STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Okeechobee Youth Correctional Center

TrueCore Behavioral Solutions, LLC.

(Contract Provider)
7200 Highway 441 North
Okeechobee, Florida 34972

Review Date(s): October 9-12, 2018

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:

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

Review Team

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

Yvrose Sylvain, Office of Program Accountability, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Program Accountability, Technical Assistance, South Region (SPEP)
Keith Bennis, Office of Program Accountability, Regional Monitor (Standard 5)
Christine Calvert, Office of Program Accountability, Regional Monitor (Standard 3)
Shantia Daniel, Palm Beach Youth Academy, Assistant Facility Administrator (Standard 2)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Standard 1)
Shirlon McCarty, DJJ Probation, Circuit 15, Reform Specialist (Standard 2)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 4)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Interviews)

Program Name: Okeechobee Youth Correctional Center
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Okeechobee County / Circuit 19
Review Date(s): October 9-12, 2018

MQI Program Code: 1288
Contract Number: 10188
Number of Beds: 16
Lead Reviewer Code: 125

Methodology

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

Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
_____ # Case Managers
1 # Clinical Staff
_____ # Food Service Personnel
1 # Healthcare Staff
1 # Maintenance Personnel
1 # Program Supervisors
3 # Staff
5 # Youth
3 # Other (listed by title): **Program Superintendent, Regional Compliance Managers, Lead teacher**

Documents Reviewed

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

Surveys

5 # Youth
3 # Direct Care Staff
_____ # Other: _____

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Standard 1: Management Accountability

Overview

Okeechobee Youth Correctional Center (OYCC) is a sixteen-bed, maximum-risk program serving males between the ages of thirteen to twenty-one. The program is located in Okeechobee, Florida and co-located with Okeechobee Youth Development Center. There is one program facility administrator (FA) responsible for both programs and the entire management team. The program has one living module to house youth. The program has a superintendent who is responsible for all five on-site programs at the facility. The management team consists of a facility administrator, assistant facility administrator, unit manager, director of case management, recreational therapist, director of clinical services, health services administrator, compliance manager, food service manager, and a human resource manager. The program provides mental health overlay services (MHOS), delinquency interventions, life skills, on-site educational classes, and vocational programming. The program offers programs geared towards intervention. Thinking for a Change (T4C), The Teen Relationship Workbook, and Impact of Crime (IOC) are three effective intervention groups taught by specific staff to assist youth in the program. All three programs run in sequence. The educational services are provided by the Washington County School System. At the time of the annual compliance review, the program had nine vacant positions, which included four youth care workers, one clinical director, two case managers, one transporter, and one master control technician.

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

The program maintains a written policy and procedures requiring compliance with the Department's background screening requirements. The program had seventeen staff members who were applicable for an initial background screening during this annual compliance review period. The program had no contracted staff or volunteers during the review period. A review of initial background screenings for the seventeen newly hired staff found the program received background screenings from the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each staff having access to youth. Documentation showed the program added all employees 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 review of five employee records revealed each employee passed both portions of the pre-employment assessment tool. There was documentation in all five 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 Enforcements automatic training management system as part of

the pre-employment background screening process. The Annual Affidavit of Compliance with Level 2 Screening Standards, along with the school board's annual screening, were completed and submitted to BSU on January 23, 2018, meeting the annual requirement.

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

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

1.03 Provision of an Abuse-Free Environment (Critical)	**Satisfactory Compliance**
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse.* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*	

The program maintains a written policy and procedures outlining an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Observations made during a tour of the program found signs posted throughout the program listing the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC), and a telephone in the living area/dormitory. The program's practice is once a youth wants to call the Florida Abuse Hotline, the youth will pick up the telephone in the dormitory with a direct connection to the Florida Abuse Hotline to place the call. If the youth are not in the dormitory area, the youth care worker will use the radio to call the shift supervisor, the shift supervisor will take the youth to the telephone in the dormitory area, and the youth will pick up the telephone with a direct connection to the Florida Abuse Hotline to

place the call. For youth eighteen years of age or older, they may request a call to the Department's CCC through the youth care worker and/or on-duty shift supervisor. The youth care worker will use the radio to call the shift supervisor, and the shift supervisor will take the youth to 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 on-duty supervisor or unit manager 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 five 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 staff was terminated base on the outcome of the investigation.

Five interviewed youth reported never being stopped from reporting abuse to the Florida Abuse Hotline or CCC. Three of the five youth reported staff are respectful when speaking with them and two reported sometimes. All five youth reported never hearing staff use curse words when speaking to youth. All five interviewed youth reported feeling safe in the program. None of the three interviewed staff reported ever seeing a co-worker deny a youth an abuse call. All three staff were able to explain the process of allowing a youth to call the Florida Abuse Hotline or the CCC, in accordance with the Florida Administrative Code 63F-7. All three interviewed staff reported they had never observed a co-worker using profanity when speaking to youth.

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

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 supported the staff was removed from direct contact with youth, placed on suspension, and was terminated base on the outcome of the investigation.

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

The program maintains a written policy and procedures regarding response to incidents, which is in accordance with Florida Administrative Code. The program had three reportable incidents during this annual compliance review period. A review of the three incident reports found all three were reported to the Department's Central Communications Center (CCC) within two hours of the incident or becoming aware of the incident. All three incidents were documented in

the program's master control logbooks. In reviewing the program's internal incident reports and grievance reports, there were no incidents which should have been reported to the CCC which were not. The program has experienced a decrease in the number of reportable incidents to the CCC compared to the last annual compliance review period. An interview with the program's facility administrator confirms the program has a policy in reference to the CCC and they ensure all matters which require reporting is verbally reported within two hours of the incident or when the program became aware of the incident.

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

The program maintains a written policy and procedures regarding the utilization of physical intervention techniques in accordance with Florida Administrative Code. The program had one Protective Action Response (PAR) incident in the past six months. There was documentation to support a monthly summary of PAR reports were submitted to the Department, as required. A review of the PAR report found four of the five staff involved completed appropriate statements prior to the end of their shift. One staff did not complete the statement at the end of the shift. The staff statement was completed on the next day. The PAR report was reviewed and processed within seventy-two hours by all required parties. The PAR report documented a Post-PAR interview was conducted with the youth by program administration within thirty minutes after the incident. The program's PAR plan was approved by the Department's Office of Staff Development and Training on May 23, 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 2.16, which is above the statewide Residential PAR rate of 1.49. An interview with the facility administrator 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)	Satisfactory Compliance
Contracted and State residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

The program maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training plan was approved by the Department's Office of Staff Development and Training on December 18, 2017. Pre-service training is provided through a combination of instructor-led and web-based courses. Five staff training records were reviewed for pre-service certification training. Four of the five 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 in progress, with the staff currently in the second training phase. 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 and still has time to complete certification prior to the 180-day time frame. 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	Limited Compliance
Residential staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.*	

The program maintains a written policy and procedures regarding in-service training for all staff. Five staff training records were reviewed for in-service training. All reviewed staff training records documented each staff member exceeded the twenty-four hours of annual in-service training requirements. All five staff had current certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). All staff completed training in professionalism, ethics, and six hours of suicide prevention training. One of the two applicable staff exceeded the eight hours of management/supervisory training. One supervisor staff did not complete any of the eight hours of management and supervisory training. The program has a training calendar, which is updated as necessary. All trainings were delivered by qualified trainers. The program maintains a written in-service training plan, which was reviewed and accepted by the Department's Office of Staff Development and Training on December 18, 2017.

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

The program has a written policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. According to program policy, procedures are in place to confirm each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's grievance procedures include informal, formal, and appeal phases with time frames of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are also provided with the opportunity to file an alternative informal request by utilizing a Let's Talk form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and Let's Talk forms were available to youth, as observed during the facility tour. Reviewed documentation showed the program had one grievance and eighteen Let's Talk forms submitted by youth since the last annual compliance review. A review of the grievance revealed the one youth's grievance was resolved at the formal phase. The grievance was addressed within the seventy-two-hour time frame. Five staff training records were reviewed for pre-service and in-service trainings. All ten training records documented each staff received the required training on the program's grievance process and procedures. During the annual compliance review, five youth and three staff were interviewed. The five youth were able to explain the grievance process to include submission of a completed grievance form into the secured grievance box. All five interviewed youth reported being able to request assistance in completing a grievance form, if needed. All three interviewed staff were able to explain the grievance process.

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

A review of the program's contract identified Thinking for a Change (T4C) as the evidence-based delinquency intervention utilized at the program. A review of the program's activity schedule and an observation of a T4C group confirmed the program is providing structured, planned programming, or activities at least sixty percent of the youth's waking hours. T4C groups are held twice a week, one hour for each group. A review of the T4C sign-in sheets validated groups are being delivered, as designed. The facility administrator and staff training records identified one staff who was trained by a certified trainer to facilitate T4C groups. An interview with the facility administrator and compliance manager confirmed T4C is used as an evidence-based delinquency intervention. According to the facility administrator, T4C helps youth identify ways to think of positive solutions to issues or situations on a daily basis. Youth have the opportunity to demonstrate skills during treatment team meetings and through interactions with other youth and staff. A review of five youth records confirmed all five youth completed a T4C group successfully and had goals in their individual performance plan to address the delinquency needs.

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

The program maintains a written policy and procedures to address life skills training for youth. The program provides life skills training through Teen Relationships groups, Living in Balance, Skillstreaming the Adolescent, and Passport. A review of the program activity schedule confirmed a life skills training group is provided to the youth once a week. All staff conducting groups received formal training and on-the-job training to deliver these groups. A review of five case management records and group sign-in sheets indicated services were delivered, as required. Reviewed documentation showed all five youth were actively participating in Teen Relationships groups. All five 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 preventing consequences.

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

The program provides activities or instructions intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youth's criminal actions and harm to others. The program provides restorative justice activities through the Impact of Crime (IOC) curriculum, which is a program with demonstrated effectiveness, as outlined in the Department's Sourcebook of Delinquency Interventions. The program provides the IOC curriculum to the youth to teach youth about the impact of crime on victims, their

families, and their communities. The program had two case managers trained on August 10, 2018, and one director of case management trained on March 11, 2016 to facilitate IOC groups. One of the two case managers was retrained on April 27, 2018, because of identified group delivery deficiencies. Documentation showed the program completed four IOC groups and one group was in progress during the annual compliance review period. The first IOC group started on January 2, 2018 and was completed on April 9, 2018. Eight youth successfully completed the group. The second group started on January 12, 2018 and was completed on April 6, 2018. Eight youth started the group and seven youth successfully completed. The third group started on March 12, 2018 and was completed on August 16, 2018. Seven youth started the group and six successfully completed. The documentation reviewed and the entries in the Department's Evidence Based System (EBS) indicated the curriculum was completed in twenty-six sessions which did not meet the minimum of thirty-two sessions required. The fourth group started on May 15, 2018 and was completed on July 24, 2018. Eight youth successfully completed the group. One youth was added to the group on May 18, 2018, after the group had started, even though IOC is a closed group. The fifth group was in progress and started on August 21, 2018, with eight youth participating. Documentation showed the program adhered to the group schedule; however, the program was not consistently following the group schedule for the third group. A review of five case management records and group sign-in sheets indicated services are being delivered, as required, with the exception of the third group. The program identified the IOC problem prior to the Department's annual compliance review. The program retrained the staff responsible for conducting the groups. However, the staff failed to follow the IOC curriculum and group schedule. Reviewed documentation found management took immediate action regarding the staff by initiating an internal investigation regarding the discrepancies on the sign-in sheets for the third group and the staff was terminated on July 31, 2018. All five interviewed youth reported they participated in IOC group and were able to explain what they do in groups.

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

All youth in the program are provided Young Men's Work, which is an evidence-based gender-specific curriculum which includes exercises specifically for males regarding issues of violence, bullying, substance abuse, and issues related to teen fatherhood. A review of five 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. During the annual compliance review week, a group was observed, and the therapist facilitated the group, as required by the curriculum. The facility administrator reported gender needs are addressed through Young Men's Work group and youth engagement in activities such as competitive football, basketball, and other sporting tournaments. Specific hygiene needs are also permitted based on cultural needs. All five interviewed youth reported they participated in substance abuse, anger management, and stress therapy groups.

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

The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert, which may not have been previously entered prior to the youth's admission. The program has an alert board in master control, which identifies each youth's special alerts, escape risk, and/or gang affiliation. The board also identifies youth placed on any type of mental health alert. The alert board has each youth's picture and arranged by 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 supervisory staff. The alerts entered into JJIS are verified through the medical staff, case management, and licensed mental health staff. Five youth records were reviewed for case management, medical, and mental health and substance abuse. All the case management and medical alerts were accurately entered into JJIS. Three reviewed records were applicable for mental health and substance abuse alerts. The three JJIS suicide alerts were entered late and two were closed late. The first youth was on precautionary observation (PO) from March 23, 2018, through March 27, 2018. The alert was created on March 26, 2018 and removed on March 28, 2018. The second record showed the youth was on PO from July 19, 2018 through July 23, 2018. The alert was created on July 20, 2018 and removed on July 24, 2018. The third youth record showed the youth was placed on PO on July 19, 2018 and the alert was entered July 20, 2018. The third reviewed record showed the alert was closed on the day the youth's status was downgraded. All internal and JJIS alerts were downgraded or discontinued by a medical staff, the program's assistant facility administrator (AFA), facility administrator (FA), and/or a licensed mental health staff. Three staff were interviewed and all three reported they are informed of youth alerts during shift meetings, they can review the program's alert board for youth alerts in master control, and an extra copy of the program's internal alerts are also placed in sub-control.

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

The program maintains individual healthcare, mental health and substance abuse, and case management records for each youth. All five reviewed case management, healthcare, mental health and substance abuse records were 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	**Failed Compliance**
The program has a formal process to promote constructive input by youth.	

According to the program compliance manager, the program has a youth daily meeting which allows youth to provide feedback daily. Documentation showed the program started holding youth daily meetings on July 30, 2018 to September 17, 2018; however, the program was not consistently conducting the daily meetings. There was no documentation of youth daily meeting from April 2018 to July 29, 2018. The program provided the Department with video footage to show how the program staff conducted the daily youth meetings, allowing youth to provide feedback daily. The program maintains a composition book of youth daily meetings minutes when meetings are conducted. Documentation showed youth completed an application to be a part of the resident advisory council from March 22, 2018 to September 12, 2018; however no council meetings have been held. The program is developing a formal process to promote constructive input from youth and stated a resident advisory council will take place twice a month. Reviewed documentation did not support the program had a formal process to promote constructive input from youth during the annual compliance review period. Five youth were interviewed, and all five youth reported the program conducted daily youth meetings for youth to express their concerns and needs.

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

The program has an advisory board, which serves six programs located in Okeechobee County. The advisory boards were combined due to a limited amount of people living in this rural community and the number of boards local representatives were currently participating in. Reviewed documentation supported the program's community advisory board meets at least quarterly. The meeting minutes were documented with an agenda and sign-in sheets for March 22, 2018, June 22, 2018, and September 20, 2018, with the next quarter meeting scheduled for December 2018. 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 form the judiciary; however, reviewed documentation demonstrated the facility administrator's recruiting efforts.

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

The program maintains a written policy and procedures identifying service, employment recognition, and tuition reimbursement. The program administration conducts comprehensive quarterly youth and staff surveys through Survey Monkey. The results of the surveys are discussed in detail at the corporate office and, subsequently, the results are reviewed during staff 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 Central Communications Center (CCC), grievances, personnel issues, youth behaviors, admissions and discharges, and any upcoming events. The program has recognitions for staff such as tuition, licensure, registration certification, employee referral bonus, 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. Three interviewed staff reported staff meetings are held monthly and shift briefings daily. Two interviewed staff reported the communication amongst the staff at the program is fair, and one staff reported 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, employee of the month, youth supervision, staff positions during sight and sound supervision, staff positive performance, and any upcoming events dates for the youth.

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

The program conducts ninety-day performance evaluations for newly hired staff, and annual evaluations for all staff. Five personnel records were reviewed, of which two contained an annual performance evaluation, two contained a ninety-day performance evaluation, and one record did not have a staff performance evaluation within the past twelve months. The performance evaluations were specific to the applicable staff's job description. All four reviewed performance evaluations found each staff's evaluation was based on the performance standards for their position. One applicable staff performance evaluation 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. Two of three interviewed staff reported receiving an annual evaluation, and one reported receiving an evaluation every six months and a ninety-day evaluation.

Standard 2: Assessment and Performance Plan

Overview

The program's case management services include initial Residential-Positive Achievement Change Tool (R-PACT) assessments, R-PACT re-assessments, Youth Needs Assessment Summaries (YNAS), individual performance plans (IPP), performance summaries, formal and informal treatment team meetings, transition, and exit plans. Case managers are members of the multidisciplinary treatment team and meet with each youth formally monthly and informally twice a month to discuss each's youth progress. Case managers are the primary liaison between the youth and their family, assigned juvenile probation officer (JPO), and committing judge. The program provides educational services for each youth through Washington County Public School System, and each youth receives their earned academic credits and have the opportunity to work towards a General Equivalency Diploma (GED) test.

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

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

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

The program has a policy and procedures regarding youth orientation. A review of five 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. The program did not have an admission during the annual compliance review week; therefore, a youth admission was not observed. A review of the program's logbooks and shift reports indicated youth orientations are documented either in

the master control logbooks or the shift reports. Three interviewed youth stated they received an orientation to the program on the date of admission and two reported within twenty-four hours of admission.

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. Five case management records were reviewed and two were applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. An additional record was reviewed. All three applicable youth records contained consent forms signed by the youth allowing the program to share, with the parent/guardian, any information related to the youth's physical or mental health screening, assessment, or treatment.

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

The program's policy and procedures clearly 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. Five 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 interim 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 interim 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 sleeping area. 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 five 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 five youth records reviewed had a reassessment completed. One of the five youth's reassessment indicated an increase of the youth's privileges or freedom of movement. The youth was allowed to move to the honor room. All five youth case management records included documentation for the reclassification of youth prior to engaging in certain activities. A review of the program's policy and procedures, individual performance plan (IPP), facility logbooks, treatment team notes, and/or performance summaries validated the youth were reclassified before engaging in increased privileges. The program is a secure maximum-risk program and youth are not allowed to participate in off-campus activities.

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

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

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

The program maintains a gang binder which contains information on youth who have been documented as gang members or associated with a gang. Five case management records were reviewed and two were applicable for youth gang involvement or association. One additional record was requested and reviewed. 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 interim facility administrator, if youth are identified as gang members during the classification meeting, the youth are assigned gang intervention goals and attend gang prevention groups.

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

The program has a written policy and procedures in place for completing a Residential Positive Achievement Change Tool (R-PACT) assessment within thirty days of each youth's admission. A review of five case management records found all five records contained a R-PACT assessment completed within thirty-days of each youth's admission to the program. The program maintained all documentation of the initial assessment in the Department's Juvenile Justice Information System (JJIS). The program also has a written policy and procedures in place to reassess each youth within ninety-days after the completion of the youth's initial R-PACT assessment. The five youth records were applicable for a R-PACT re-assessment. Documentation revealed each R-PACT re-assessment was completed within ninety-days of the completion of the youth's initial R-PACT assessment. All five youth records showed the R-PACT re-assessments were completed, when deemed necessary, by the intervention and treatment team in order to effectively manage each youth's progress. The program maintains the re-assessments in JJIS and places copies in each youth's case management record.

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

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

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

The program has a policy and procedures in place regarding performance plan development, goals, and transmittals requiring the intervention treatment team to meet within thirty days of each youth's admission to the program. Five youth case management records were reviewed, and all records contained a developed performance plan with goals, which matched each youth's assessed needs. All five youth reviewed records indicated the initial performance plans were completed within thirty days of each youth's admission into the program. All five performance plans documented youth responsibilities, staff responsibilities, and target dates for goal completion. All of the records documented all parties were involved in the development of the youth's initial performance plan goals and all pertinent parties signed the plan. None of the records contained an initial performance plan with parental signature. All five records contained letters to the parent/guardian requesting their signatures on the performance plans; however, the program never received the signed plans back from the parents/guardians. All five youth records documented a copy of the initial performance plan was sent to the judge, juvenile probation officer (JPO), and parent/guardian within ten days of being developed. One applicable youth record had documentation showing a copy of the performance summary was sent within ten working days to the assigned Department of Children and Families (DCF) worker. The Department Agency for Persons with Disabilities (APD) behavior support plan was not applicable for the five youth records reviewed. A review of three closed records found transition activities were targeted for the last sixty days of each youth's anticipated stay. All five youth reported during their interviews they participated in the development of their performance plans. All five interviewed youth stated they received a copy of their performance plan and were aware of their current performance plan goals.

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

The program has a policy and procedures in place regarding performance plan revisions. Five youth case management records were reviewed for revisions to the individual performance plan (IPP). Documentation confirmed each IPP was revised based on the Residential Positive Achievement Change Tool (R-PACT) reassessment results and newly acquired information. Two of the five youth IPPs demonstrated lack of progress toward completing a goal. In three youth records, the IPP demonstrated progress toward completing a goal and goal completion. A review of three closed records showed the youth revisions to the individualized performance

plans were made due to requiring facilitation of transition activities during the last sixty days of the youth's stay.

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

The program has a policy and procedures in place regarding performance plan summaries and transmittals being completed for each youth at ninety-day intervals from the signing of the performance plan or in shorter intervals when requested by the committing court. Five case management records were reviewed. Four of the five youth case management records demonstrated performance summaries were reviewed every ninety days and one was completed late. Documentation showed the youth was admitted to the program on February 9, 2018, and the youth's first performance summary was not completed until June 14, 2018. All five youth records had documentation to support performance summaries were signed and dated by all required parties. Four of five youth records had the performance plan transmittal letter and copies of performance plans were sent to youth's committing court, juvenile probation officer, and parent/guardian within ten working days of completion. One was sent late to all parties. There was documentation in all five youth records to support performance plan summaries were completed every ninety-day from the initial performance plan. Three closed records were reviewed for release summary information, and all five records contained supportive documentation signed and sent to the correct parties within the required designated time frames. All three reviewed records had release summaries sent within forty-five days of their release. Four of the five interviewed youth stated they received a copy of their performance summary sent to the court and one reported not receiving a copy with no explanation.

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

The program has a policy and procedures which addresses the encouragement of parent/guardian involvement in case management services. Program administration stated each parent/guardian is called by the case manager upon each youth's admission to the program and a welcome letter is mailed within forty-eight hours of admission. Youth are also allowed a call to their parent/guardian once a week. Documentation confirmed involvement of the youth's parent/guardian in the case management process. Reviewed documentation confirmed efforts had been made to include the parent/guardian in the assessment process, treatment team meetings, in the development of the performance plan, and transition planning. There was documentation in the youth records which showed letters were sent to the youth's parent/guardian advising them of the date, time, and encouraging their participation either in writing, in person or via telephone. Interview with the facility administrator confirmed youth's parent/guardian are invited by program staff to participate by telephone and/or provide input in

writing and encourages parents to join the treatment team process. During the annual compliance review week, informal treatment team meetings were observed. The program staff reached out to the youth's parent/guardian by telephone; however, the parents/guardians were not available.

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

The program has a policy and procedures in place regarding treatment team and members participation. The program assigns each youth to a treatment team upon admission into the program. The treatment teams are comprised of the youth, case manager, a representative from education, a mental health therapist, the youth's parent/guardian, assigned juvenile probation officer (JPO), medical staff, a representative from the living unit, and a representative from the program's administration. Documentation showed all required parties were in attendance during formal and informal treatment team meetings. One record was applicable for youth supervised by the Florida Department of Children and Families (DCF) and the youth's record documented the participation of the DCF case worker on the youth's treatment team.

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

The program has a policy and procedures in place to ensure the incorporation of treatment or care plans from other agencies into each youth's performance plan. A review of five youth case management records revealed each youth's performance plan contained goals or information from the mental health and substance abuse treatment plans, educational plans, and medical plans. One applicable youth record had documentation the Department of Children and Families incorporated (DCF) plan was incorporated into his performance plan. The program did not have any youth who had Agency for Persons with Disabilities plans, which needed to be incorporated into a performance plan.

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

The program has a policy and procedures in place regarding formal and informal treatment team meeting reviews. The program conducts formal and informal treatment team meetings monthly, on a bi-weekly basis. Also, special treatment team meetings are held for youth having difficulty in the program, which allows the treatment team to make necessary revisions to the

individual performance plan. Five youth case management records were reviewed for formal and informal treatment team meetings. Formal treatment team meeting documentation included the youth's signature, review date, attendees, comments by treatment team members, and a brief synopsis of the youth's progress in the program. Reviewed documentation supported the youth's performance plan goals were discussed. All youth records contained documentation of the youth's input during treatment team meetings. Each reviewed record confirmed the treatment team leader invited and encouraged participation of the youth's juvenile probation officer (JPO) and parent/guardian. The annual compliance review team was unable to observe a formal treatment team meeting, as none were scheduled during the annual compliance review week. Each record showed informal treatment team meetings were conducted at least once a month and special treatment team meetings were held for youth having difficulty in the program, when necessary. Observations of informal treatment team during the annual compliance review week revealed all required parties were in attendance, to include education staff, and provided verbal and written input. Youth were provided an opportunity during the informal treatment team meeting to demonstrate some of the skills learned in the program and their progress in treatment was discussed. Five interviewed youth reported they are provided the opportunity to demonstrate skills they have learned in the program during their treatment team meetings.

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

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

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

The program operates on a year-round basis providing educational services. Interviews with the school principal reported educational services are provided 250 days a year, with 300 minutes of instruction five days a week. During the annual compliance review week, youth were observed receiving the required minimum 300 minutes of daily instruction. Each youth has a separate educational portfolio, which is maintained throughout the duration of the youth's placement in the program. According to the school principal, educational staff attend and/or submit written input during formal treatment team meetings, transition conferences, and the exit conference for each youth. A review of five 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 five youth case management records contained evidence of youth receiving these educational accesses. The facility master control logbook entries further documented youth are attending school during the times indicated on the activity schedule. Three interviewed youth reported there are no interruptions during educational instruction and two reported only during General Equivalency Diploma (GED) test and reading hours.

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

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

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

The program has a policy and procedures in place regarding transition planning, conferences, and community re-entry team (CRT) meetings. A review of five youth case management records revealed none of the youth were in the transitional phase of the program. Three youth closed records were also reviewed. All three closed records demonstrated the transition conferences were held at least sixty days prior to targeted release date. Documentation showed the interim facility administrator or designee participated in all three of the transition conferences.

Documentation in the three closed records showed all treatment team members were invited and encouraged to participate in the transition conference. There was documentation in two of the three records the program received an invitation to the CRT meetings, and the case manager and youth participated in one of the meetings. One youth record had no documentation of the program's case manager and youth participated in the CRT meeting. In one of the three youth records, the youth's juvenile probation officer (JPO) did not send the program staff notification of the CRT meeting. The two applicable youths' CRT meetings were conducted prior to the youth's release.

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

Three closed youth case management records were reviewed, of which two contained copies of state issued identification cards, copies of Social Security cards, and birth certificate. One youth record had no documentation of a copy of state issued identification cards, copy of Social Security cards, and birth certificate. Reviewed documentation in all three closed youth records showed each youth had a completed calendar, résumé, a completed sample job application, and the youth's education transition plan. All three closed records contained documents of school transcripts. Reviewed documentation confirmed the program staff forwarded the exit portfolio information to the juvenile probation officer (JPO) and verified each portfolio at the exit conference and at the time of each youth's release.

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

Five case management records were reviewed, and none were applicable for an exit conference. Three closed records were reviewed. All three reviewed records indicated the exit conference was conducted at least fourteen days prior to each youth's release. Each reviewed record contained documentation to the parent/guardian and juvenile probation officer (JPO), which confirmed the youth's release date and transportation arrangements for their return to the community. In all three closed records, documentation showed the parent/guardian, education staff, assigned JPO, and facility administrator participated in the exit conferences. All three closed records had documents in the case records, including dates, signatures, and a summary pending transition goals. All three closed records contained documentation the community re-entry team (CRT) meeting, transition meeting, and exit meeting were all conducted on different occasions. The dates of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS).

Standard 3: Mental Health and Substance Abuse Services

Overview

The program provides specialized treatment in the form of mental health overlay services. All program clinical services are supervised, coordinated, and conducted under the direct supervision of the licensed designated mental health clinician authority (DMHCA). The mental health clinical staff consists of two master's-level therapists and a licensed mental health counselor serving as the interim DMHCA. Mental health services include admission screenings, comprehensive mental health and substance abuse assessments, and psychotherapy services to include individual, group, and family therapy. Services are prescribed to each youth based on the youth's individualized treatment plan. The program's clinical staff provides, at a minimum, group therapy seven days a week and individual and family therapy once a month. Family therapy is offered face-to-face, by telephone, and through Skype internet services. Youth with co-occurring disorders receive substance abuse treatment group services and all youth receive substance abuse prevention education. The program carries a Chapter 397 license through the Florida Department of Children and Families to provide outpatient substance abuse services to adolescents. The program also provides groups focused on the influences of trauma, psychosocial skills training, delinquency, anger, and self-esteem. The program ensures completion of a psychiatric evaluation for all youth within fourteen days of admission and any youth prescribed psychotropic medication are provided medication management services monthly. Suicide prevention services, crisis intervention, and emergency mental health and substance abuse care are available to all program youth and includes a twenty-four-hour response capability with access to acute care settings through the local emergency room and crisis stabilization unit. Each youth's mental health record at the program is marked "confidential" and stored within a locked cabinet accessible only to clinical staff.

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

The program's designated mental health clinician authority (DMHCA) position is currently vacant. The position has been vacant since May 2018. Recruitment and hiring efforts provided by the human resources department show the position has been posted internally and on external job boards. Reviewed position postings included Zip Recruiter, the local newspaper, radio stations, Indian River State College, Indeed.com, and the Okeechobee Chamber of Commerce. The program's recruitment specialist maintains all posting and candidate tracking on a real time tracker. The recruitment specialist reported there is a current interested candidate and a copy of the electronic mail correspondence was received. Two candidates have previously been offered the position and provided documentation showed one rescinded the offer in July 2018 and the other in September 2018. The program is situated on a campus inclusive of five total residential programs sharing a treatment director position. The treatment

director is currently serving as the program's DMHCA. The interim DMHCA is on call twenty-four hours a day, seven days a week, and is responsible for the coordination and implementation of mental health, substance abuse, and specialized services at the program. The program's regional clinical director and the program's psychiatrist are also on call twenty-four hours a day, seven days a week. The interim DMHCA holds a free and clear, active license in the State of Florida with an expiration date of March 31, 2019. The interim DMHCA is a licensed mental health counselor. The program has an operating capacity of sixteen youth and does not utilize a clinical coordinator. An interview with the interim DMHCA found they are responsible for providing weekly clinical supervision and daily face-to-face support to all clinical staff. The interim DMHCA explained she meets weekly with the psychiatrist during mini-treatment team meetings. The interim DMHCA is also responsible for signing assessments and treatment plans completed by the two non-licensed master's-level therapists and ensures documentation deadlines are met. In addition to supervision, the interim DMHCA facilitates groups and counseling sessions, leads staff trainings, conducts drills, oversees fidelity monitoring, and provides crisis stabilization services. The interim DMHCA reported being on-site 8:00 a.m. to 5:00 p.m., Monday through Friday. A review of the interim DMHCA's position description validated services provided.

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

The program has one full-time licensed mental counselor (LMHC) serving as the treatment director and the interim designated mental health clinician authority (DMHCA). The program's DMHCA position has been vacant since May 2018. The program maintains an agreement for professional services with a state of Florida board-certified licensed psychiatrist. The psychiatrist is scheduled to be on-site weekly. The program maintains an agreement with both a certified behavior analyst and a licensed psychologist, as-needed, for services. The reviewed documentation found each licensed clinician maintained a clear and active license in the State of Florida. The reviewed records reflected each staff is working within the scope of their licensure, experience, and training. The DMHCA, regional clinical director, and the psychiatrist are on-call for emergencies and consultation twenty-four hours a day, seven days a week.

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

The program has two master's-level non-licensed therapists. The program maintains a current Chapter 397 license through the Department of Children and Families to provide adolescent outpatient substance abuse treatment. All non-licensed clinical staff work under the direct supervision of the treatment director who is serving as the interim designated mental health clinician authority (DMHCA). The DMHCA supervises two non-licensed clinicians providing mental health overlay specialized services to all youth. The non-licensed clinical staff provide substance abuse prevention and education under the direct supervision of the licensed mental

health counselor (LMHC). A review of the clinical supervision logs found one of the two non-licensed mental health staff received at least one hour of face-to-face direct supervision from the DMHCA each week. The second non-licensed staff was applicable for thirty-one weeks of direct supervision since the last annual compliance review. Documentation for four weeks of direct supervision logs did not clearly reflected direct supervision was provided for the second non-licensed staff. An interview with the regional clinical director explained the staff previously providing direct supervision is no longer working at the program, and the corresponding logs could not be located. The program also maintained weekly clinical supervision meeting minutes. The reviewed documentation found the clinical supervision log included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documentation strengths, findings, trends, and/or problem areas, situational concerns and training. Each reviewed direct supervision log includes all information, as outlined on the Department's MHSA 019 form. Training records for the two non-licensed staff validated each has completed the required twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each training 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 MHSA 022. An interview with the interim DMHCA revealed weekly supervision and regular coaching sessions are conducted to address staff training needs, professional development, and to regularly review arising needs of the program.

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

The program maintains a written policy and procedures to ensure all youth admitted to the program are pre-screened and placed by the Department based upon individualized history and identified needs of the youth. Five records were reviewed for mental health and substance abuse admission screening. Three were not applicable due to screenings being completed prior to the last annual compliance review. An additional record was requested for a required sample size of three. Each record documented a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) was completed the day of admission and a review of available information was completed. None of the records were applicable for staff believing a youth had a substance abuse, mental health, or suicide risk not indicated on the MAYSI-2 nor was there a need for a suicide or crisis assessment. Each reviewed record showed a document review summary completed the day of admission. An interview with the interim facility administrator revealed all youth are assessed for suicide risk upon admission utilizing the MAYSI-2 and youth with an indicator for suicide are placed on suicide precautions and immediately assessed using the Department's Assessment of Suicide Risk (ASR). 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™, and Substance Abuse Subtle Screening Inventory™ assessments upon admission and throughout treatment, as indicated by the therapist. One of the three applicable reviewed records showed the MAYSI-2 was administered and scored in the Department's Juvenile Justice Information System (JJIS). Two of three records did not document the MAYSI-2 was administered and scored in JJIS, as outlined in the program policy and Florida Administrative Code 63N-1.0053. The MAYSI-2 for the first reviewed record documented administration on February 9, 2018; however, was not entered and completed in JJIS until February 14, 2018. The MAYSI-2 for the

second reviewed record documented the MAYSI-2 was created by the medical records clerk on the day of admission, September 14, 2018, and was completed by the designated mental health clinician authority (DMHCA) on October 6, 2018. The records clerk is trained in MAYSI-2 administration; however, the screening documented the assessment was administered by the master's-level therapist. An interview with the interim DMHCA and regional compliance manager explained the MAYSI-2 is administered using the paper and pencil screening with the therapist upon intake and the file clerk data enters it into JJIS. The interim DMHCA reported the assessment completed on October 6, 2018 was missing the name of the assessor, date, and time of assessment. Two of the three reviewed MAYSI-2s indicated "no referral necessary based upon available information" despite there being an indication for further assessment indicated in the MAYSI-2 results. An interview with the regional clinical director found program practice is to automatically assess all new admissions using the MAYSI-2, and the ASR upon admission.

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

The program maintains a written policy and procedures outlining all youth who present with clinical concerns during the initial mental health or substance abuse screening, or during the course of the program, shall be referred to a licensed mental health service provider for a comprehensive mental health and/or substance abuse evaluation. The program policy is to complete a new compressive mental health and substance abuse evaluation regardless of identified needs for each new admission. Five youth records were reviewed for mental health and substance abuse evaluations and two were not applicable. One youth record had not reached thirty days since admission and the comprehensive evaluation was not yet due, and the other contained a comprehensive evaluation completed prior to the last annual compliance review. Each of the three applicable reviewed records contained a comprehensive evaluation completed within thirty days of admission, as required. Two were signed the same day by the licensed interim designated mental health clinician authority (DMHCA) and the third was signed the next day. Each reviewed new evaluation contained identifying information, reason for evaluation, relevant background information, behavioral observations, mental status examinations, procedures administered, discussion of findings, diagnostic impressions, and recommendations. Each of the three reviewed records were applicable for a substance abuse diagnosis and contained a substance abuse assessment. Each record documented a consent for substance abuse services and urinalysis. Each substance abuse evaluation was completed within thirty days. Each reviewed substance abuse assessment contained reason for assessment, behavioral observations, methods of assessment, patterns of alcohol and drug abuse, impact of alcohol and drug abuse on major life areas, risk factors of continued alcohol and other drug abuse, clinical impressions, and recommendations. None of the three reviewed records were applicable for an updated substance abuse evaluation. The interim DMHCA explained the program practice is to compile the findings of the Massachusetts Youth Screening Instrument – Second Version screening completed at intake with subsequent intake screenings, records review, interviews with the parent/guardian, and youth observations in developing each comprehensive assessment.

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

The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to all youth at the program who are determined to meet clinical criteria to receive services. Five records were reviewed and applicable for a multidisciplinary team assignment upon admission. Each youth's multidisciplinary team was comprised of the youth, program administration, the residential living unit, and other staff responsible for delinquency intervention and treatment services. Five reviewed records validated each treatment team was comprised of a representative from administration, education, medical, mental health, youth, and parent/guardian, when applicable. Each reviewed treatment plan review documented an attempted, or actual parent/guardian contact by telephone. Each reviewed record's weekly clinical progress notes section documented attempted and actual parent/guardian contacts made by telephone, inviting participation in treatment team meetings. Four of the five reviewed records were applicable for substance abuse treatment. Each record contained a signed authorization for disclosure of protected health information, consent for urine collection and analysis, and a youth consent for release of substance abuse treatment records. Three youth records showed the youth were eighteen or older and two were under the age of eighteen. Both minor youth records contained an Authority for Evaluation and Treatment (AET) signed by the parent/guardian. The program maintains a Chapter 397 license through the Department of Children and Families to provide outpatient substance abuse services. Each of the five reviewed mental health and substance abuse treatment records contained notes which included all elements of the Department's MHSA 018 form. Progress notes were completed weekly and each reviewed progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and primary counselor's signature. A review of sign-in sheets for the last six months and group observations conducted during the annual compliance review showed group therapy at the program is limited to less than ten youth for mental health, and less than fifteen youth for substance abuse groups. Individual therapy, group therapy, family therapy and psychosocial skills training services were documented as being received, as prescribed by the treatment plan, in each of the reviewed records' chronological notes section. During an informal interview with the interim designated mental health clinician authority (DMHCA), it was reported the program offers mental health and substance abuse groups, treatment planning and reviews, assessments, and family and individual counseling at the program. On-site observations of a restorative justice group during the annual compliance review showed twelve youth in attendance in a classroom setting. Three staff were interviewed regarding who facilitates mental health and substance abuse groups at the program. All three staff reported groups are facilitated by the program therapist. An interview with the interim DMHCA explained mental health staff are assigned a group case load, conduct groups, and scan completed sign-in sheets to the DMHCA. This process assists the program in ensuring services are provided. There were no scheduled formal multidisciplinary treatment teams conducted during the annual compliance review. An interview with five youth confirmed each

participated in anger management, mental health and substance abuse youth groups while attending the program.

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

The program maintains a written policy and procedures outlining responsibilities and required elements of mental health and substance abuse treatment services and planning. Five youth records were reviewed, and three records reflected an initial treatment plan was completed prior to the last annual review. An additional youth record was request for a sample size of three initial treatment plans. Each reviewed initial treatment plan showed completion on the day of admission on the program's form. Each contained all elements outlined in the Department's MHSA 015 form. Each initial treatment plan contained youth identifying information, reason for mental health/ substance abuse treatment, initial diagnostic impressions, presenting symptoms, initial treatment methods, and initial treatment goals and objectives. Each initial plan was applicable for substance abuse treatment goals. Each initial plan was also signed by all treatment team members, who participated in the development of the plan. Each of the three reviewed records documented the development of the initial treatment plan in the mental health chronological record. Five records were reviewed for individualized treatment plans. One record showed thirty days since admission had not passed and it was not due. The second record showed the individualized treatment plan was developed prior to the last annual compliance review. The three remaining records were applicable and reviewed. Each individualized plan was documented on the program's form containing all of the elements of the Department's MHSA 016 form. The program's individualized treatment plan form includes youth identification information, youth Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, youth and family strengths, needs, and ability preferences, services to be provided, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, and signatures of treatment team members. Each reviewed plan was signed by the clinical staff person creating the plan, all treatment team members who participated in plan development, and then the licensed staff member within ten days. None of the reviewed individualized plans were applicable for medication, but each documented a pro re nata (PRN) psychiatric medication and monitoring service treatment indication. The interim designated mental health clinician authority (DMHCA) explained each therapist uses the comprehensive assessment as a guide for development of each youth's individualized treatment plan. The assigned therapist reportedly meets with the youth and team prior to completing the plan and finalizes the plan with the youth to ensure a collaborative effort in the individualized plan development.

Five records were reviewed for individualized treatment plan reviews. One record showed thirty days since admission have not passed and it was not due. Four reviewed youth records were applicable. Each prescribed the services to be received and contained treatment plan reviews completed at twenty-eight-day intervals. Each reviewed record was applicable for substance treatment goals which were addressed in the treatment plan review. Each record also contained a monthly American Society of Addiction Medicine (ASAM) summary and recommendation. Each reviewed treatment plan review form contained identifying youth information, DSM-5 diagnosis, symptoms supporting diagnostic criteria, any changes in diagnosis, clinical goals, youth interpretations of clinical goals, objectives, status and date, target completion dates, progress summary, summary of additional services, youth overall progress in program, medication details, services to be provided, and signatures of treatment team members. One youth record contained a treatment plan completed in February 2018 prescribing life skills to be provided sixty minutes a week by the transition services manager and there was no supporting documentation to support the service was received. Each of the remaining reviewed weekly progress notes documented youth received services, as prescribed. An interview with the DMHCA regarding review and updates of treatment plans explained the treatment team meets with the psychiatrist weekly, and with the youth monthly for treatment team meetings. During these meetings, behavioral observations, medication responses, and progress in treatment are discussed. All youth goals are reviewed in the monthly formal treatment team meetings and revisions to the plan are made as indicated.

Three closed records were reviewed for discharge plans. Each record contained a discharge plan documented on the program's form and included all of the elements outlined on the Department's MHSA 011. Each reviewed discharge plan was completed by the individualized treatment team on the same day of each youth's exit staffing. None of the records were applicable for notification of suicide risk upon discharge. Each youth's discharge plan contained a statement regarding the youth's lack of suicidal ideation. Each youth's discharge summary documented services needed, and documented youth and parent/guardian participation. Participation was also supported in the exit conference notes. The program practice is to provide a copy of the discharge plan to the youth and parent/guardian upon release and provide a copy to the juvenile probation officer (JPO) by Fed Ex upon release. Reviewed Fed Ex receipts and signed discharge plans supported parent/guardian and JPO notifications were provided.

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

The program is contracted to offer mental health overlay services for youth. The program carries a Chapter 397 outpatient substance abuse license through the Department of Children and Families. All youth receive psychoeducational and prevention substance abuse groups through the Passport and Project Towards No Drugs curriculum. Dual diagnosed youth receive substance abuse group services through the Living in Balance or Seeking Safety substance abuse treatment curriculums. The Seeking Safety substance abuse curriculum is a trauma informed group curriculum. The program has an agreement with a certified behavior analyst and a psychologist who offer services, as-needed. An interview with the regional clinical director explained the program's clinical staff work closely with the recreational therapist and behavior management programming. The program has recently implemented Skype family counseling services, and clinical staff regularly participates in visitation and family day events to meet family

members and offer clinical services. An interview with the facility administrator confirmed the program offers mental health overlay services for all youth. An interview with the interim designated mental health clinician authority (DMHCA) regarding specialized services reported the program offers substance abuse and mental health counseling. The interim DMHCA explained services are provided through group counseling lessons and individual sessions with youth. The interim DMHCA is responsible for monitoring services provided through trackers and group sign-in sheets to ensure all youth receive group, individual, and family sessions according to the contract. The DMHCA explained trackers and electronic records are also reviewed to ensure timely completion of treatment plans, reviews, and comprehensive evaluations.

3.09 Psychiatric Services (Critical)	**Satisfactory Compliance**
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program maintains an independent psychiatrist agreement with a practicing child and adolescent psychiatry doctor. The reviewed license showed the program psychiatrist carries a medical doctor (MD) license. The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2019. The program's psychiatric services include psychiatric evaluations, psychiatric consultation, medication management, and medical supportive counseling. Weekly sign-in sheets and psychiatric treatment team notes verified the psychiatrist is at the program weekly, as contracted. The program has had only two youth prescribed psychotropic medications since the last annual compliance review. Both youth are currently attending the program and neither of the two reviewed records showed the youth were admitted with prescribed psychotropic medications. Both applicable youth were prescribed medications while attending the program. The program practice is to refer all youth for an initial psychiatric evaluation, regardless of medication status. Five reviewed records showed each reviewed record contained a psychiatric initial diagnostic interview completed within fourteen days of admission. Each diagnostic interview documented youth history, mental status examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medications, explanation of medications, and frequency of medication monitoring. All reviewed records documented the initial diagnostic psychiatric interview on the Clinical Psychotropic Progress Note (CPPN). Each contained a page number three of the CPPN, clearly documenting a treatment plan discussion with youth and parent/guardian. The program psychiatrist is on-call twenty-four-hours a day. The program psychiatrist has an arrangement with an alternate psychiatrist for illness and vacations whom also carries an MD license in adolescent psychiatry in the State of Florida. The program does not utilize a psychiatric advanced registered nurse practitioner (ARNP) for services. No youth were applicable for psychotropic medication consent for youth in foster care since the last annual compliance review. The two youth records whom were newly prescribed psychotropic medications contained appropriate parent/guardian consent/notification on page three of the CPPN. The records for both youth prescribed medications documented medication management appointments monthly. An interview with the program's psychiatrist supported participation in weekly treatment team and weekly on-site visits. The psychiatrist explained 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 clinical coordinator every week to review youth concerns at the program. The psychiatrist also reported on call status twenty-four hours a day, seven days a week for all primary care physicians, and urgent care situations.

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

The program maintains a written plan detailing suicide prevention procedures. A review of the program's plan reflected inclusion of identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The suicide prevention plan is reviewed annually and was last signed on August 5, 2018 by the facility administrator (FA) and July 20, 2017 by the corporate officer. The plan was signed by the psychiatrist on August 8, 2018 and the interim designated mental health clinician authority on September 4, 2018. An interview with the FA indicated the program provides suicide prevention training during the mandatory pre-service and in-service trainings. The FA also reported the program conducts emergency mental health drills, to include emergency response to suicide attempts or self-inflicted injury, at least quarterly on each shift.

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

The program has a written suicide prevention plan outlining an established review process for every suicide attempt or reported suicidal ideation. The program maintains three complete suicide response kits located in master control, sub-master control, and the medical office. Each suicide response kit was inspected and included needle nose plyers, wire cutters, and a knife for life. Five youth records were reviewed for suicide prevention services and two were applicable for suicide events. An additional youth record was requested for a required sample size of three. Each reviewed suicide event showed the youth was placed on suicide precautions following self-reported suicidal ideation. Each was applicable for completion of a Follow-Up Assessment of Suicide Risk (ASR). Each reviewed record documented telephone contacts with a parent/guardian, and an electronic mail sent to the juvenile probation officer (JPO) when a youth was maintained on suicide precautions. Suicide precaution observation logs were maintained for each of the three reviewed records. Precautionary observation did not limit a youth's activity to an individual cell for any of the reviewed records. Each ASR was completed within twenty-four hours and precautionary observation (PO) status was maintained for each until a Follow-Up ASR and conference between clinical and supervisory staff was completed. Two of the three reviewed ASRs documented the reason for the assessment completion and one did not indicated the reason for the assessment. Each record documented transition to close supervision and maintenance on close supervision until the completion of a mental status examination. The program reported no youth were applicable for secure observation status since the last annual compliance review. The program has a policy and plan and process for

every serious suicide attempt or self-inflicted injury occurring at the program. An interview with the interim designated mental health clinician authority (DMHCA) explained all program staff are trained to understand all youth exhibiting suicidality should be immediately placed on PO and referred to mental health staff and the facility administrator both verbally and in writing. The interim DMHCA explained the program practice for when a youth displays suicidal gestures and/or ideation is to contact a shift supervisor. The shift supervisor is then responsible for oversight of supervision and documentation requirements. The supervisor will notify master control, licensed mental health staff, and the facility administrator of the youth's status. Any change in the youth's status will be added to the program's alert board, relayed to program staff, and discussed during shift briefing. Three staff were interviewed regarding the responsibilities of direct care staff when a youth expresses suicidal thoughts. All three staff reported they would notify mental health staff, search the youth and room for sharp objects, maintain constant sight and sound supervision, document supervision, and notify a supervisor. None of the interviewed staff reported they would place a youth in a locked room. Three staff were interviewed regarding the location of the programs suicide response kit. All three staff reported the suicide response kit is maintained in the program's sub-master control. Two staff reported the suicide response kit is also located in the medical office. One staff reported the suicide response kit is also located in the program's main master control.

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

The program has a written suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO). Two of the five reviewed youth records were applicable for suicide PO logs and one additional record was reviewed for a sample size of three. Each of the three applicable reviewed records documented a review by the mental health clinical staff. Two of three records documented signature by the shift supervisor. One reviewed PO log did not contain a shift supervisor signature. The second reviewed log was signed by the "A" shift and "B" shift supervisors, but there was no documentation of the date or time of the signature. Each PO log was documented on the Department's MHSA 006 form and was maintained for the duration each youth was on suicide precautions. Two of the three PO logs did not indicate safe housing areas. Each reviewed record documented observations conducted in real time. One of the three records documented thirty-five minutes between notations, exceeding the thirty-minute requirement. The second record contained a one hour thirty-five-minute lapse in documented supervision. The third reviewed record contained no lapses in documented observations. Three youth interviews conducted during the annual compliance review week reflected staff did not leave any youth alone for any period of time while youth were on PO status. Two of the three records documented a daily review by the mental health staff. One record for PO supervision on June 26, 2018, documented a review and signature of the mental health staff on August 5, 2018. An additional suicide PO log was received when reviewing a crisis assessment completed on April 26, 2018. The observed PO log documented a warning sign and there was no documented notification or consultation with mental health staff.

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

A review of five pre-service and five in-service training records for direct care staff, supervisory staff, mental health and substance abuse licensed and non-licensed staff, and nursing staff showed each staff completed the required six hours of annual suicide training. A review of mock suicide drills since the last annual compliance review showed participation in suicide drills at least semi-annually by all staff with direct contact with program youth. A review of mental health drills reflected the program completed at least one drill, each shift, on a quarterly basis. Mock drills were also shown to include cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED) demonstrations. Each reviewed emergency drill clearly documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. The program practice is to review all mock suicide and/or mental health drills during the morning management meetings and during monthly all-staff meetings.

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

The program has a crisis intervention plan to establish a method of crisis intervention services which will be provided to all youth. The crisis intervention plan is reviewed annually and was last signed on July 10, 2017, by the corporate officer and on August 5, 2018, by the facility administrator. The plan was signed by the psychiatrist on August 8, 2018, and the interim designated mental health clinician authority (DMHCA) on September 4, 2018. The reviewed crisis intervention plan includes provisions for the notification and alert system, means of referral, communication, supervision, documentation, and review as required.

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

The program has completed two on-site crisis assessments since the last annual compliance review. Both assessments were completed due to a death of a family member. Each of the reviewed crisis assessments included the reason for assessment, mental health status

examination and interview, determination of danger to self and/or others, initial clinical impressions, supervision recommendations, treatment recommendations, and recommendations for follow-up. Both crisis assessments contained parent/guardian notification. One crisis assessment was completed by a licensed mental health professional. The second crisis assessment was completed by a master's-level therapist and reviewed and signed by the licensed designated mental health clinician authority (DMHCA) within twenty-four hours as required. A review of the Department's Juvenile Justice Information System (JJIS) for each of the reviewed records determined both were placed on precautionary observation (PO) and the appropriate alerts were entered and removed immediately as required. None of the records were applicable for an off-site crisis assessment since the last annual compliance review.

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

The program has a written emergency mental health and substance abuse plan. The plan contained all the elements required by Florida Administrative Code 63E-7 and 63N-1. The plan includes procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. The plan was last signed on July 10, 2017, by the corporate officer and on August 5, 2018, by the facility administrator. The plan was signed on August 8, 2018, by the psychiatrist and on September 4, 2018, by the interim designated mental health clinician authority. The reviewed plan outlined transport for emergency substance abuse assessment and treatment to Raulerson Hospital in Okeechobee, Florida. The plan outlines transport for emergency mental health evaluation and treatment to New Horizons of the Treasure Coast in Fort Pierce, Florida.

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

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

Standard 4: Health Services

Overview

The program provides comprehensive on-site healthcare services to youth admitted to the program. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols which are also reviewed by the corporate office and the facility administrator. The program has a comprehensive process for the provision of episodic care and first aid. Problem oriented charting is used to document the episodic care provided. All staff are trained in emergency procedures and emergency numbers are posted next to each office telephone, as well as master control and sub-control. Nursing staff train supervisory staff on the administration of the EpiPen Auto Injector and over-the-counter medication. The program provides timely referrals and coordination of medical services to an off-site healthcare provider for emergent and non-emergent situations and documents such services, as required by the Department. The program conducts periodic evaluations to ensure youth with chronic conditions receive regularly scheduled evaluations and follow-up. Sick call is offered seven days a week for youth who have health concerns. The program has a policy and procedures to ensure all medications have a current, valid order and are given pursuant to a current prescription or practitioner's order.

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

The program has a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. The program currently has an agreement with a licensed physician (MD) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The physician serves as the designated health authority (DHA) for the program and is responsible for providing clinical healthcare services. Reviewed documentation of the medical license confirms the DHA is licensed in the State of Florida, with an expiration of January 31, 2020. The licensed physician is expected to be on-site one day a week, for approximately two hours. A review of the program's medical sign-in and sign-out logs validated the DHA was on-site during the months of April to September 2018. However, sign-in and sign-out logs did not consistently reflect the DHA was on-site for the expected two hours a week, as outlined in the agreement with the DHA, on ten separate occasions. During the annual compliance review period, the program did not utilize an advanced registered nurse practitioner (ARNP). During vacation or scheduled absences, coverage is provided by another licensed physician. The DHA is responsible for communication with the registered nursing staff and administration regarding youth medical needs and is available for consultation twenty-four hours a day, seven days a week. An interview with the DHA confirmed he communicates with the program's staff regarding the youth's medical needs, and the availability by telephone for consultation, emergency care, and coordination for off-site care twenty-four hours a day. The program also maintained agreements with a dentist and optometrist and each was found to be up-to-date.

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

The program has a written policy and procedures for all health-related procedures and protocols specific to the program. The facility administrator signed each health-related facility operating procedure on August 5, 2018. The psychiatrist and designated health authority (DHA) signed each health-related facility operating procedure in August 2018 to confirm their review and approval. A review of the program's documentation supported the program also maintained nursing protocols, which were reviewed and updated by the DHA on July 10, 2018. All healthcare staff signed the nursing protocols and facility operating procedures acknowledging changes/updates in August 2018 and October 2018. The program had one new healthcare staff hired since the last annual compliance review. Reviewed documentation confirmed the newly hired staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, provided by the program's registered nurse.

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

The program has a written policy and procedures regarding the authorization of treatment for all youth admitted into the program. A review of five individual healthcare records (IHCR) found three youth were eighteen years of age or older and each signed a program release of information authorization form. Two youth were applicable for an Authority for Evaluation and Treatment (AET). Each AET had a parent/guardian signature along with a witness signature. Each IHCR included a copy of a completed parental notification behind the AET. Both reviewed AETs were copies stamped with the word "COPY" stamped in red. None of the reviewed records indicated there were youth in the care of the Department of Children and Families (DCF) at the time of the annual compliance review. Each AET was valid until the youth's eighteenth birthday.

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

The program has a written policy and procedures to inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed. Five youth individual healthcare records (IHCR) were reviewed for parental notifications. Three youth were eighteen years of age or older and did not require parental notification. All three youth records documented each provided verbal consent for any medical treatment needed. Two IHCRs found parental notification was sent when significant changes occurred to existing medications, notification of over-the-counter medications beyond those covered by the Authorization for Evaluation and Treatment (AET), for changes to the youth's chronic conditions, and for off-site care. There were verbal notifications and witnessed by another staff with a written follow-up sent by mail. None of the reviewed records indicated there were youth in the care of the Department of Children and Families (DCF) at the time of the annual compliance review.

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

The program has a written policy and procedures to inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances of medications or psychotropic medication adjustments. Five individual healthcare records were reviewed and two were applicable for parental notification regarding a prescription for a new psychotropic medication. Reviewed documentation confirmed both youth were eighteen years of age or older and did not require consent of a parent/guardian. One additional record was requested and reviewed. Reviewed documentation confirmed the program's practice is to send out a Clinical Psychotropic Progress Note (CPPN), which provided written notification when a psychotropic medication was started or altered by the psychiatrist for all youth. Youth eighteen year of age or older are asked to consent prior to share information with parent/guardian. The one applicable youth's parent/guardian provided verbal consent to the psychiatrist. The verbal consents were witnessed by a staff person and this was documented on each reviewed CPPN. Two youth provided verbal consent for any medical treatment needed. There were notifications, along with the CPPN page three, sent through certified mail to the parent/guardian for signature. There were no youth who were in the care of the Department of Children and Families (DCF) at the time of the annual compliance review.

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

The program has a written policy and procedures to obtain each youth's immunization history, status, and verify them to meet State and Department requirements. A review of five youth healthcare records (IHCR) found each included a copy of the youth's immunization information from Florida Shots and/or the Florida Department of Health. Each youth's immunization status was verified within thirty days admission into the program. There were no applicable youth claiming religious exemption from immunization. An interview with nursing staff indicated they obtain immunization records from Florida Shots and/or the Florida Department of Health for every youth admitted to the program within thirty days of admission.

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

The program has a written policy and procedures regarding healthcare screening for each youth upon admission into the program. Five individual healthcare records were reviewed. Each reviewed record reflected an initial healthcare admission screening was completed on the date of each youth's admission into the program. All screenings were completed by a registered nurse on the Department's Facility Entry Physical Health Screening form.

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

The program has a written policy and procedures to alert staff of medical issues which may affect the security and safety of the youth in the program. A review of five youth healthcare records, in comparison with the program's internal alert system, validated youth identified with allergies, chronic conditions, physical limitations, or medication side effects 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. Alerts for each youth with medical conditions were also entered in the Department's Juvenile Justice Information System (JJIS), as required. An informal interview with nursing staff indicated youth alerts are updated daily, and copies are provided to all program staff. Three staff were interviewed and all three reported they are informed of youth alerts during shift meetings, they can review the program's alert board for youth alerts in master control, and an extra copy of the program's internal alerts are also placed in sub-control.

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

The program has a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. A review of five youth individual healthcare records (IHCR) documented each youth received a general healthcare orientation on the day of admission. Each youth received a health education packet which covered all required topics, including: how to access sick call, what constitutes an "emergency," how medication is administered, the right to refuse care, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. Each youth was also orientated on what to do in case of 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 facility administration. Each healthcare orientation was signed and dated by the youth and medical staff. A list of healthcare contacts is maintained by the program and nursing staff are required to keep it updated.

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

The program has a written policy and procedures to notify the designated health authority (DHA) of all youth admitted into the program identified with chronic health conditions or youth in need of emergency care. The program's practice is to notify the DHA by telephone, and if on-site, in person, of all youth admissions to the program, regardless of a youth's health status and/or medical condition. Every youth admitted to the program is placed on the DHA's list of youth to be seen. Five youth individual healthcare records were reviewed. Documentation showed the DHA was notified by telephone on the date of each youth's admission by a licensed healthcare staff. Two of the five youth were identified with chronic health conditions. One additional record was reviewed. Each youth record contained a DHA Notification of Admission form acknowledging notification of each youth's admission. None of the youth were identified as in need of an emergency response.

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

The program has a written policy and procedures ensuring a healthcare admission rescreening and a new Facility Entry Physical Health Screening (FEPHS) shall be completed each time the physical custody of a youth changes and they are subsequently returned or readmitted. A review of five youth healthcare records found there were no applicable youth who had a change in their physical custody. An informal interview with administration confirmed the program has not had any youth with change in physical custody since the last annual compliance review.

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

The program maintains a written policy and procedures ensuring the Health-Related History (HRH) form is completed by nursing staff, no later than seven calendar days following the date of admission for each youth. A review of five youth individual healthcare records (IHCR) documented each youth had a HRH form completed within seven days of admission. Three of the five records HRH forms were new, and two HRH forms were updated. All five HRH forms were completed by a licensed nurse prior to the completion of the Comprehensive Physical Assessment (CPA). Reviewed documentation confirmed each HRH form was reviewed by the designated health authority.

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

The program has a written policy and procedures ensuring each youth shall receive or have on file a current Comprehensive Physical Assessment (CPA) within seven days of admission. A review of five youth healthcare records found each CPA was completed by the designated health authority (DHA). Each CPA included the youth’s medical grade and was completed in accordance with the Department’s requirements. All sections of the CPA were completed in full utilizing “O” or a “X.” None of the youth refused any part of the examination on the CPA. Reviewed documentation validated the Department’s Problem List was updated for each youth when applicable.

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

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

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

The program has a written policy and procedures ensuring each youth receives a healthcare screening and evaluation for tuberculosis. A review of five youth healthcare records validated each youth had at least one verified tuberculin skin test (TST) documented within the past year to determine exposure to tuberculosis. All Tier I Tuberculosis screenings were conducted within twenty-four hours of each youth's admission. There were no applicable youth with symptoms suggestive of active tuberculosis. A review of each healthcare record found the results of the TST were documented on the Department's Infectious and Communicable Disease (ICD) form and the Comprehensive Physical Assessment (CPA). A review of the program's facility operating procedures (FOPs) found the program was in compliance with the Centers for Disease Control and Prevention and Occupational Safety and Health (OSHA) Standards.

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

The program has a written policy and procedures ensuring all youth admitted shall be screened and medically evaluated for sexually transmitted infections (STI). A review of five youth healthcare records found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Each youth was referred for further evaluation. Reviewed documentation reflected testing was ordered and was performed. Test results were filed in the laboratory 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.

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

The program has a written policy and procedures to address human immunodeficiency virus (HIV) counseling, testing, and referrals for treatment. A review of five youth healthcare records confirmed each youth was offered the opportunity to receive counseling and testing for HIV. Four of the five youth healthcare records found each youth provided consent to receive counseling and testing by signing the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. One youth signed, declining counseling and testing. The program's designated health authority (DHA) is authorized to provide pre-counseling, testing, and post-counseling. Reviewed youth records validated when youth receive pre-counseling, testing, and post-counseling, the youth's health education record is updated in the healthcare record. A review of the four applicable youth records found results were placed in a sealed envelope marked 'Confidential' documented on the outside of the envelope. The program maintains an active HIV Testing Tracking Log for all youth who received testing. A review of the program's internal alert system found the program does not include any youth's HIV status. Five interviewed youth reported they could request a HIV/AIDS test.

4.18 Sick Call Process – Requests/Complaints	**Satisfactory Compliance**
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The program has a written policy and procedures outlining the sick call process. Youth are able to request a sick call by placing a completed sick call form in the locked box labeled sick call. Medical staff and shift supervisors review all requests placed in the sick call box throughout the day. During the facility tour, sick call forms were observed in the youth's living area. The program offers youth the opportunity to receive sick call services seven days a week, once a day, conducted by the licensed nursing staff. Sick call is scheduled Monday through Friday at 12:00 p.m. Nursing staff check the sick call request box every two hours daily from 7:00 a.m. to 6:00 p.m. When there are no licensed staff on-site, there are trained direct care staff using approved standard protocols for non-licensed healthcare staff to provide services to the youth. In the event of emergency, non-licensed staff are required to call 9-1-1, call the designated health authority (DHA), and registered nurse. A review of five youth healthcare records found two youth completed a sick call request form at least once during their stay. One additional healthcare record was reviewed and found the youth completed a sick call request form at least once during his 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, the program's practice is to automatically refer the youth to the DHA treatment for similar sick call complaints three or more times. There were no situations where a youth made a complaint of severe pain which staff was unfamiliar with. Each reviewed record contained at least one sick call request form, which were filed in the nursing progress notes section.

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

The program has a written policy and procedures outlining the sick call process. A review of five youth healthcare records found two youth submitted a sick call request form during their stay. One additional record was requested and reviewed. Reviewed documentation supported the registered nurses (RN) addressed each sick call complaint within twenty-four hours of submission, and each visit was completed in full, including youth vital signs, treatment, education, and/or follow-up plans, along with the youth and nursing staff signatures. Completed sick call request forms are filed in chronological order in the nursing chronological note section of the youth healthcare record. A review of documented practices found all sick calls, were documented on the Department's Sick Call Index and on the Sick Call Referral Log filed in the youth's individual healthcare record. The program did not have any sick calls during the week of the annual compliance review. However, the registered nurse was able to explain the sick call process in accordance to the program's and the Department's policies. An observation of the medical clinic found there is a private area to see all youth with no other youth present to hear or see the examination. Three staff were interviewed and all three indicated the nurse conducts sick call. Five youth were interviewed and three youth reported they can see a nurse within one day when they submit a sick, one reported immediately, and one reported never submitting a sick call request.

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

The program has a written policy and procedures in place for controlled observation. Five youth individual healthcare records (IHCR) were reviewed. Three applicable controlled observation reports were reviewed during the annual compliance review and documentation verified youth were placed in controlled observation due to violent behavior and physically out of control. The reviewed reports indicated medical services and/or prescribed medications were provided for each youth while placed in controlled observation. During the annual compliance review, there were no youth who required medical attention while in controlled observation, and there were no youth which would require daily visit from medical staff due to remaining in control observation for a twenty-four-hour period.

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

The program has 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. A review of five individual healthcare records (IHCR) found four youth had a least one episodic event. Each contained appropriate documentation of the episodic care events. Documentation included the subjective, objective, assessment, and plan (SOAP) format, as well as documentation of the date and time of episodic care, nature of the complaint, findings of person rendering care, treatment rendered, referral made for off-site care, where necessary, education and/or instruction for the youth to follow, where needed, and plans for follow-up care, where required, as well as the printed name and credentials of the staff providing care. Each youth was seen by a license medical staff person. The program maintains two Automated External Defibrillators (AED), six first aid kits, and two suicide response kits containing a knife-for-life, wire cutters, and needle nose pliers. The AEDs were observed in master control and sub-control. The suicide response kits were observed located in master control, sub-control, medical and clinic. All kits were sealed, contained the required items as approved by the DHA, and did not contain any expired items. Reviewed weekly checks of each first aid kit for the last six months found they were completed by a registered nurse and replenished, when needed.

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

The program has a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. The program also maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered. Observations during the facility tour found postings throughout the facility informing staff of their right and responsibility to call 9-1-1. Emergency telephone numbers were maintained in master control, medical clinic, and sub-control. The program maintains two AEDs. One AED was located in sub control and the other was located in master control. Nursing staff conduct weekly checks to ensure it is functioning adequately. The AED provides audio instructions on step-by-step procedures. An observation of the AEDs also found an instruction pamphlet located on the inside of both AEDs.

The registered nurse demonstrated both AEDs and validated they were in working order. The AED located in master control had a battery which expires July 2022 and were last changed in June 14, 2017. The AED pads expire in February 2019 and has not been changed. The AED located in sub-control had a battery which expires October 2022 and were last changed in March 18, 2017. The AED pads expire in December 2020 and were last changed on July 13, 2018. Reviewed training records for five pre-service and five in-service staff supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid, cardiopulmonary resuscitation (CPR) with AED. The program conducts mock medical drills monthly on each shift. Reviewed practice found the program conducted a CPR/AED drill six times on each shift in the last twelve months. Three interviewed staff indicated they would call master control since there is no cellular telephone on the unit. Master control would then call 9-1-1.

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

The program has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. Five healthcare records were reviewed, and one youth was applicable for off-site care and/or emergency care. Two additional healthcare records were requested and reviewed. One of the three healthcare 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 his signature and date. One youth required follow-up care and the youth was scheduled to receive services as prescribed.

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

The program has a written policy and procedures for the provision of treatment for youth identified as having a chronic medical condition and periodic evaluations. A review of five youth healthcare records indicated two youth were admitted with an identified chronic condition. One additional healthcare record was requested and reviewed. One of three youth's chronic condition was documented on the Facility Entry Physical Health Screening form. Two of the youth health's condition was captured on the health screening admission forms and documented in the nurse's chronological notes. All three youth were classified with a medical grade two through five. There were no youth currently undergoing treatment for a physical health condition which included a body mass index greater than thirty. Reviewed documentation supported each youth received a new Comprehensive Physical Assessment (CPA) within seven days of their admission. All three applicable youth received periodic evaluations and had a specialized treatment plan documented in their healthcare record. A review of the supporting documentation indicated there were no lapses in care or any missed periodic evaluations. An interview with the designated health authority (DHA) indicated he prefers to evaluate the youth at a minimum of every sixty days. The Department's Problem List was updated, as required, for each applicable youth. The facility administrator (FA) indicated a pre-classification meeting is

held with staff daily to discuss important medical issues and medical alerts. The alert roster is reviewed and updated daily by medical staff. All medications are tracked and the DHA oversees medical treatment on-site.

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

The program has a written policy and procedures addressing medication management. Reviewed documentation confirmed each medication was verified by the nurse during the admission screening process. A review of five youth healthcare records indicated two youth were admitted into the program on prescribed medication. One additional record was requested and reviewed. A review of the Facility Entry Physical Health Screening (FEPHS) forms confirmed the three applicable youth were taking medication at the time of admission. Reviewed nursing admission notes documented the youth's current medication and the DHA Notification of Admission documented current prescribed medication. The nursing staff verbally notified the DHA on each youth's day of admission. The DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records validated the practice. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian.

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

The program has a written policy and procedures requiring all medications to have a current, valid order and are given pursuant to a current prescription or practitioner's order. Two of five reviewed youth healthcare records were applicable for medication management. One additional healthcare record was requested and reviewed. All three applicable records documented current, valid orders and were administered pursuant to a current prescription. When each youth's current medications were continued, discontinued, changed, or new medications were ordered, the designated health authority (DHA) placed an order on the appropriate forms. Three youth were applicable for over-the-counter (OTC) medications. All OTC medications not listed on the Authority for Evaluation and Treatment (AET) are administered according to the approved nursing protocols and non-licensed staff protocols.

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

The program has a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. An observation of the medical clinic found the area to be well organized, clean, and neat. All medications were 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. Oral medications were not stored with injectable or topical medications. The program stores all sharps separate from medications and do not retain syringes. The program's syringes and the refrigerator are located

at the main medical clinic. The program maintains a written process for the disposal of expired and/or discontinued medications. All non-controlled medications are sent back to 1st Choice Pharmacy. All controlled medications are disposed by the pharmacist consultant and witnessed by the registered nurse or designee. The program's disposal practice is to flush the medication and document the disposal on the Consultant Pharmacist Monthly Inspection form. The pharmacy consultant also documents the disposition of medication on the Controlled Substance Medication Administration Record. The nurse verifies disposal by signing the Medication Administration Record.

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

The program has a written policy and procedures ensuring all medication, sharps and pharmaceutical products are inventoried. 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. Sharps are counted through a perpetual inventory and are verified weekly. The program does not retain syringes on-site. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist's license expires December 31, 2018. Observations conducted during the annual compliance review week confirmed a count of three sharps with the ending count matching the inventory number. An inventory of three youth medications, three OTC medications, and three sharps were conducted and found all counts matched the inventory number. A review of the program's counts for the past six months validated no discrepancies were identified with the counts.

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

The program has a written policy and procedure regarding medication management. 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 II 3:1 Pharmacy Technician Ratio Approved certification with 1st Choice Pharmacy with an expiration date of February 28, 2019. The program stores all controlled medications in a double-locked metal medication cart located inside the nurse station. All medications are in blister pack packaging which indicated the number of pills for each medication. The program documents the remaining balance of each medication after each dosage on the youth's individual controlled medication inventory record. The program maintained a shift-to-shift inventory count of all controlled medication. Procured medications are administered by nursing staff when they are on-site and by a trained non-licensed staff member when nursing staff are not on-site. The program only had one youth being administered controlled medication during the annual compliance review. Observations of the one controlled medication during the annual compliance review showed an accurate count located on the medication log, and count matched the ending inventory numbers.

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

The program has a policy and procedures in place regarding the Medication Administration Record (MAR). The program utilizes the Department's Medication Management Administration Records (MAR). A review of five youth healthcare records found two applicable youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice Pharmacy Medication Administration Record (MAR) to document administration of medication. One additional record was requested and reviewed. 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. All three reviewed healthcare records indicated the youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. The MAR clearly indicates medication start dates and stop dates when applicable. Licensed staff initialed the MAR for each administered medication entry. The nurses documented a minimum of weekly side effects monitoring. There were no indications of lapses and/or errors in the medication administration. 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. A review of the Central Communications Center reports validated there were no incidents of missed medications.

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

The program has a written policy and procedures ensuring authorized prescribers, including consultants, shall utilize the formulary 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 gets the medication. None of the youth were applicable for requiring parenteral medication since the last annual compliance review; however, procedures are in place for only the registered nurse (RN) to administer the medication. An observation of medication pass was observed during the annual compliance review week. Medication pass is conducted at 7:00 a.m. and 5:00 p.m. daily. Observations of medication administration by a RN indicated the medication was administered in accordance with the five rights of medication administration. The RN blocked the door to the clinic with the medication cart and the youth approached one at a time and identified self, told the nurse the medication prescribed, purpose of the medication, side effects, and whether the youth was experiencing side effects at the time of medication administration. The youth care worker stood behind the youth when the medication was administered. The RN then checked the youth's mouth to ensure the medication was swallowed and the youth care worker also checked. The RN did not pre-pour the medication from the blister pack after administration. The work space was observed very clean, organized, and neat with the RN keeping control of the medication cart during the medication pass.

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

The program has 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 there is no licensed healthcare staff on-site. Five review healthcare records found one applicable youth who was administered medication by a non-licensed staff. Two additional records were reviewed. Each record had all required documentation. Reviewed documentation confirmed both the youth and staff signed the Medication Administration Record (MAR) and the Report of On-Site Healthcare by Non-Healthcare Staff form. When applicable, refusals are clearly documented on the MAR and Refusal form. A review of training for non-healthcare staff authorized to assist in medication administration was conducted and found two supervisory staff are trained in assisting youth. Three interviewed staff indicated a nurse will provide medications to the youth. Two staff indicated trained supervisors distribute medications if a nurse is not on duty. Four interviewed youth reported not taking medication. One interviewed youth reported the nurse gives out medication.

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

The program maintains a written policy and procedures ensuring youth diagnosed with a Diagnostic and Statistical Manual of Mental Disorders, 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 contractor agreement with a State of Florida licensed psychiatrist. 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. The program's psychiatrist utilizes the Department's Clinical Psychotropic Progress Note (CPPN) for the initial evaluation. The CPPN is also utilized for youth who are subsequently prescribed psychotropic medications. There were no youth admitted on psychotropic medications since the last annual compliance review.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

The program has 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 the Centers for Disease Control and

Prevention (CDC) guidelines. The plan was reviewed and approved by the facility administrator, corporate officer, and designated health authority. The plan was reviewed and approved by the facility administrator on August 8, 2018, and designated health authority on August 30, 2018. 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. There were no instances of infectious disease in the facility since the last annual compliance review which required notification to the Centers for Disease Control and Prevention (CDC), the Department's Central Communications Center (CCC), or local county health department.

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

The program has a written policy and procedures in place regarding infection control education. The program maintains an infection control education plan inclusive of pre-service and in-service training for all staff, and youth infection control education, as required by the Centers for Disease Control and Prevention (CDC) guidelines. A review of five staff training records found each staff received the required training. A review of five youth healthcare records and five staff training records validated all received training on infection control to include prevention of communicable diseases and prevention of blood-borne pathogens.

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

The program has 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 is written in accordance with the Occupational Safety and Health Administration (OSHA) standards and includes a comprehensive process for needle stick post-exposure evaluation, risk assessment, and methods of compliance. The plan was reviewed and approved by the facility administrator (FA), corporate officer, and designated health authority. The plan was reviewed and approved by the FA on August 8, 2018, and designated health authority on August 30, 2018. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of youth or staff. There were no documented instances of staff having experienced a facility or occupational

exposure since the last annual compliance review. The FA reported during an informal interview the exposure control plan is located in the FA's office, assistant FA's office, master control, and sub-control. The plan is available and accessible to all program staff.

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

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

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

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

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

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

Standard 5: Safety and Security

Overview

The program is a sixteen-bed maximum risk residential facility for males ages thirteen to twenty-one years old. The program is currently contracted through and operated by TrueCore Behavioral Services, LLC. Youth housing for this program consists of one dormitory (Kennedy) located on the campus. Supervision of all youth is provided twenty-four hours a day, seven days a week. The facility administrator, assistant facility administrator, shift supervisors, and youth care workers are responsible for the safety and security of the youth and the facility. Due to position vacancies, the program is having staff work twelve hour shifts since March of 2018. Youth counts are conducted formally and informally throughout the day, as well as prior to any youth movement from one area of the facility to another. Formal counts are called upon by master control throughout the day and is documented in the program's logbooks. Master control is responsible for all persons entering and exiting the program, as well as key control. The program's physical plant manager is responsible for the safety and security regarding tools, facility vehicles, flammable, toxic, caustic, and poisonous materials which are maintained and stored outside of the facility. The program has a staff member who maintains an active certification in automotive service excellence (ASE) and is a certified mechanic. Recreational and leisure activities are provided to all youth each day for at least one hour. The program has filled the recreational therapist position since the last annual compliance review. The program utilizes a level-based behavioral management system (BMS) in place which is designed to foster compliance with the program rules, decrease unwanted behaviors, and increase desired behaviors through reinforcements. The BMS also teaches youth alternative pro-social methods for dealing with problems by way of utilizing both rewards and a system of progressive discipline. When non-physical interventions are not effective on youth in the program, the program utilizes controlled observation.

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

The program maintains a written policy and procedures regarding youth supervision. The program promotes safety and security by maintaining active supervision of youth which includes interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observing the behavior of youth, redirecting inappropriate behavior, and consistently applying the program's behavior management system. The program has a daily schedule posted in the youth living areas and throughout the facility. Youth and staff observations were conducted each day throughout the week of the annual compliance review. During outdoor activities and/or movement, staff were observed to be strategically positioned to ensure proper supervision and to ensure there were no physical obstructions in their view of the youth. Observations made throughout the annual compliance review week included youth movement from dormitory to classrooms, classroom to classroom, and from dormitory to the outdoor recreation area. Youth-to-staff ratios were observed to be compliant with the program's contract of one staff for every eight youth. During the observations, staff were actively supervising youth. All youth and staff movement, as well as youth counts made throughout the day, are

documented in the facility logbook. Formal and informal resident counts are consistently completed throughout each day. Prior to any movement, staff informed master control of the count and waited for permission to move the youth. Informal interviews were conducted with supervising staff each day and confirmed staff understood the steps to take when there is a discrepancy in youth counts. Observations of interactions with program staff and the youth reflected they were positive and followed the program's behavior management system.

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

The program has a clearly written behavior management system (BMS), which the program refers to as their positive performance system. The BMS was approved by the facility administrator on August 5, 2018 and has not changed since the last annual compliance review. The BMS is a five-tiered level system which is designed to decrease unwanted behaviors and increase desired behaviors through reinforcements as well as foster accountability for behavior and compliance with the residential community's rules and expectations. The five levels include Level One: Orientation/Assessment, Level Two: Trainee, Level Three: Independent, Level Four: Maintenance, and Level Five: Honors. The BMS outlines daily, weekly, and monthly incentives to include responsibilities, expectations, and level advancement. A review of five youth case management records confirmed youth are oriented upon their admission to the program through the program's youth handbook, which includes an outline of the BMS. A review of five staff pre-service training records and five staff in-service training records confirmed each staff was trained in the program's BMS, as required. Furthermore, the program provided sign-in sheet documentation of staff members from the school board receiving training on the program's BMS on April 20, 2018. Observations made of the facility while on the tour reflected the program has postings of the BMS and a list of youth who have earned privileges in each dormitory. A review of the program's facility operating procedures, coupled with an interview with administrative staff, confirmed fidelity checks are used to monitor rewards to ensure rewards outnumber consequences at a minimum ratio of four-to-one positive to negative consequences. Rewards include, but are not limited to, later bedtimes, personal hygiene items, snacks, games, movies, and verbal praise. Negative consequences are in direct relation to the severity or seriousness of inappropriate behavior exhibited. Five interviewed youth each confirmed they were aware of the BMS, knew it is posted throughout the program, and were provided information on it within their youth handbook. Three youth rated the BMS as fair, one youth rated it as good, and one youth rated it as very good. The five interviewed youth confirmed rewards include extra snacks, hygiene, phone calls, certificates, and later bed times. Three interviewed staff each confirmed they were trained in the BMS and were able to explain their understanding of the BMS, which mirrored the program's policy. The facility administrator was interviewed and stated they use a BMS Tracker/Level system which includes orientation, trainee, maintenance, independent, and honors levels through treatment team behavior referrals and special treatment teams, when needed. The program also utilizes daily, weekly, and monthly incentives. The facility administrator stated rewards outnumber consequences and they monitor these through their BMS tracker, level systems, and daily, weekly, and monthly incentives.

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

The program has a clearly written behavior management system (BMS) approved by the facility administrator on August 5, 2018. The BMS provides for positive and negative consequences in a ratio of four-to-one positive to negative consequences. The system makes provisions for staff to explain to the youth the reason for any sanctions imposed, youth to explain their behavior to staff, and gives staff and youth the opportunity to discuss the behavior's impact on others, reasonable reparations for harm caused to others, and alternative acceptable behaviors. Consequences and sanctions for rule violations are directly related to the seriousness of the inappropriate behavior and are clear and constantly imposed. The BMS is not used solely to increase a youth's length of stay, deny a youth basic rights or services, promote the use of group punishment, allow youth to sanction other youth, or include disciplinary confinement. The program utilizes "Let's Talk" forms where the youth may submit a Let's Talk form to informally voice any concerns or requests with staff prior to filing a formal grievance. The program does not utilize room restrictions as a form of imposing sanctions for inappropriate behavior. A sample of randomly selected staff position descriptions were reviewed and reflected they specified implementation of the BMS as a job requirement. Reviewed documentation confirmed staff receive an initial ninety-day performance evaluation, followed by an annual evaluation thereafter, which includes an evaluation of the staff's implementation of the BMS. Three staff and five youth were interviewed and confirmed staff discuss sanctions imposed, consequences, and alternative acceptable behaviors with the youth. Each of the interviewed youth were aware of the BMS, knew it is posted throughout the program, and were provided information on it within their youth handbook. Two of the three interviewed staff stated they do not receive feedback from supervisors regarding their implementation of the BMS while one said they receive feedback as needed. This was advised to the regional compliance manager to follow-up with staff. Each staff was able to describe different types of rewards provided to youth which includes daily incentives, extra snacks, hygiene, and level parties. An interview was conducted with the facility administrator regarding how the implementation of the BMS is monitored to ensure it is administered fairly and consistently among all staff. The facility administrator confirmed the program utilizes a BMS tracker, the level systems, and daily/weekly/monthly incentives to monitor the implementation of the BMS. Furthermore, he confirmed staff receive ninety-day evaluations after their hire date and have annual performance evaluations thereafter where they are evaluated on their implementation of the BMS.

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

The program has a written policy and procedures in place for staff to conduct and document ten-minute room checks every ten minutes on a ten-minute check log when youth are in their sleeping quarters. Staff must ensure the youth's skin, or a body part, is seen to confirm the youth's presence. Staff are not allowed to enter a youth's room alone and must conduct a visual check from the entrance to the youth's room. An interview with the program's facility investigator confirmed the Kennedy dormitory has a total of two cameras which were both operational at the time of the annual compliance review. Reviewed documentation of 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, 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. A review of ten-minute check logs from six randomly selected days and different shifts, along with the corresponding video recording, verified checks were conducted with fidelity at least every ten minutes and were documented accordingly in real time. The program's practice is to have master control staff call out by way of radio communication of when checks are to be conducted. Supervisors are required to conduct three room checks each night and visibly see flesh of each youth in their room. The program's practice is for supervisors to document these checks in red on the ten-minute log sheets to include the time of the check and their initials. Reviewed documentation confirmed a supervisor conducted ten-minute checks, as required, on the six different days reviewed and were documented in red on the ten-minute check logs. Three interviewed staff each confirmed room checks are conducted every ten minutes for non-suicidal youth.

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

The program has a written policy and procedures to track the daily census of youth. Youth are accounted for at all times by a physical count 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. A review of randomly selected dates and times in the facility logbooks for

the past six months was conducted and reflected youth counts were completed at the beginning of each shift, after outdoor activities, and after movements from one area of the facility to another. Documentation in the logbooks also included youth temporarily away from the program, emergency counts, missed counts, and reconciliation of the count. Observations of youth counts were made during the annual compliance review and reflected prior to any youth movement, master control was contacted to inform of the number of youth being moved and to what location. Staff waited for clearance from master control before they moved the youth. Three staff were interviewed and confirmed the importance of emergency counts and how often those counts must be performed, which aligned with the program's policy.

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

The program has a written policy and procedures regarding logbooks to provide procedures and documentation for a daily account of routines and emergency situations involving youth using logbooks. The program maintains a bound logbook with numbered pages which is stored within master control to document information and daily events at the facility. The master control operator is responsible for documenting the daily account of situations in the program's logbook. Reviewed documentation reflected the logbook documented population counts, perimeter checks, emergency situations, incidents, transports, removal of youth from population, admissions, releases, Central Communications Center (CCC) calls/incidents, Florida Abuse Hotline calls/incidents, and supervisors leaving special instructions pertaining to the supervision of specific youth. Reviewed documentation of randomly selected days within the logbooks reflected each entry was legible and made in ink with no erasures or white-out. There were inconsistencies of errors made in the logbooks. A majority of the entries which contained errors, were struck through with a single line and were initialed by the staff member making the correction; however, there were a few entries observed throughout the logbooks of errors made which were not struck through with a single line nor initialed by the staff member making the correction. In these instances, staff would write over the error in more bold ink or strike through the error without initialing next to the error/correction. This was brought to the attention of the program's regional compliance manager and administrative team to follow-up with staff. The program conducts staff briefings prior to the beginning of each shift. 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 was having staff work twelve hour shifts since March of 2018. A review of the program's shift reports verified information is shared with incoming staff prior to the beginning of the shift and staff sign the shift reports to reflect they have been briefed about its contents.

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

The program has a written policy and procedures for key control and security which includes assignment, inventory, tracking, and the storage of keys. The program has a daily tracking key log which is utilized each day to track program keys. Reviewed documentation reflected the log included the name of the staff and what type of key they are to be assigned according to their position duties. Facility keys are maintained in master control within a secure locked key box. Facility keys are kept on a tamper resistant, color-coded ring which includes a brass colored tag with the initials of the staff positions and a tracking number. When staff arrive to the facility to begin their shift, they gain access to the facility by way of master control. Staff submit their personal keys to the master control operator and receive a facility key in exchange. Staff initial the key log next to their name before and at the end of each shift. Staff's personal keys are placed in the key box next to the corresponding staff's name. 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 program's warehouse clerk is responsible for conducting a complete inventory of keys bi-annually and reviewed documentation confirmed this was completed. 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 replaced. They also advised if lost keys have not been found within two hours, the incident is reported to the Central Communications Center (CCC). Staff were informally interviewed at random throughout the week of the annual compliance review and confirmed none had their personal keys in their possession. Three interviewed staff each knew the key control process including how keys are assigned and the process for missing or lost keys, damaged keys, and restricted keys. A random interview with youth indicated they do not have access to the facility keys.

5.08 Contraband Procedure	Satisfactory Compliance

The program shall develop and implement a system to prevent the introduction of contraband into the program.

A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.

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

The program has a written policy and procedures 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 their 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 it contains a list of the required unauthorized items not permitted which includes personal cellular telephones or devices capable of taking photos and/or audio/video recordings. The program conducts contraband searches of the youth's rooms daily on each shift. Furthermore, searches of the physical plant and facility grounds are conducted throughout each day. 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 the logbooks, daily search reports, and safety perimeter check inspection reports for the past six months verified searches and facility checks are conducted daily on each shift. An interview with the facility administrator indicated discovery of unauthorized contraband is confiscated and either discarded, returned it to the original owner, mailed to the youth's home, or stored and returned to the youth upon his release. Any illegal contraband will be handed over to the local police department.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

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

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

The program has a staff member who maintains an active certification in automotive service excellence (ASE) and is a certified mechanic. This staff member performs regular maintenance and annual inspections on the program's vans. The program has two operable vans utilized to transport youth. Reviewed documentation confirmed both vans were found to have annual inspections completed and are 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, an appropriate number of seat belts, and a first aid kit. First aid kits are housed and remain in the master control area until transports are ready to leave the facility. There were no transports applicable to be observed during the week of the annual compliance review. Informal interviews with staff confirmed youth are never attached to any part of the vehicle by any means other than proper use of a seat belt and both youth and staff wear seatbelts during transportation.

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

The program has a written policy and procedures to ensure the 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, window punch, and first aid kit. First

aid kits are housed and remain in the master control area until transports are ready to leave the facility. Each van was observed to have rear passenger doors which 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 program or staff vehicles. The program maintains a list of staff who are approved to transport youth and have eligible driver's licenses. Driver's license checks are conducted monthly. A youth transport could not be observed during the week of the annual compliance review due to none being scheduled. Informal interviews with staff coupled with a review of the program's policy confirmed the program maintains a minimum ratio of at least two staff for every five youth during any transport. Informal interviews also confirmed staff utilize their personal cell phones to take with them on transports to communicate during any emergency situations when transporting youth. Staff never leave youth unsupervised while in a vehicle. An inspection of approximately thirty randomly selected personal vehicles was conducted throughout the week of the annual compliance review to determine if staff locked their personal vehicles while working on-site. The results of the inspection founded two vehicles to have one of their doors unlocked. These discoveries were reported to the master control operator to advise the applicable staff to lock their doors. Furthermore, this information was advised to the regional compliance manager and administrative staff to follow-up with staff.

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

The program maintains a written policy and procedures requiring weekly safety and security audits of the physical plant, grounds, and perimeter. The program's policy meets all the requirements of Florida Administrative Code 63E-7.013(5). The program's physical plant manager or designee is responsible for conducting safety and security audits every seven days, monthly, quarterly, semi-annually, and annually. Reviewed documentation reflected unit managers 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 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 the morning management meetings to discuss a course of action to correct the deficiency. A work order is submitted to the Department for any applicable physical plant deficiencies. An informal interview with the program's administrative staff and regional compliance manager confirmed the program's practice.

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

The program has a written policy and procedures for tool management to ensure the proper control of tools and kitchen utensils used within the facility, as part of an overall strategy to prevent escapes and eliminate the threat of harm against youth, staff, visitors, volunteers, and interns. The program's policy identifies the physical plant manager as the designated tool control manager. The maintenance department has a total of five different buildings which 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 which is attached to the door of each

locked cabinet containing tools and/or chemicals in the various buildings. The monthly inventory of tools was compared against actual tools at the program and there were no discrepancies noted. Each tool is labeled, color-coded, on a shadow board layout, and are inventoried at the end of each day. Observations made of the tool storage areas indicated it was clean, neat, and each maintenance staff indicated youth are not allowed to utilize tools. A review of five staff training records and five youth case management records indicated staff and youth are trained on the safe use of Class B tools only. Five interviewed youth confirmed they use mops and brooms. One of the five youth also stated they use a scrub brush and another one of the five-youth reported they use paint brushes.

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

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

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

The program maintains a written policy and procedures to address outside contractors performing work projects at the program. The program restricts tools to those necessary, checks tools upon the worker's arrival and departure, and ensures immediate reporting of any tool the worker cannot locate and follows up if any tool is missing. The program requires all outside contractors to review and sign a Contractor's Guidelines form with an attached copy of the visitor's contraband list. Furthermore, they must also review and sign a Prison Rape Elimination Act (PREA) acknowledgment form to document their understanding and agreement with the rules, requirements, and guidelines to which the contractor must adhere to while working on-site at the program. A random selection of completed outside contractor forms compared with sign-in 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 physical plant manager confirmed when a contractor is on-site, a maintenance staff is assigned to supervise the contractor until the work is complete.

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

The program maintains a written continuity of operations plan (COOP) which was approved by the Department on May 18, 2018. The COOP requires the program to conduct unannounced fire drills once a month for each shift. Drills are to be conducted on a random basis under varied conditions when a majority of the youth are available. Program staff document drills on a Facility Drill form, which includes the beginning and ending time of the drill, the nature of the drill, participants, brief scenario, and the findings/recommendations. Reviewed documentation of drills confirmed the program completed drills in accordance with their COOP. The program completed three COOP drills relating to safety and/or evacuation involving an escape, lightning in the area, and a chemical spill. An interview with the facility administrator reflected fire drills are completed once on each shift every month while COOP drills are completed quarterly. Five interviewed youth each confirmed they had been instructed on what to do in the case of a fire. An interview with three staff revealed they participated on various drills within the last six months including drill scenarios involving major disturbances, weather, bomb threats, chemical spills, flooding, terrorism, escape, medical emergencies, and fires.

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

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 has been identified should the program have to be evacuated due to an emergency or disaster. An informal interview with the facility administrator confirmed a copy of the COOP is maintained in master control, the medical office, and the administration building for staff to have access.

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

The program maintains a written policy and procedures regarding the control of hazardous and chemical materials. Toxics are maintained off-site and locked in the facility's maintenance shed. Observations made reflected the program maintains a list of materials and staff positions who are authorized to utilize the chemicals posted on the outside door. All caustic materials are stored according to type and use. A review of the flammable, poisonous, and toxic items list compared with actual inventory verified the items stored. A Safety Data Sheet (SDS) logbook is

located inside the storage area with a picture of each chemical and a number corresponding to the SDS. The program records the daily use of chemicals on a daily chemical usage log, inclusive of the name of the authorized staff using each chemical. Observation of the storage area indicated it is clearly marked hazardous chemicals and is securely locked. Items were neatly stored on metal shelving and were numbered and color-coded to easily identify them. Flammable items are stored in a metal cabinet clearly marked as flammable items.

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

The program has a written policy and procedures to ensure youth do not handle poisonous, flammable, or toxic items and materials. The program's physical plant maintenance staff maintains control over all flammable, poisonous, and toxic items in the program. These items are kept off-site with limited access. Observations made during the annual compliance review confirmed the youth in the program do not have access to the areas where the toxic items are stored or used. An informal interview with physical plant manager indicated youth are not allowed to handle or use any hazardous materials. Observations were made of a youth performing daily cleaning activities of sweeping the floor with a broom. The youth was being directly supervised by a direct care staff member and was searched after completing the detail. Five youth were interviewed and four stated they do not use any chemicals or cleaning products while one youth stated he uses paint. When asked to explain, the youth stated staff pour paint into cups and youth paint small areas in the dorms.

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

The program maintains a written policy and procedures for the disposal of chemicals. The policy 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, toxic material 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. Reviewed documentation coupled with informal interviews with maintenance staff reflected liquid waste not resulting from work details are disposed of in the plumbing area of each housing unit with a drain and liquid waste resulting from work details are disposed of in the plumbing drains located in the mop storage areas. The program continues to maintain a contract with Mid Florida Portable Toilet Service to dispose of kitchen grease accumulated from cooking. The company comes on-site and pumps out the grease trap for disposal and performs maintenance on a quarterly basis. An interview with the facility administrator confirmed this practice.

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

The program has a written policy and procedures regarding recreation and leisure activities. 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 one recreational therapist position assigned to Okeechobee Youth Correctional Center and Okeechobee Youth Development Center. The educational requirements listed state the candidate should preferably have a bachelor's-level degree of science in recreation and sports management with a track in recreational therapy. The last annual compliance review occurred on February 13-16, 2018. The recreational therapist position was filled on March 13, 2018. The hired staff went on medical leave on April 1, 2018. On July 23, 2018, the recreational therapist position was filled by a newly hired recreational therapist. The regional recruiter reported there were recruitment efforts through Facebook, career fairs, career source, and the employer's referrals system during the three months vacancy. Reviewed documentation reflected the employee has a bachelor's-level degree of science in youth and family studies and has approximately seven and a half years of experience working with youth. 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 for each applicable youth's individualized treatment plan. The activity schedule includes recreation time 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. Reviewed documentation of the program's activity schedule coupled with observations made during the annual compliance review of recreational activities confirmed youth are provided with at least one hour of outdoor recreation a day. Observations confirmed staff put out a water cooler for the youth during recreation to prevent over exertion, heat stress, and/or dehydration. Indoor activities are conducted due to the rainy weather or when the heat index is too high. Five youth were interviewed regarding if they are provided physical and leisure activities for at least one hour each day. Three of the five youth stated the program does provide them with at least one hour of recreation and leisure time a day. Two of the five interviewed youth said they do not receive at least one hour a day. The two youth were asked to explain their responses further and each stated sometimes they only receive about thirty to forty minutes of recreation and leisure time and they do not always get the full hour. This was advised to the program's administrative staff to follow-up on. Each youth reported they can play football, basketball, cards, board games, and watch television during recreation and leisure time. Three staff were interviewed and indicated the type of recreation and leisure activities are provided to youth are basketball, football, television, and board games for at least one hour.

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

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

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

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

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

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

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

5.23 Visitation and Communication	Satisfactory Compliance

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

The program maintains a written policy and procedures regarding visitation and communication with family members to re-establish family and community ties with the youth. Upon admission, youth are informed of visitation during the orientation process and receive a youth handbook which outlines visitation. The program encourages communication and visitation from the parent/guardian by sending out a welcome letter upon the youth’s admission to notify the parent/guardian of the days and time for visitation, who can visit, incoming and outgoing mail, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in each youth’s case management record. Youth are provided writing material and a self-addressed stamped envelope to send letters to family members. Youth are allowed to have unimpeded access with the courts, attorneys, juvenile probation officer, and/or the Department of Children and Families case worker, if applicable. Observations of the facility indicated the visitation schedules were visibly posted in the youth’s living areas. A review of five case

management records indicated each record included a completed orientation check list, which includes the process of visitation and communication at the program. Reviewed documentation confirmed each record contained an approved visitor list, telephone list, and mail list. Five interviewed youth each stated they are provided the opportunity to communicate with family members by phone, telephone or at visitation.

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

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

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

The program maintains a written policy and procedures for the use of controlled observation. The program utilized controlled observation five times within the last six months. Reviewed documentation reflected controlled observation was authorized by a supervisor prior to use to determine if it would further jeopardize the safety and security of the youth and others. Each youth placed in controlled observation was either deemed to be an imminent risk of physically harming himself, staff, or others or the youth was engaged in major property destruction and was likely to compromise the security of the program or jeopardize the youth's safety or the safety of others. Reviewed documentation of five Controlled Observation Safety Check forms confirmed the program conducted safety checks every ten minutes for each youth, which exceeds the fifteen-minute requirement. Each controlled observation report contained a completed Health Status Checklist form. Staff discussed the reason for the controlled observation as well as expectations for removal with the youth. Three of the five reviewed placements lasted for longer than two hours and each contained documentation of receiving extensions every two hours by the facility administrator or designee.

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

The program maintains a written policy and procedures for the use of controlled observation safety checks and for releasing youth from controlled observation. The policy requires safety checks to be completed every fifteen minutes on all youth placed in controlled observation. A review of five Controlled Observation Safety Check forms was conducted and found all

observations were completed every ten minutes, thus exceeding the requirement. Each entry indicated the time, code explaining youth's behavior while observed in controlled observation, and the staff's initials who observed the youth. A youth may be released from controlled observation when it is determined the youth is no longer an imminent threat to himself or others. A review of five controlled observation reports reflected the facility administrator or supervisor staff member authorized each youth's release from controlled observation based on the youth's verbal and physical behavior reflecting he was no longer an imminent threat of harm to self or others and an in-house alert was entered for each applicable youth. Each report was reviewed and approved by the facility administrator or assistant facility administrator within fourteen days of the youth's release from controlled observation to determine if placement was warranted and handled appropriately.

Program Name: Okeechobee Youth Correctional Center
Provider Name: TrueCore Behavioral Solutions, LLC.
Location: Okeechobee County / Circuit 19
Review Date(s): October 9-12, 2018

MQI Program Code: 1288
Contract Number: 10188
Number of Beds: 16
Lead Reviewer Code: 125

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.08 In-Service Training	1.16 Youth Input
	3.04 MH/SA Admission Screening
	3.12 Suicide Precaution Observation Logs*