place for the staff mentors to review the sick call request form to determine if it requires immediate care. Completed sick call request forms are filed in chronological order in the nursing chronological note section of the youth healthcare record. Reviewed documented practice found all sick calls, were documented on the Department's Sick Call Index and on the Sick Call Referral Log. There were no sick call requests submitted during the annual compliance review week; therefore, a sick call encounter was not observed by the review team. Informal interviews with five youth indicated four youth received sick call while in the program and each indicated sick call was conducted by nursing staff and confidentiality was maintained. Youth also indicated are able to see the doctor when requested. Nine youth were interviewed regarding how quickly they see a nurse after submitting a sick call. Eight youth reported within one day and one youth reported never submitting a sick

call request. Eight of the nine-interviewed staff reported sick call is conducted by the program's nurse and one reported by the doctor.

4.20 Room Restriction/Controlled Observation

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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 Department's Non-Healthcare Staff On-Site Care Form. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of nine youth healthcare records found five youth requiring episodic and/or first aid care at least one time. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in problem-oriented subjective, objective, assessment, and plan (SOAP) charting. 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 four automated external defibrillator (AED), thirteen first aid kits, and seven suicide response kit containing a knife-for-life, wire cutters, and needle nose pliers. The AED were observed in the gymnasium, administration, maintenance, and the director of case management office. The suicide response kits were observed located in the cafeteria, Adams Cottage, Carver Cottage, Johnson Cottage, Robinson Cottage, Koger Cottage, and Marshall Cottage. The first aid kits were observed located in maintenance, administration, medical clinic, gymnasium, cafeteria, school, laundry room, Marshall Cottage, Adams Cottage, Carver Cottage, Johnson Cottage, Koger Cottage, and Robinson Cottage. The first aid kits and suicide response kits are checked weekly and the AED is checked monthly by nursing staff. An interview with the program nurse reported the 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. The nurse reported the program uses a health services provider tracker to track youth who are sent off-site for first aid or emergency care and a daily shift report. Nine youth were interviewed regarding the ability to see a dentist and/or doctor while at the program. All the nine-youth reported they can see a dentist and/or doctor if needed.

4.22 Emergency Care

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. The program also maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains four AED located in the gymnasium, administration, maintenance, and the director of case management office. The master control has one AED; however, it is assigned to the Okeechobee Youth Development Center and Okeechobee Youth Correctional Center. Nursing staff conduct monthly checks to ensure each is functioning adequately. All four AEDs provide audio instructions with step-by-step procedures. The health services administrator demonstrated one of the AEDs and validated it was in working order. The nursing staff track the expiration dates of the AED batteries and pads and all were current. The batteries were last changed in March and April 2017 for two and April 2018 for the other two. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. All four registered nurses each maintained current certifications in CPR/AED and basic first aid. The program conducts mock medical drills monthly on each shift. Reviewed practice found the program conducted a CPR/AED drill three times on each shift since the annual compliance review conducted in January 2019. Observations during the tour of the program found postings informing staff of their right and responsibility to call 911. Emergency telephone numbers were maintained in master control, medical clinic, the supervisor's office, clinical director's office, and director of case management's office. Three of the nine staff interviewed reported being able to call 911 in an emergency situation. Six staff stated they would contact master control staff to make the call because they only have access to the radio. The program had three youth currently prescribed an Epinephrine Auto-Injector and the program identified and trained seven staff in the usage. Staff included three shift supervisors, facility administrator, two case

managers, and one youth care worker II. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of nine youth healthcare records found five youth requiring off-site care and/or emergency care. Three youth records documented parental notification; two youth were eighteen years of age. The Summary of Off-Site Care Form was completed for each youth and was filed in the healthcare record. Reviewed documentation supported the DHA reviewed each completed off-site care form and applicable discharge paperwork as evidenced by their signature and date. Three youth required follow-up care and each youth was scheduled and received services as prescribed. 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 reported the DHA documents the review on the off-site care form and nursing staff track any follow-up appointments by use of the daily shift report, episodic log, and health service provider tracker.

4.24 Chronic Illness/Periodic Evaluations

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the period evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. For youth who have a chronic condition or communicable disease and are receiving prescription medication excluding anti-tuberculosis medications and psychotropic medication, a periodic evaluation is conducted at least every two months and documented on the physician progress note form. A review of nine youth healthcare records indicated all nine youth were admitted with an identified chronic condition or were taking prescribed medication on an on-going basis as documented on the Facility Entry Physical Health Screening form. All nine youth were classified with a medical grade of two through five. There was one youth currently undergoing treatment for physical health condition which included a low body mass index (BMI) and received protein supplemental shakes. During the examination conducted by the designated health authority (DHA), the practice is to calculate the youth's BMI utilizing the Centers for Disease Control and Prevention (CDC) BMI Percentile Calculator for Child and Teen. Reviewed records supported each youth received periodic evaluations as required. An interview with the designated health authority indicated youth receive an evaluation at a minimum of every sixty days. The psychiatrist evaluates the youth every thirty days. There was no indication of lapses in care or missed periodic evaluations. Reviewed documentation supported each youth receives a new Comprehensive Physical Assessment (CPA) within seven days of their admission. The DHA and/or psychiatrist diagnosis the medical 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 as required for each applicable youth. An interview with the program nurse and the DHA reported youth with chronic conditions are seen by the DHA every sixty days and as needed.

4.25 Medication Management - Verification

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the education is verified and indicated. Nursing staff complete the Facility Entry Physical Health Screening to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. A review of nine youth healthcare records indicated six youth were admitted into the program on prescribed medication; three youth on psychotropic medication and three youth on inhalers. Reviewed nursing admission notes documented the youth's current medication and the DHA Notification of Admission documented the current prescribed medication. The nursing staff notified the DHA on the youth's day of admission by telephone. The program practice is to notify the DHA of all admissions. The DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the practice. The program sends a Pharmacy Notification identifying the prescribed medications to 1st Choice Pharmacy. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian.

4.26 Medication Management - Orders/Prescriptions

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures all medications have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of nine youth healthcare records validated each was applicable for medication management and each documented a current and valid prescription order. Six youth were admitted into the program on prescribed medication; three youth on psychotropic medication and three youth on inhalers. The medications prescribed prior to admission were continued as ordered. Each reviewed youth healthcare record indicated the prescribed medication was continued, discontinued, changed, or a new medication was ordered. Each time the doctor's order sheet clearly documented the medication and dosage. Over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET) were administered in accordance with the physician's order. An interview with the program nurse indicated verification is made through the parent/guardian. The Medication Administration Record (MAR) comes in with the youth along with the medication. The DHA is notified of all admissions.

4.27 Medication Management - Storage

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Observations of the medical clinic found all medications securely stored and inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart. Narcotics and other controlled medications were observed securely stored in the medication cart. The program practice is to store the medications in a locked box located in the locked medication cart. The

key to the controlled medication box was located in a key pad locked box mounted to the wall. Oral medications were not stored with injectable or topical medications. The program maintains a refrigerator for medications requiring refrigeration. The program securely stored sharps and syringes separate from medications. The program maintains a written process for the disposal and destruction of expired and/or discontinued medications. The registered nurse (RN) 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 RN reported the program keeps a perpetual and a weekly inventory of all medication. A review of medication inventory logs supported the practice. The program also maintains an exemption certificate from the Department of Health for biomedical waste with an expiration date of September 30, 2019. The program utilizes Stericycle Steri-Safe for monthly medical waste services. All non-controlled medications are sent back to 1st Choice Pharmacy for credit. All controlled medications are disposed of by the consultant pharmacist and witnessed by nursing staff. Disposal practice is to place the medication in Rx Destroyer and document the disposal on the Medication Administration Record. The program nurse reported the program maintains all medications in the medication cart and perpetual and weekly inventory are maintained. A review of medication inventory logs supported the practice.

4.28 Medication Management - Medication and Sharps Inventory

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring 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. Reviewed documentation and nursing interviews confirm all over-the-counter (OTC) are inventoried at least weekly. Program 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 substance with a shift-to-shift inventory conducted by nursing staff. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The 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. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report. 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, designated health authority, and consultant pharmacist. 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. The program maintains written procedures for the disposal of narcotics and other controlled substances. Disposal practice is to place the medication in Rx Destroyer and document the disposal on the Medication Administration Record. Observations conducted during the annual compliance review week supported three youth prescribed medications inventories were accurate. Three OTC medications were reviewed, and the inventories were accurate. Three sharps were reviewed, and inventories were accurate. Three youth with prescribed psychotropic medications found the inventories were accurate. A review of the program's counts from the past six months validated no discrepancies were identified with the counts. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as required by the Board of Pharmacy and Department requirements. The program maintains a Modified Institutional Class II Type B permit with an expiration date of February 28, 2021. The program maintains a Community Pharmacy Schedule II and III. The approved certification with 1st Choice Pharmacy with an expiration date of April 19, 2020. The program procures medication through 1st Choice Pharmacy and observations found all controlled substances are maintained in the securely locked box within the secure medication cart located in the medical clinic in the cafeteria. The medications are in blister packs clearly documenting in color-coded labels morning, noon, and evening medications. The number of pills is clearly marked on each blister pack. Controlled medications are administered by the registered nursing staff. Nursing staff are on-site seven days a week from 6:00 a.m. to 7:00 p.m. According to the program's contract, the campus shall have one health services administrator for forty hours a week, seven and one-half registered nurses for 300 hours a week with a total of 340 combined. The nursing services schedule may vary depending on staff availability. The Exhibit 9 Nursing Schedule proposes three full-time RNs. In practice the program is utilizing the HSA, one lead RN, and rotate nursing staff from other three programs under the same contract number. In addition, the program utilizes four pre-re-nata (PRN) RNs. The program has seven non-licensed staff trained to administer over-the-counter medication when nursing staff are not on-site. The youth's individual controlled medication inventory record is updated after each administration. Shift-to-shift inventories are conducted by two RNs in the evening and again in the following morning. A review of three random youth prescribed psychotropic medication and a review of the inventories were found 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring medications shall be provided pursuant to a physician order written in the youth's individual healthcare record or pursuant to a youth's current prescription container if a youth's medications are administered from a current individual container with a current patient specific label. Oral prescription medications shall be administered, according to instructions. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. A review of nine youth healthcare records found each youth was prescribed medications and reviewed documentation supported 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. A review of nine youth healthcare records indicated six youth were admitted into the program on prescribed medication; three youth on psychotropic medication and three youth on inhalers, and the initial MAR matched the medication listed. The nine reviewed youth healthcare records supported the MAR documented the youth received the medication(s) as ordered. The MAR clearly indicates medication start dates and stop dates, when applicable. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration for the sample reviewed. A review of the Central Communications Center (CCC) reports indicated there was one incident in March 2019 whereby the registered nurse (RN) noted a discrepancy with the pill count. After an internal investigation, the error was found to be a documentation error and all nursing staff received additional training. There was a CCC incident reported in May 8, 2019 whereby the medication inventory for one youth was incorrect. One prescribed psychotropic medication was missing. An internal investigation was conducted, and the pill could not be located. As a result, the nursing staff are now required to have a second nurse and/or supervisory level staff member present after the evening medication pass to conduct medication count of controlled and prescribed medication for all youth receiving medication throughout the day. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. In addition, program nursing staff documented weekly psychotropic medication side effects on the Weekly Psychotropic Medication Monitoring Tool. Refusals were clearly documented on the MAR and nursing staff complete the Department's Refusal of Treatment form when a youth refuses a medication dosage. Nine youth were interviewed, five youth reported the nurse administers medications and four youth reported not taking medication at the program. Nine staff were

interviewed regarding who administer medication to youth and each reported the program's nursing staff administer medications to the youth.

4.31 Medication Management - Medication Administration By Licensed Staff

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring authorized prescribers, including consultants, shall utilize the prescribed medication list when providing appropriate healthcare to youth. Prescribed medication used for physical health conditions, psychological, and/or psychiatric conditions, and medications specifically prescribed for pain relief, inclusive of narcotics and other controlled substances, shall be administered in a single-dose under the direct supervision of the healthcare staff to ensure the youth receives the medication as ordered. The program has one health services administrator responsible for all four programs under the contract, one full-time lead registered nurse (RN), four rotating RNs from other programs under the same contract, and four part-time nurses. Nursing staff are on-site seven days a week from 6:00 a.m. to 7:00 p.m. The full-time lead RN is scheduled to work four ten-hour days. Each RN maintained current licenses in the State of Florida. The program also has one regional health services administrator available to provide on-site services. A review of nine youth healthcare records 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 RN to administer the medication. The program did have one youth who is on an insulin pump and is monitored and levels checked three times a day. Interview with the RN

indicated nursing staff administer vaccinations upon an order from the designated health authority. Reviewed Medication Administration Records (MAR) for each youth, as well as the prescription, validated the youth received the medication as ordered and at the scheduled time frames. Refusal of medications were clearly documented on the MAR and the Refusal of Treatment form was also completed and filed in the youth's healthcare record. Observations of five separate medication administrations by the RN indicated the medication was administered in accordance with the five rights of medication administration. The RN opened the clinic Dutch door and the youth approached one at a time and identified self, telling the nurse the medication prescribed and side effects. The medication cart was stationed against the wall adjacent to the opened Dutch door. The shift supervisor stood beside the youth when the medication was administered. One youth who was wearing a long sleeved sweat shirt was requested to roll up the sleeves prior to the administration of medication. The RN and shift supervisor then instructed the youth to cough to ensure the medication was swallowed. The RN did not pre-pour the medication from the blister pack subsequent to administration. The medical clinic and working space was observed to be clean and well organized. The observed process was structured and interactive. Nine youth were interviewed regarding who administers medication at the program. Nine youth were interviewed, five youth reported the nurse administers medications and four youth reported not taking medication at the program. Nine staff were interviewed regarding who administer medication to youth and each reported the program's nursing staff administer medications to the youth.

4.32 Medication Management – Medication Administration By Non-Licensed Staff

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures for youth self-administration of oral medications, topical, or inhaled prescribed medications assisted by non-licensed trained staff. Non-licensed staff shall provide self-administration medication only when licensed healthcare staff are not on-site. The designated health authority (DHA) developed and approved non-licensed staff medical and emergency protocol guide for staff to utilize when assisting with self-administration of over-the-counter (OTC) medications. Reviewed documentation supported the program has seven trained non-healthcare staff mentors to provide (OTC) medications to youth when nursing staff are not on-site. Nursing staff are scheduled on-site from 6:00 a.m. to 7:00 p.m., seven days a week. A review of nine youth healthcare records supported there were no examples of non-licensed staff providing OTC medications. Nursing staff interviews indicated there were two examples since the last annual compliance review conducted in January 2019

whereby non-licensed staff provided OTC medications when nursing staff were not on-site. One youth received his prescribed inhaler and one youth received Tylenol for tooth pain. Both incidents were documented on the Department's Report of On-site Healthcare by Non-Healthcare Staff form. The RN staff reviewed the form and conducted a follow-up assessment the next morning and then signed the form. Nine youth were interviewed, five youth reported the nurse administers medications and four youth reported not taking medication at the program. Nine staff were interviewed regarding who administer medication to youth and each reported the program's nursing staff administer medications to the youth.

4.33 Medication Management - Psychotropic Medication Monitoring

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring youth diagnosed with a Diagnostic and Statistical Manual – Fifth Edition (DSM-5) mental disorder and is prescribed medication, the psychotropic medication shall be provided pursuant to a physician's order. All staff administering medications shall have knowledge or be informed of the common side effects and precautions of prescribed medications. The program maintains an independent psychiatrist agreement with a State of Florida licensed psychiatrist signed on July 3, 2018. The psychiatrist

license expires January 31, 2021 and maintains professional liability insurance with an expiration July 31, 2019. The independent psychiatrist agreement, second amendment indicates psychiatric services shall be provided with Okeechobee Youth Treatment Center, Okeechobee Youth Development Center, Okeechobee Youth Correctional Center, and Okeechobee Intensive Halfway House up to eight hours each week. However, the current contract indicates the psychiatrist is required to provide on-site services for two hours each week. Reviewed logs indicated there were three weeks where he did not provide on-site services since the last annual compliance review conducted in January 2019. There was no documented lapse in services to youth. The psychiatrist is scheduled to be on-site campus-wide each Monday. The program's practice is to refer a youth admitted with prescribed psychotropic medications to the psychiatrist for an initial psychiatric evaluation within fourteen days of admission. The program's psychiatrist utilizes the TrueCore's Psychiatric Progress Note and the third page of the Department's Clinical Psychotropic Progress Note (CPPN) for the initial evaluation. The third page of the CPPN is also utilized for youth who are subsequently prescribed psychotropic medications. A review of nine youth healthcare records validated seven youth were admitted with prescribed psychotropic medications. Seven youth healthcare record of prescribed psychotropic medications subsequent to admission was also conducted. Each youth was assessed by the psychiatrist and prescribed psychotropic medications. Reviewed documentation supported medication monitoring is conducted by the psychiatrist at least monthly. The psychiatric evaluation was documented on TrueCore's Psychiatric Progress Note and the third page of the Department's CPPN. The program practice is to complete the evaluation in the Lauris system. The psychiatrist also completes the Abnormal Involuntary Movement Scale (AIMS) for prescribed dopamine blocking medications to monitor Tardive Dyskinesia. Nursing staff documented daily side effects on the Medication Administration Record (MAR) and weekly side effects on the Weekly Psychotropic Medication Monitoring Tool. Administration and counts were also documented on the TrueCore Controlled Medication Inventory Record. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The program did not have standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. The psychiatrist does not provide the program with pro re nata (PRN) order for psychotropic medications.

4.34 Infection Control - Surveillance, Screening, and Management

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures ensuring there is an approved plan for infection control. The infection control plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal regulations and guidelines. The plan was reviewed and approved by the facility administrator on August 17, 2018, corporate officer on July 10, 2017, and designated health authority (DHA) on August 30, 2018. The interim DHA signed the plan on January 4, 2019 and the new DHA signed the plan on June 10, 2019. 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 outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorists agents, chemical exposures, and methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for hepatitis B immunizations and access to protective equipment. The program 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 Steri-Safe. The program maintains a current operating permit through the Department of Health for biomedical waste. The program did not have instances in which the Okeechobee County Health Department, Center for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) were notified of an infectious disease.

4.35 Infection Control - Education

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program's control of infectious and communicable disease plans included staff training during the pre-service phase and in-service training, annually. A review of nine staff training records found eight staff received the required training. One staff was missing the training as validated by the training department. A review of nine youth healthcare records and eight of nine staff training records validated all received training on infection control to include prevention of communicable diseases and prevention of blood-borne pathogens. An interview with the program nurse reported the campus wide training department and health services administrator conduct infection control training for staff every six months. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written exposure control plan addressing risk assessment, methods of compliance, engineering and work-place control, and training requirements in order to provide a safe environment for youth, staff, and visitors. The infection control plan is combined with the program's exposure control plan. The plan was reviewed and approved by the facility administrator on August 17, 2018, corporate officer on July 10, 2017, and designated health authority (DHA) on August 30, 2018. The interim DHA signed the plan on January 4, 2019 and the new DHA signed the plan on June 10,2 019. The program's exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910). The exposure control plan included a comprehensive process for needle stick post-exposure evaluation and the plan is available to all staff. The program reports there were no

incidents involving a contagious disease requiring the quarantine or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. Interview with the facility administrator (FA) indicated the exposure control plan is located in the policy manual located in the FA office, master control, and in the medical clinic. The plan is available and accessible to all program staff. Education on handling exposures is conducted several times a year and is completed in all-staff meetings, through the Department's Learning Management System (SkillPro), and through drills. An interview with the program nurse reported the health services administrator is responsible for providing training to all staff on the program's exposure control plan.

4.37 Prenatal Care - Physical Care of Pregnant Youth

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. This is an all-male program, therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. This is an all-male program, therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. This is an all-male program, therefore, this indicator rates as non-applicable.

4.39 Prenatal and Neonatal Staff Education

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. This is an all-male program, therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable Rating** for this indicator. This is an all-male program, therefore, this indicator rates as non-applicable.

Standard 5: Safety and Security

5.01 Youth Supervision

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains written policies and procedures regarding youth supervision. The program promotes safety and security by maintaining active supervision of youth to include closely observing their behavior, interacting positively with youth, engaging youth in a full schedule of constructive activities, redirecting inappropriate behavior, and consistently applying the program's behavior management system. The program has a daily schedule which was observed to be posted in each youth living area and throughout the facility. Youth and staff observations were conducted each day throughout the week of the annual compliance review. Staff were observed to be strategically positioned to ensure proper supervision of the youth and to ensure there were no physical obstructions in their view during youth activities and/or movement. Observations made throughout the review week included youth movement from cottages to classrooms, classroom to classroom, classroom to cottages, cottages to cafeteria, cafeteria to cottages, and from the cottages to the gym for indoor recreation due to inclement weather. Observations made each day while on-site of youth supervision confirmed staff-to-youth ratios were compliant with the program's contract of one staff for every eight youth. During the observations, staff were actively supervising youth and engaged. Informal interviews were conducted with two supervising staff each day of the annual compliance review and reflected all but one staff were able to advise and provide an accurate count of how many youths they were supervising during movement. One staff provided an inaccurate count and had to count how many youths were in line. This was advised to the facility administrator to follow-up. All interviewed staff understood the steps to take when they cannot reconcile the count. Reviewed digital video recordings of ten-minute checks were conducted on day three of the annual compliance review by another member of the review team. The dates and times were chosen at random. Reviewed video footage reflected on two different occasions, two staff were observed to be supervising sixteen youth. During each occasion, one staff was observed to leave the cottage for approximately three minutes leaving only one staff to supervise sixteen youth. Staff to youth ratio was out of compliance for these two instances. Prior to any movement, staff inform master control of the count by way of radio communication and waited for permission to move the youth. All youth and staff movement, as well as youth counts made throughout the day, are documented in the facility logbook by the master control operator. Formal and informal youth counts are consistently completed throughout each day and are documented in the facility logbook. Observations found interactions with program staff and the youth were positive and followed the program's behavior management system.

5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures to address the program's behavioral management system (BMS). The program's written BMS is a multi-level system designed to promote positive social change, foster compliance with the program rules, and teach youth alternative pro-social methods of dealing with problems while holding youth accountable for their actions utilizing both rewards and a system of progressive discipline. Staff are to focus on the positive when reinforcing the youth's behaviors while applying a minimum ratio of four positive reimbursements to each one negative reinforcement. The planning and criteria for daily incentives, and larger weekly and monthly incentives is to include input from youth and all levels of staff within the program. Reviewed documentation confirmed youth receive orientation to the BMS upon their admission to the program and each youth was provided with copies of the BMS as part of the youth handbook. Observation was made during the program tour of daily incentive calendar for the month of June 2019 and a posting of the weekly incentive weekly Nine staff, including three supervisors, were interviewed and all nine explained their understanding of the behavior management system (BMS) to include behavior referrals, special treatment team meetings and incentives. However, none of the nine interviewed staff indicated the structure of the BMS included provision of both positive reinforcement and negative consequences in a ratio of the four-to-one positive to negative consequences. The program used to provide off-campus outings as monthly incentives, however, the interviews with youth and staff indicated the monthly incentive outings have not occurred due to the vacancy in the recreation therapist

position. The youth did indicate the new recreation therapist who started one month ago has recently sought input from the youth as to what incentives they would like. One interviewed staff indicated attending church off-campus is used as an incentive and expressed church should not be used as an incentive, but they don't go on outings very often because of a lack of staff. Six of nine interviewed staff were direct care staff, four of whom indicated they do not receive feedback from their supervisors on their implementation of the BMS.

5.03 Behavior Management System Infractions and System Monitoring

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program maintains a written policy and procedures to address 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 conducted for those youth whose behavior requires immediate intervention. The program does not utilize room restriction for major infractions. Observation was made during the program tour of posted BMS daily level postings in each cottage which indicated whether or not each youth behaved appropriately to earn their day and/or their cumulative weeks. Nine staff, including three supervisors, were interviewed and eight of the nine confirmed the program's behavior management system (BMS) allows youth opportunities to explain their behavior. The five interviewed direct care staff stated they do not receive feedback from supervisors regarding their implementation of the BMS and two of three interviewed supervisors indicated they provide training to direct care staff on how to complete behavior referrals, while one supervisor said they provide coaching on the BMS at least monthly. A review of nine staff personnel records indicated the positions descriptions and annual performance evaluation both address staff application of the BMS. An interview was conducted with the facility administrator regarding how the use of rewards in the BMS is monitored through the daily tracker of youth making their days. However, he acknowledged the BMS positives, including award ceremonies, certificates, and raffles were lacking with vacancy in the recreation therapist position. However, he indicated now the recreation therapist position has been filled, the program is planning to reinstitute the consistent recognition of prosocial behaviors. Nine youth were interviewed, and all nine youth stated all staff are consistent in the use of rewards and they do not play favorites among the youth. Three of nine interviewed youth rated the BMS as very good, while five youth rated it as good and one rated the BMS as fair.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 describe 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)

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Failed Compliance rating** for this indicator. The program maintains a written policy and procedures requiring staff to conduct and document room checks every ten minutes on a ten-minute check log when youth are in their assigned sleeping quarters. Staff are to conduct a visual check from the entrance of each youth's room and staff must see the skin, or a body part, of each youth to confirm the youth's presence. Reviewed documentation maintained in the program's ten-minute check log binder reflected staff document the actual time of the room check and initial on the ten-minute check log sheets, recording which staff completed the room check. If a youth is not in his room, an "X" is marked

in the box for the time of the conducted room check. The program's practice for master control staff to announce by way of radio communication the time for each check to be conducted. Supervisors are required to conduct three room checks each night and must also visualize the skin of each youth in their room. The program's practice is for supervisors to document these checks in red on the ten-minute log sheets noting the time of the check conducted as well as their initials. Nine staff were interviewed and each stated room checks are conducted at least every ten-minutes when youth are placed in their rooms for sleeping or non-disciplinary reasons. A review was conducted of ten-minute check logs and the corresponding video recordings from randomly selected one-hour periods on ten randomly selected dates, two from each of the five cottages. The observation of video footage verified checks were conducted on seven of the ten reviewed dates with fidelity at least every ten minutes and were documented accordingly in real time. Observed video for one of the ten dates validated the staff performed three ten-minute checks which were not documented on the ten-minute log sheet. Additionally, reviewed video footage of two other dates did not support the checks were conducted as documented on the ten-minute check logs and the staff on those two recordings appeared to be sleeping while seated. In the Koger Cottage on May 22, 2019 staff documented checks were completed on four different occasions; however, video surveillance confirmed these checks were not conducted as indicated. On another occasion on May 26, 2019, staff indicated a ten-minute check was conducted at 12:06 a.m.; however, video surveillance confirmed staff was observed seated and the check was not conducted as indicated. These incidents were called into the Department's Central Communications Center (CCC) and accepted. Reviewed documentation confirmed a supervisor conducted ten-minute checks, as required, on the ten reviewed dates which were documented in red on the ten-minute check logs.

5.05 Census, Counts, and Tracking

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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 logbooks 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures to address tracking the daily census of youth. Youth are to be accounted for at all times through physical counts and through random head counts when requested by master control. The daily census is documented in the facility's

master control logbook by master control staff. Additionally, the count of youth and staff present for each co-located program on the campus is posted on a dry erase board on the wall in master control. A review of randomly selected dates and times in the facility logbooks for the prior six months was conducted and reflected youth counts were documented at the beginning of each shift, after outdoor activities, and upon movement of youth from one area of the facility to another. Documentation in the logbooks also noted youth temporarily away from the program, emergency counts, missed counts, and reconciliation of the count. Observation of youth counts were made during the annual compliance review prior to any youth movement when master control was contacted and informed of the number of youth being moved and the destination. Staff awaited confirmation from master control prior to moving the youth to a new location. Nine staff were interviewed, and each confirmed the importance of youth counts, how often the counts are performed, and what happens when there is a discrepancy, as detailed in the program's written policy. A review of logbooks noted a few instances of errors overwritten rather than stricken through. However, the logbooks were neat and easy to read, and entries were color coded making entries easy to identify.

5.06 Logbook Entries and Shift Report Review

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures regarding logbooks to provide procedures and documentation for a daily account of routines and emergency situations involving youth using logbooks. The program maintains a centralized bound logbook with numbered pages which is stored within master control. The master control operator is responsible for documenting the daily account of situations in the program's logbook. The program also has an internal practice where staff utilize chronological logbooks within the units to take notes throughout the day of events, which are reported to master control and relayed to staff during shift briefings. Reviewed documentation reflected the master control logbooks documented population counts, perimeter checks, emergency situations, incidents, transports, removal of youth from population, admissions, releases, Central Communications Center (CCC) calls/incidents, Florida Abuse Hotline calls/incidents, and supervisors are able to leave special instructions pertaining to supervision of youth. Reviewed documentation of randomly selected days within the logbooks reflected entries were legible and made in ink with no erasures or white-out. Reviewed documentation reflected there were inconsistencies of errors made in the logbooks. Several entries which contained errors were struck through with a single line and were initialed by the staff member making the correction; however, there were other entries observed throughout the

logbooks of errors made which were not struck through with a single line nor initialed by the staff member making the correction. In these instances, staff would write over the error in more bold ink or scribble over the error without initialing next to the error/correction. Examples of this were shown to program staff for review and follow-up. A review of the facility logbooks for the past six months verified this practice. The program conducts staff briefings prior to the beginning of each shift and shift reports are completed summarizing the events, incidents, and activities documented in the program's central logbook. Incoming staff are briefed on the previous shift and sign the shift report to acknowledge information was shared. Observations of a staff briefing could not be made during the week of the annual compliance review, as the program is currently having staff work twelve hour shifts from 6:00 a.m. until 6:00 p.m. A review of the program's shift reports verified information is shared with incoming staff by a shift supervisor prior to the beginning of the shift and staff sign the shift reports to document they have been briefed.

5.07 Key Control

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Limited Compliance rating** for this indicator. The program has a written policy and procedures for key control and security, which includes assignment, inventory, tracking, and storage of keys. The program has a daily tracking key log which is utilized each day to track program keys. Reviewed documentation reflected the log indicates the name of the staff, the date and time the key was signed out, and what chit number they were assigned according to their position duties. Facility keys are maintained in master control within a securely locked key box and are maintained on a tamper resistant color-coded ring which includes a brass colored tag with the initials of the staff position and a tracking number. When staff arrive to the facility to begin their shift, they gain access to the facility by way of master control. Staff submit their personal keys to the master control operator and receive a facility key in exchange. Observations of the distribution of keys were made on the

first day of the annual compliance review and reflected the master control operator documented the staff's name and the time they sign out/in the key before and at the end of each shift. According to the program's policy, once an employee receives the assigned facility keys, they must sign the key control log to acknowledge receipt of keys and sign the key control log again upon returning keys to master control reflecting the keys were returned. An informal interview with the master control operator coupled with reviewed documentation of the last six months of key logs and observations made confirmed the master control operator signs the keys in and out on the key log on behalf of the staff instead of having staff sign. The program provided documentation of corrective action immediately taken the following day of the review reflecting master control staff received training on the program's key control policy. Reviewed documentation of updated practices reflected staff are now signing the sign out/in log for keys. Staff's personal keys are placed in the key box next to the corresponding staff's name/key they are assigned. If an employee does not possess personal keys, they are provided a chit labeled 'no keys' and is placed on the corresponding assigned key hook. Restricted keys are maintained in a separate key box located in master control. Only medical staff has access to the restricted key box. When medical staff report to work, they enter master control, obtain their facility key, and deposit their personal keys in the medical key box. The program maintains a list of staff who are assigned permanent keys. Staff who are authorized to possess permanent keys must sign an acknowledgment form indicating a key identification number and the number of keys issued. Reviewed documentation of the current key inventory was compared with the keys in use and the inventory matched the actual keys in use. The master control operator was interviewed and advised damaged keys are turned over to master control and maintenance personnel and administration is notified to have the key repaired or replaced. It was also advised if lost keys have not been found within two hours, the incident is reported to the Central Communications Center (CCC). While on-site, a CCC report was called in and accepted regarding lost keys. According to the report, a teacher informed additional staff she could not locate her assigned keys (two total) which operate a classroom door and doors within the school area. A search was conducted of the program and of all youth. The CCC was contacted and a report was taken. During the completion of the CCC report while on the telephone with program staff, it was advised another teacher had found the keys in the grass within the school area and took the keys home with her. This staff was contacted and returned the keys to the program. An updated report to this CCC incident was later called in. According to the update, it was discovered the staff did not find the keys in the school area but accidently took the keys from on top of the one staff member's office desk, mistakenly thinking they were her assigned keys. An informal interview with the program's facility investigator confirmed the keys were found and returned as originally reported. Supporting documentation of the program's internal investigation was provided to the review team by the facility investigator. A check was conducted throughout the week of the review of three randomly selected staff, including administrative staff, confirming none had their personal keys in their possession. The program's warehouse clerk is responsible for conducting a complete inventory of facility keys on a bi-annual basis. Reviewed documentation confirmed a complete key inventory was last completed in March of 2019, thus confirming the practice. Nine staff were interviewed, and each were able to explain the program's key control process including how keys are assigned and reconciled as well as the process for missing or lost keys, damaged keys, and restricted keys. Interviews conducted with nine staff also confirmed staff were made aware of the program's sign in/sign out policy and procedures regarding key distribution and collection, which is to be followed.

5.08 Contraband Procedure

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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 the Department's 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures regarding contraband control and searches to maintain the safety and security of the program by searching for, detecting, storing, and disposing of contraband/unauthorized items within the program. The policy identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's youth handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Each youth receives a youth handbook upon admission to the program. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, and visitor contraband list verified a list of the required unauthorized items not permitted which includes personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program conducts contraband searches in the youth's rooms daily on each shift. Contraband searches are documented on a daily search report. If any contraband is found, this is documented on this form including the method of disposal. A review of daily search reports and the safety perimeter check inspections reports for the past six months verified searches and facility checks are conducted daily on each shift. An interview with the facility administrator (FA) reflected if there is any contraband found, an incident report is completed as well as a search form to indicate where the contraband was found. The FA is notified and if a decision is made if the Department's Central Communications Center needs to be contacted or not. All contraband discovered are removed from the compound and all documentation is forwarded to the facility investigator, who will initiate an internal investigation. The FA also confirmed any illegal contraband is confiscated and the local authorities are contacted for disposal.

5.09 Searches and Full Body Visual Searches

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures to ensure searches and full body visual searches are conducted in accordance with Florida Administrative Code. When conducting any type of search, staff ensure search procedures reflect trauma informed practices. Youth are searched upon their admission to the program and before and after off-campus activities, outdoor activities, visitation, school, group, outdoor recreation, meals, and vocational or work projects involving the use of tools. Youth who are a new admission, re-admission, returning from visitation, returning from off-campus, suspected of contraband, or are a security risk are searched and are required to sign a search form indicating the search procedure was explained. Reviewed documentation confirmed searches occurred after these activities. Searches are to be conducted by two staff members of the same sex as the youth being searched, and the search is to be conducted in a private area. Parents/guardians are notified of searches during visitation by way of a parent intake notification letter. This letter is sent to the parent/guardian at the time of the youth's admission. Observations of searches were conducted of a youth's admission, of youth after using cleaning tools, and of youth group movements from cottage to classroom, from classroom to classroom, from cafeteria to classroom, after school, and before group. Youth were given instructions regarding the search, were searched by an appropriate number of staff, were searched by a staff of the same sex, were conducted in a manor not to degrade the youth and were based on the Protective Action Response training manual. There were no scheduled vocational instruction projects applicable during the week of the annual compliance review. Nine interviewed staff were each able to explain how and when youth searches are conducted. Nine interviewed youth each indicated searches are conducted after movement, when returning from off-campus, after outdoor activities, when items are missing, after visitation, after meals, and after s work detail.

5.10 Vehicles and Maintenance

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a staff member who is a certified mechanic and maintains an active certification in automotive service excellence (ASE). This certification expires on June 30, 2022. This staff member performs regular maintenance and annual inspections on the program's vans. The program has two operable vans utilized to transport youth. Reviewed documentation confirmed both vans were found to have annual inspections completed, as required. Each van is

equipped with a safety screen separating the driver's compartment from the passenger's compartment. Reviewed documentation confirmed transportation staff conduct daily and weekly inspections of the vehicles. Each vehicle was observed to be equipped with an up-to-date fire extinguisher, seatbelt cutter, window punch, and an appropriate number of seat belts. A first aid kit is assigned to each van and are maintained in the master control area until transports are ready to leave the facility. Informal interviews with staff confirmed youth and staff always wear seatbelts during transports. Additionally, it was confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt.

5.11 Transportation of Youth

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures to ensure the safety and security of youth, staff, and the community when youth are transported outside of the facility. The program has two operable vans utilized to transport youth. Observations made of each van confirmed each contained an up-to-date fire extinguisher, seatbelt cutter, and window punch. Each van is assigned a first aid kit which is stored in the master control area until transports are ready to leave the facility. Each van was observed to have rear passenger doors which are unable to be opened from the inside. Staff are not allowed to transport youth in their personal vehicles nor are youth allowed to operate staff vehicles. The program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted monthly by the program's human resources manager. Observations coupled with informal interviews with staff and a review of the program's policy confirmed the program maintains a minimum ratio of at least two staff for every five youth during any transport. Informal interviews confirmed staff are provided a program-issued cellular telephone to take with them on transports to communicate during emergency situations when transporting youth. Staff never leave youth unsupervised while in a vehicle. An inspection of approximately twenty-five randomly selected personal vehicles were conducted throughout the week of the annual compliance review to determine if staff locked their personal vehicles while working on-site. The results of the inspection founded two vehicles had the driver's side door unlocked. This information was advised to the facility administrator (FA) and he advised they would follow-up with staff regarding this and have them secure their doors. Observations were made of a youth transport during the annual compliance review and confirmed youth and staff wore seatbelts

during transports and the program was complaint with the staff to youth ratio. Nine staff were interviewed and asked what type of communication device staff are provided with during transport. Six of the nine staff stated either a two-way radio or cellular telephone is provided while the remaining three staff said they have not been on a transport before. Each interviewed staff also verified staff are not allowed to transport youth in their personal vehicles.

5.12 Weekly Safety and Security Audit

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's physical plant manager or designee is responsible for conducting safety and security audits every seven days, monthly, quarterly, semi-annually, and annually. Reviewed documentation reflected supervisors utilize a program specific safety/perimeter check inspection form to document the weekly completion of audits and document any deficiencies which need to be addressed. A review of safety and security inspection forms was conducted and reflected there was documentation to support the process and form are completed weekly. The program addresses any deficiencies found during the weekly inspections at their morning management meetings to discuss a course of action to correct the deficiency. A work order is submitted to the Department for any applicable physical plant deficiencies. An interview with the facility administrator confirmed this practice.

5.13 Tool Inventory and Management

The program originally received a **Limited Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program has a written policy and procedures for tool management to ensure the proper control of tools and kitchen utensils used within the facility, as part of an overall strategy to prevent escapes and eliminate the threat of harm against staff, visitors, volunteers, interns, and youth. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department has a total of five different buildings which house tools and other supplies needed for maintenance. These buildings include the auto mechanics building, plumbing building, carpentry building, a large warehouse, and the physical plant manager's office, which is

attached to the program's lock shop. The physical plant manager maintains a perpetual inventory of all tools in these buildings which are attached to the door of each locked cabinet containing tools and/or chemicals throughout the various buildings. Each tool is labeled, color-coded, on a shadow board layout, and are inventoried at the start and end of each day. Observations made of the tool storage areas indicated it was clean, neat, and indicated youth are not allowed to utilize tools. A minor deficiency was identified on January 11, 2019 during the initial annual compliance review. The deficiency identified kitchen tools were not inventoried since November 17, 2018, an inventory list and sign in/out logs were not maintained for the vocational tools, and one staff was not trained in the use of tools. Observations made of the program's kitchen tools reflected they are stored within a locked room in the kitchen and are maintained on a numbered shadow board. Reviewed documentation confirmed the food service providers have been inventorying the tools since February without issue. Observations made of the program's on-site vocational woodshop program, which is operated by the Washington School District, reflected staff have recently made a complete tool inventory list which is posted in the tool room and matched the tools maintained on a shadow board in this building. Reviewed documentation confirmed though the inventory list has been created, staff have not been completing perpetual or daily inventories of the tools since the deficiency was identified in January. An informal interview with the vocational staff confirmed they were unaware this had to be completed. A review of nine staff training records and nine youth case management records indicated each youth and eight of the nine staff received training on the intended and safe use of tools while one staff has not. Nine staff were interviewed regarding what tools youth use. Three staff said a scrub brush, eight staff said mops and broom, and four staff specified either a dust pant, toilet brush, scrub pads, and/or plungers. The facility administrator advised the would follow-up with the applicable staff regarding this deficiency.

During the re-review the program received a **Limited Compliance rating** for this indicator. 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

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY19-20 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures in place for youth tool handling and supervision. Each cottage contains a storage closet which includes a broom, mop, mop bucket, plunger, and dust pan. Youth are not allowed to handle tools unless a Risk Assessment has been completed determining the youth is not at-risk. Reviewed documentation of nine youth case management records verified Risk Assessments are completed monthly and identify if a youth is eligible to handle tools. A review of nine staff's in-service training records indicated eight staff were trained in the use of tools and while one was not. The program also has a vocational program operated by Washington County school system were youth utilize class A tools. An informal interview with the superintendent confirmed the program's practice is to conduct a Risk Assessment on all youth each month. A review of nine randomly selected youth enrolled in the vocation program indicated each had an up-to-date risk assessment indicating they are eligible to handle tools. Nine youth were interviewed and indicated they only use mops, brooms, and scrub brushes. Nine staff were interviewed and stated youth are only allowed to use mops and brooms.

5.15 Outside Contractors

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures to address outside contractors performing work projects while at the facility. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, ensures immediate reporting of any tool the worker cannot locate, and follows up if any tool is missing. The program requires all outside contractors to review and sign a guidelines form with an attached copy of the visitor's contraband list and sign a Prison Rape Elimination Act (PREA) acknowledgment form to document their understanding and agreement with the rules, requirements, and guidelines to

which the contractor must adhere to while working on-site in the facility. A random selection of completed outside contractor forms compared with sign-in logs and submitted invoices were reviewed and confirmed the program's practice of having outside providers on-site. No youth are allowed in the work area while outside contractors are on-site. An informal interview with the facility administrator confirmed when a contractor is on-site, a maintenance staff member is assigned to supervise the contractor until the work is complete.

5.16 Fire, Safety, and Evacuation Drills

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written Continuity of Operations Plan (COOP) which was approved by the Department on May 17, 2019. Reviewed documentation coupled with an informal interview with the facility administrator (FA) confirmed the COOP requires the program to conduct unannounced fire drills once a month for each shift. Drills are to be conducted on a random basis under varied conditions when a majority of the youth are available. Program staff document drills on a Facility Drill form, which included the beginning and ending times and the nature of the drill. Reviewed documentation confirmed the program completed drills in accordance with their COOP. The program completed COOP drills relating to safety and/or evacuation involving an escape, a chemical spill, an active shooter, a riot/disturbance, flooding, and a hurricane. Nine youth were interviewed and eight of the nine confirmed they had been instructed on what to do in the case of a fire. The one remaining youth stated he has not participated on a drill since he was admitted. Reviewed documentation of this youth's case management record confirmed the youth received orientation to the program, which includes what to do in case of a fire. An interview with nine staff confirmed they participated on various drills within the last six months including drill scenarios involving major disturbances, weather, bomb threats, chemical spills, flooding, terrorism, escape, medical emergencies, and fires.

5.17 Disaster and Continuity of Operations Planning (COOP)

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a Continuity of Operations Plan (COOP) which encompasses a coordinated disaster plan. The plan was approved by the Department on May 18, 2018 and provides for basic care and custody of youth in the event of an emergency or disaster. The COOP addresses phases of a disaster plan, as well as emergency management including preparedness, response, and recovery. The COOP also addresses emergencies including fire prevention, bomb threats, evacuations, chemical spills, severe weather, and terrorist attacks. A review of the plan indicated alternative housing should the program have to be vacated due to an emergency or disaster. An informal interview with the facility administrator (FA) confirmed a copy of the COOP is maintained and available to all staff in the FA's office, master control, the medical office, and the administration building.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures for the storage and inventory of flammable, poisonous and toxic materials. These items are stored off-site in locked facility maintenance buildings accessible only to staff. A list of staff positions who are authorized to use chemicals are posted on the outside of all storage doors. All caustic materials are stored according to type and use. A safety data sheet (SDS) binder is maintained 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. The program also has a chemical daily usage log used to track all flammable, poisonous, and toxic items and materials when in use by authorized staff. The form identifies the date signed out, chemical number, description, amount used, amount remaining, date signed in, amount received if applicable, total, and initials of staff. Observations of the storage areas indicated they are clearly

marked hazardous chemicals and are 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. Each cottage contains a locked storage closet used to store mops, a mop bucket, brooms, dust pans, a plunger, and toilet brush. Chemicals used to clean the cottages are stored in a locked closet located in the administration/programming building. The facility administrator maintains spray bottles filled with chemicals used for cleaning in this building as well as a limited supply of cleaning chemicals. Observations reflected a SDS binder and sign out/in logs are maintained here as well. The remaining chemicals along with an SDS binder with sign-out logs are stored in the program's warehouse building behind a large, securely locked, sliding metal door. When chemical levels are low within the administration programming building, staff retrieve chemicals from the warehouse manager and refill as necessary. Reviewed documentation confirmed an inventory sheet is maintained for each chemical and each inventory matched what was stored.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. 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 obtain a supply of chemicals from the administration/programming building used to clean the cottages each day. The remainder of the cleaning chemicals are maintained by the warehouse manager in the program's warehouse building. A sign in/out log is maintained within the administration programming building. A review of the logs verified staff sign out chemicals when in use and sign the chemicals back in when done. Youth are not allowed to possess flammable, poisonous, toxic and caustic items. When youth conduct daily cleaning activities, staff spray the applicable cleaning chemical on the designated area and the youth will wipe it/clean it. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waste. Observations of youth during daily cleaning activities confirmed this practice. Nine youth were interviewed, and each stated they do not use any chemicals or cleaning products.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program maintains a written policy and procedures for the disposal of chemicals which was developed to be in accordance with Occupational Safety and Health Administration (OSHA) standards. The program's facility maintenance staff dispose of unused flammable, poisonous, and toxic materials during Okeechobee County's free Amnesty Day. This day is set by the county for disposal of such materials. Signed documentation from the county is received indicating what materials are being disposed. At the time of the annual compliance review, a date has not yet been set by the county for this year's Amnesty Day. Reviewed documentation reflected the program last disposed of materials on Amnesty Day in January of 2018. An informal interview with the maintenance file clerk confirmed the program generally uses all of the chemicals before disposing of the bottles and don't often have waste disposal. If items need to be disposed of, the program will follow in accordance with the manufacturer's safety data sheet. Liquid waste not resulting from work details are disposed of in the plumbing area of each housing unit with a drain. Liquid waste resulting from work details is disposed of in the plumbing drains located in the mop storage areas. The program uses KRK Enterprises, Inc. to dispose of kitchen grease accumulated from cooking. The company comes on-site and pumps out the grease trap for disposal and performs maintenance on a quarterly basis. A review of a service invoice from May coupled with an informal interview with the facility administrator (FA) confirmed this practice. An informal interview with the FA also confirmed the program has not had any chemical spills occur since the last annual compliance review.

5.21 Recreation and Leisure Activities

The program originally received a **Failed Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures regarding recreation and leisure activities. These activities are geared to provide a range of supervised and structured indoor and outdoor recreation activities for the youth and shall be based on the developmental levels and needs of the youth in the program as well as youth input about their preferences and interests in various activities. According to the contract, the program is required to have two recreational therapist positions. The educational requirements listed state the candidate should preferably have a bachelor's degree of science in recreation and sports management with a track in recreational therapy. The program has filled one recreational therapist position on May 13, 2019 while the other position is vacant. This other position was initially vacant on January 11, 2019 and was filled on May 13, 2019. This position became vacant again on June 7, 2019, and is a key/essential/critical position, and remains vacant at the time of the annual compliance review. Reviewed documentation reflected the one recreational therapist employee has a Bachelor of Science degree in sports management and meets the educational requirements. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. Recreational therapy activities are provided and are incorporated into goals on each applicable youth's individualized treatment plan. The activity schedule includes recreation each afternoon for one hour with each dormitory in alternating rotation with group sessions. The program maintains a monthly calendar of indoor and outdoor recreation activities planned for the youth targeted to promote team building and leadership skills. Randomly selected dates and times were reviewed in the program's facility logbooks and confirmed the youth have allotted time each day for recreation. Observations were made of two cottages participating in indoor recreation and leisure time within the program's large gymnasium room due to inclement weather. Staff were strategically positioned to ensure proper supervision of the youth and to ensure there were no physical obstructions in their view. Staff took precautionary measures to prevent overexertion, heat stress, and dehydration by reviewing the heat index prior to recreation and also by having a jug of water available for the youth to hydrate. Nine youth were interviewed regarding if they are provided physical and leisure activities for at least one hour each day. Each youth stated the program does provide them with at least one hour of recreation and leisure time a day. Each youth reported they can play/participate in football, basketball, kickball, cards, board games, corn hole, pushup competitions, jumping jacks, and watch television during recreation and leisure time. Nine staff were interviewed and indicated the type

of recreation and leisure activities are provided to youth are basketball, football, television, and board games.

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

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. This program does not participate in any water elated activities; therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. This program does not participate in any water elated activities; therefore, this indicator rates as non-applicable.

5.23 Visitation and Communication

The program originally received a **Satisfactory Compliance rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. 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.

During the re-review the program received a **Satisfactory Compliance rating** for this indicator. The program has a written policy and procedures for youth to have visitation and communication with family members to re-establish family and community relationships while in the program. Youth are informed of visitation upon their admission to the program during the orientation process. The program encourages visitation from each youth's parents/guardians by mailing 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 nine youth case management records verified each record contained an approved correspondence, visitation, and telephone log. The program holds visitation in their cafeteria building on Saturdays from 1:00 p.m. to 4:00 p.m. An informal interview with staff confirmed special visitations are also provided for those parents/guardians who are unable to participate on the regularly scheduled visitation days. Each youth is also provided weekly telephone calls, writing materials, and a self-addressed and stamped envelope to talk and send letters to approved family members. Youth are afforded unimpeded access with the courts,

attorneys, their Department of Juvenile Justice probation officer, and/or their Department of Children and Families case worker. Observations of each cottage indicated the visitation and telephone schedules were visibly posted in the living areas. Nine interviewed youth each stated they are provided the opportunity to communicate with family members by telephone or at visitation.

5.24 Search and Inspection of Controlled Observation Room

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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 and Release Procedures

The program originally received a **Non-Applicable rating** for this indicator during the FY18-19 annual compliance review, conducted January 8-11, 2019. The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

During the re-review the program received a **Non-Applicable rating** for this indicator. 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

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

Limited Ratings	Failed Ratings
1.12 Restorative Justice Awareness for Youth	1.09 Grievance Process
1.19 Staff Performance	2.09 Performance Plan Development, Goals and Transmittal*
3.03 Non-Licensed MH/SA Clinical Staff	2.11 Performance Summaries and Transmittals
5.07 Key Control	5.04 Ten-Minute Checks*
5.13 Tool Inventory and Management	