STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Youth Correctional Center

TrueCore Behavioral Solutions, LLC.

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

Review Date(s): September 29 – October 2, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Yvrose Sylvain, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Christine Calvert, Office of Accountability and Program Support, Regional Monitor (Interviews)
Camelia Daley, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Peter Keelan, Office of Education, Southeast Region Education Coordinator (Standard 2)
Patrick Morse, Office of Accountability and Program Support, Regional Supervisor (Standard 3)
Maryann Sanders, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 2)

Program Name: Okeechobee Youth Correctional Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): September 29 – October 2, 2020

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

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

Overall Rating Summary

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

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

Limited Ratings	Failed Ratings
3.06 Mental Health and Substance Abuse Treatment	1.06 Protective Action Response (PAR) and Physical Intervention Rate
3.07 Treatment and Discharge Planning *	1.10 Delinquency Intervention and Facilitator Training
3.08 Specialized Treatment Services*	1.12 Restorative Justice Awareness for Youth
5.09 Searches and Full Body Visual Searches	1.16 Youth Input
	2.01 Initial Contacts to Parent/Gaurdian and Court Notification
	2.04 Classification Factors, Procedures, and Reassessment for Activities
	2.09 Performance Plan Development, Goals and Transmittal *
	3.02 Licensed Mental Health and Substance Abuse Clinical Staff *
	3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff
	3.13 Suicide Prevention Training *
	5.01 Youth Supervision *
	5.04 Ten Minute Checks *
	5.14 Youth Tool Handling and Supervision

Overall Rating Summary for Standard 1
This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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	Failed
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Failed
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Failed
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Failed
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

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

Overall Rating Summary for Standard 1

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

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	Failed
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Failed
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Failed
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
2.22	Safety Planning Process for Youth	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 *	Failed
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Failed
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Limited
3.07	Treatment and Discharge Planning *	Limited
3.08	Specialized Treatment Services*	Limited
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Failed
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/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Non-Applicable
4.19	Licensed Medical Staff*	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

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

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Program Overview

The Okeechobee Youth Correctional Center (OYCC) is a sixteen-bed program, for thirteen to twenty-one-year-old males, located in Okeechobee, Florida. The program is co-located with Okeechobee Youth Development Center. There is one program facility administrator (FA) responsible for both programs and the entire management team. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides mental health overlay services (MHOS), life skills, on-site educational classes, and vocational programming services. In addition, the program fosters each youth by providing Thinking for a Change (T4C), Skillstreaming the Adolescent, and Impact of Crime (IOC). The three effective intervention groups are taught by specifically trained staff to assist youth in the program. The program also provides Living in Balance, Young Men's Work, Passport Program, Towards No Drugs, Strategies for Anger Management, Anger Management for Mental Health, Thinking Feeling Behaving, and The Teen Relationship. Additional treatment services provided includes group therapy seven days a week, and individual and family therapy once a month.

Program administration is comprised of a campus-wide superintendent, campus-wide assistant superintendent, facility administrator, unit manager, shift supervisors, health services administrator (HSA), food service director, compliance managers, and a human resources manager. Case management services are provided by the director of case management, transitional services manager, and one case manager. Mental health staff at the program includes a designated mental health clinician authority (DMHCA), director of clinical services, one recreational therapist, one therapist, and an independent psychiatrist agreement with a licensed psychiatrist. Medical services are offered twenty-four hours a day, seven days a week. Sick call is offered seven days a week for youth who have health concerns and are provided by the registered nurses (RN), a HSA, and an independent contractor agreement with a licensed medical doctor who serves as the designated health authority (DHA). Educational services are provided by Okeechobee County School District. The youth receive academic credits and have the opportunity to work towards the General Equivalency Diploma (GED) test.

At the time of the annual compliance review, the program had six vacant positions which included two youth care workers, two therapists, one facility administrator, and one physical plant manager. The layout of the program includes the dormitory, medical area, one administration building, a cafeteria, school areas, and a master control building. The program has ninety-eight operating security cameras providing coverage, all of which were operational at the time of the annual compliance review. The digital video recorder (DVR) has a recording capacity and storage for a maximum of forty-five days. At the time of the annual compliance review, the program had a census of four active youth. One of the four youth records was reviewed in 2018, two youth records were reviewed in 2019 with one youth re-admitted to the program on December 2019, and the fourth youth is the only newly admitted youth for this annual compliance review period.

Standard 1: Management Accountability

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

The program maintains a written policy and procedures requiring compliance with the Department's background screening requirements. The program had five staff members who were applicable for an initial background screening during the annual compliance review period. A review of initial background screenings for the five 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 and confidential records. Documentation revealed the program added all staff to the program's roster in the Clearinghouse. The program utilizes an ergometric pre-employment assessment tool for all direct care applicants. Documentation indicated applicants must have a minimum score of sixty-five percent to pass the human relations video portion of the assessment and a minimum score of sixty percent on the reading portion of the assessment. A review of two applicable direct-care staff records revealed each staff passed both portions of the pre-employment assessment tool. There was documentation in all reviewed staff records indicating the hiring specialist reviewed the Department's Central Communications Center (CCC) system, Staff Verification System (SVS), and the Florida Department of Law Enforcement's Automatic Training Management System (ATMS) as part of the pre-employment background screening process. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to the BSU on December 30, 2019, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was completed and submitted to the BSU on December 30, 2019, meeting the annual requirement. There were no contracted staff or volunteers who required an initial background screening since the last annual compliance review.

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 resources manager tracks the five-year anniversary of hire dates and processes the five-year background

re-screenings for all staff. A review of the program's staff roster and contracted staff lists indicated there were four staff and one volunteer applicable for a five-year background rescreening during the annual compliance review period. Each staff's background re-screening was completed and submitted to the Department's Background Screening Unit/Clearinghouse prior to the anniversary date. The volunteer's background re-screening was submitted on the anniversary date; therefore, was completed late. There were no contracted staff who required five-year background re-screenings since the last annual compliance review.

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

The program maintains a written policy and procedures outlining an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. Observations made during the program tour found signs posted throughout the program listing the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The program's administrator reported youth are escorted to a case manager or therapist office upon requesting an abuse call. If the youth is not in the dormitory area, the youth care worker will use the radio to call the shift supervisor in which the shift supervisor will escort the youth to a telephone where the youth can pick up the telephone and then place the call to the Florida Abuse Hotline. Youth eighteen years of age or older may request a call to the CCC through the youth care worker, on-duty shift supervisor, unit manager, and/or the program's facility administrator (FA). The youth care worker will use the radio to call the shift supervisor and the shift supervisor will escort the youth to place the call.

The program's policy states allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline and the CCC. The FA, unit manager, or the facility investigator will immediately begin a review of all documents, statements, and video as part of an internal review. Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline. A review of three staff personnel records documented the staff signed a

form acknowledging their understanding of the code of conduct. The youth orientation handbook is provided to each youth upon admission. The youth's handbook includes the youth's rights, the program's grievance process, and the telephone numbers for the Florida Abuse Hotline and the CCC. Documentation showed the program completed Trauma Responsive and Caring Environment (TRACE) youth and staff surveys on March 26, 2020.

There were no abuse allegations reported to the Florida Abuse Hotline or the CCC during the annual compliance review period. Three interviewed youth reported never being stopped from reporting abuse to the Florida Abuse Hotline or CCC. All three youth reported staff are respectful when speaking with them. Each youth reported never hearing staff use curse words when speaking to youth. All of the youth reported feeling safe in the program. The youth reported never exchanging personal contact information with staff. None of the three interviewed staff reported ever witnessing a co-worker deny a youth an abuse call. All three staff explained the process of allowing a youth to call the Florida Abuse Hotline or the CCC, in accordance with the Florida Administrative Code. All interviewed staff reported they never observed a co-worker use profanity when speaking to youth. An interview with the FA revealed all staff receive training on the Florida Abuse Hotline and the CCC prior to having contact with the youth in the program. The FA reported youth and staff have unhindered access to report allegations of abuse to the Florida Abuse Hotline and if the youth eighteen years of age or older, to the CCC.

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

The program maintains a written policy and procedures ensuring management takes immediate action to address incidents of physical, psychological, and emotional abuse. The program's practice is to initiate an internal investigation regarding the complaint and remove the staff member from youth contact, when necessary. There were no abuse allegations reported to the Florida Abuse Hotline or the Department's Central Communications Center (CCC) during the annual compliance review period. An informal interview with the program administrator revealed the program has not had any incidents of physical, psychological, and/or emotional abuse since the last annual compliance review.

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

The program maintains a written policy and procedures regarding response to incidents in accordance with Florida Administrative Code. The program had eight reportable incidents since the last annual compliance review. A review of five incidents found all were reported to the Department's Central Communications Center (CCC) within two hours of the incident or staff becoming aware of the incident, as required. The five incidents were documented in the program's facility logbook. A review of the program's internal incident reports found there were no incidents which should have been reported to the CCC. The program has experienced an increase in the number of reportable incidents to the Department's CCC compared to the last

annual compliance review period. An informal interview with the program's facility administrator confirmed the program has a policy in reference to the Department's CCC and ensures all matters which require reporting is verbally reported within two hours of when the program became aware of the incident.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Failed 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 reported one Protective Action Response (PAR) incident in the past six months. However, based on the Department's Central Communications Center (CCC) report and the program internal incident report, there were two separate PAR incidents which should have generated a PAR report. A review of the one completed PAR report found not all of the involved staff completed appropriate statements prior to the end of their shift. The PAR report was reviewed by the same staff for supervisor review and PAR instructor, and the staff was the lead member of the incident. There was documentation to support monthly summaries of PAR reports were submitted to the Department which showed zero PAR incidents each month. However, documentation indicated the PAR reports submitted to the Department were incorrect. Based on inaccurate PAR incidents reported to the Department, the program has not experienced an increase in the number of PAR reports compared to the last annual compliance review period. The program's PAR rate during the annual compliance review period was 0.31, which is below the statewide Residential PAR rate of 2.23. An interview with the FA reported staff were instructed to complete a PAR report at the end of their shift, if a PAR occurred; signatures and any corrective action taken after the PAR must be documented. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020.

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

The program maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training plan was approved by the Department's Office of Staff Development and Training on February 17, 2020. Pre-service training is provided through a combination of instructor-led and web-based courses. Three staff training records were reviewed for pre-service certification training. All three reviewed training records documented each staff completed the certification process within 180 days of hire. The staff completed the required trainings related to Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All completed trainings were documented in the Department's Learning Management System (SkillPro) within thirty days of training completion and were delivered by qualified trainers.

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

The program maintains a written policy and procedures regarding in-service training for all staff. Three staff training records were reviewed for in-service training. All three reviewed staff training records documented each staff exceeded the twenty-four hours of annual in-service training requirements. All three staff had current certifications in Protective Action Response (PAR). Each staff had certifications in first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR), as well as six hours of suicide prevention training. The one applicable staff exceeded the required eight hours of management/supervisory training. The program has a training calendar which is updated as necessary. All trainings were delivered by qualified trainers and were documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. The program maintains a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on February 17, 2020.

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 maintains a written policy and procedures specifying the process for youth to grieve actions of program staff and conditions or circumstances in the program related to the violation or denial of basic rights. According to the program's policy, procedures are in place to confirm each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The program's grievance procedures include informal, formal, and appeal phases with time frames of seventy-two hours to provide feedback to the youth to correct the grieved situation or condition. The youth are provided with the opportunity to file an alternative informal request by utilizing a "Let's Talk" form as a first opportunity to voice an objection and informally resolve a complaint. Grievance and "Let's Talk" forms were available to youth, as observed during the program tour. Reviewed documentation found there were no grievances and "Let's Talk" forms submitted by youth during the previous twelve months.

Three staff training records were reviewed for pre-service trainings. All three training records documented staff received the required training on the program's grievance process and procedures. During the annual compliance review, three youth and three staff were interviewed. The three youth were able to explain the grievance process to include submission of a completed grievance form into the secured grievance box. All three interviewed youth reported being able to request assistance in completing a grievance form, if needed. All three interviewed staff explained the grievance process. An interview with the facility administrator (FA) revealed grievance forms are available to the youth on the dorm and the sealed grievance box located at

the cafeteria entrance. The FA checks the grievance box and “Let’s Talk” forms daily and addresses each youth’s complaint within seventy-two hours.

1.10 Interventions and Facilitator Training	Failed Compliance
The program shall implement interventions for each youth. Interventions shall include, but are not limited to, evidence-based practices, promising practices, or practices with demonstrated effectiveness. Staff whose regularly assigned job duties include the implementation of a specific intervention and/or curriculum must receive training in its effective implementation.	

The program maintains a policy and procedures regarding interventions and facilitator training. A review of the program’s contract determined required services included Thinking for a Change (T4C) as an evidenced-based intervention curriculum. The program had two staff trained to facilitate T4C. There was no documentation indicating the program conducted T4C since the last annual compliance review dated October 4, 2019. The program’s administrators did not provide an explanation as to why groups were not conducted when asked by the annual compliance review team. A review of two youth records confirmed neither youth received the required T4C group to address their delinquency needs. Three interviewed youth did not mention receiving T4C group during the interviews.

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

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

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

The program maintains a policy and procedures for the provision of restorative justice awareness to the youth. A review of the program’s contract indicated the Impact of Crime (IOC) curriculum is a required service to be provided to all youth in the program. The program had two staff trained to facilitate IOC groups. There was no documentation indicating the program

conducted IOC groups since the last annual compliance review dated October 4, 2019. There was no valid documented practice for restorative justice for June through September 2020.

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

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

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 maintains a policy and procedures addressing youth alerts. The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert which may not have been previously entered prior to the youth's admission. The program has an alert board in master control which identifies each youth's special alerts, escape risk, and/or gang affiliation. The alert board identifies youth placed on any type of mental health alert. The alert board has each youth's picture, arranged by cottage, and the alert associated with the youth. Reviewed documentation indicated the program's internal alert report is reviewed daily during shift briefings by the program's shift supervisory staff. An extra copy of the program's internal alert report is located in master control, near the door on a clip board, and is accessible to all staff. Two youth records were reviewed for case management, medical, mental health, and substance abuse alerts and all applicable alerts were accurately entered into JJIS. Each JJIS alert was included on the program's internal alert system, as required. All internal and JJIS alerts were downgraded or discontinued by a medical staff, case manager, and/or licensed mental health staff. Three staff were interviewed, to include one supervisor. Each staff reported they are informed of youth alerts during shift meetings, reviewing safety plans, and alerts sheets are available in master control. An interview with the facility administrator (FA) revealed all internal alerts are discussed during morning meetings and are labeled on the housing roster in

master control. In addition, the JJIS alert system is updated accordingly by specific departments. The alert information is reported to master control where the controller will update the alert board for the program.

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

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

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

The program maintains a written policy and procedures to allow for youth feedback outlined in the grievance procedures. The program policy stated a resident advisory council is to be created where elected youth could represent their respective dormitories. The program did not provide documentation indicating a formal process was in place for the past six months to promote constructive input by the youth. The program indicated there were no attempts to solicit input from youth, through avenues such as a youth advisory board. The program admitted youth surveys were conducted once; however, the information was share with the corporate office and the program did not utilize the information on-site. Three youth were interviewed, and each stated they can provide input through the student counsel, or they can talk to staff regarding what happens at the program.

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

The program maintains a policy and procedures ensuring the program has a community advisory board which meets quarterly. The program has an advisory board serving seven programs located in Okeechobee County. Each program's advisory board was combined to have one for all programs due to a limited amount of people living in the rural community and the number of boards the local representatives to participate. The program maintains a list of thirty-eight community advisory board members consisting of representatives from local law enforcement, school board officials, the judiciary community, community partners, faith-based organizations, a mentoring agency, victim advocacy representatives, business community, and parents/guardians of former residents. Reviewed documentation of the community advisory

board's agendas and sign-in sheets reflected the program's community advisory board met on March 3, 2020.

The program tentatively scheduled the next quarterly advisory board meeting in June 2020; however, it was cancelled due to the COVID-19 pandemic and the Department canceling all visitation according to the facility administrator (FA). Documentation showed the last quarterly was meeting conducted virtually on September 29, 2020. A telephone interview conducted with a current board member confirmed the board member's involvement with the community advisory board. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. An interview with the campus-wide superintendent confirmed community advisory meetings are held quarterly.

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

The program maintains a written policy and procedures identifying service, employment recognition, and tuition reimbursement. The program administration conducts comprehensive quarterly youth and staff surveys. The program admitted youth surveys were conducted once; however, the information was share with the corporate office and the program did not utilize the information on-site. The results of the surveys are discussed in detail at the corporate office and subsequently, the results are reviewed and shared with staff during the all staff monthly meetings. The program conducts daily management meetings, shift briefings, and monthly meetings for all staff to discuss relevant issues affecting the program's operation and to keep staff informed of corporate objectives. The program's daily management meetings follow a pre-set agenda and includes the discussion of Protective Action Response (PAR) incidents, calls to the Florida Abuse Hotline and/or the Department's Central Communications Center (CCC), youth behaviors, admissions and discharges, and any upcoming events.

The program has recognitions for staff such as employee appreciation and staff celebration. The program utilizes a system called the "TrueCore Way," which allows supervisory staff to recognize staff for exemplifying the "TrueCore Way" which is a positive culture, teamwork, and going above and beyond. Three interviewed staff reported staff meetings are held monthly and shift briefings are held daily. Two staff reported the communication amongst the staff at the program is very good and one staff reported fair. According to the interviewed staff, the topics discussed during the monthly meetings at the program includes employee of the month, safety and security, searches, drills, company changes, code of conduct, the COVID-19 pandemic, and program closure. The facility administrator (FA) reported a morale committee meets monthly to focus on activities which identifies different ideas to build staff morale and events to reduce staff turnover in the program.

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

The program conducts ninety-day performance evaluations for newly hired staff and annual evaluations for all staff. Six personnel records were reviewed of which three contained an annual performance evaluation and three contained a ninety-day performance evaluation. The performance evaluations were specific to the applicable staff's job description. All six reviewed

performance evaluations found each staff's evaluation was based on the performance standards for their position. The two applicable staff performance evaluations included the effective delivery of the evidence-based curriculum delivered by the staff. The evaluations rated the staff's quality of work, modeling appropriate behavior, a positive reinforcement in a four-to-one ratio, and each evaluation included ratings on the staff's job-specific responsibilities. Two of the three interviewed staff reported receiving a ninety-day evaluation and one reported receiving an annual evaluation. The facility administrator (FA) reported staff are given a ninety-day performance evaluation and an annual performance evaluation by their supervisor. The FA reported annual evaluations are utilized to determine how the staff performed throughout the year and is used as a tool to identify staff who qualify for different incentives from the company.

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

The program maintains a written policy and procedures regarding recreation and leisure activities. According to the contract, the program is required to have a recreational therapist position. A review of the program's contracted amendment executed in April 2019 indicated the recreational therapist shall have a bachelor's-level degree in recreational therapy or related field with at least one-year experience working with youth. This was a previously preferred qualification criterion. The recreation therapist was hired in 2017 and was grandfathered into the position with the original contract requirement. The program provides a variety of recreation and leisure activities for the youth in the program. The recreational therapist is responsible for planning, developing, and implementing daily recreation and leisure time activities designed to be physically challenging, educational, and constructive for the youth. The recreational and leisure activities are provided during the weekdays and on weekends. Youth are provided at least one hour daily of large muscle activity promoting or creating teamwork, healthy competition, and mental stimulation. The program provides activities such as basketball, chess games, card games, and board games. The program maintains a monthly calendar of indoor and outdoor recreation activities for the youth targeted to promote team building and leadership skills. The weekday activity schedule includes recreation each afternoon for one hour. When the heat index is above the approved temperature or when there is inclement weather, the youth are afforded one hour of recreation time inside the facility. A review of two youth records documented recreational therapy activities were provided and were incorporated into goals on each youth's individualized treatment plan. Randomly selected dates and times were reviewed in the program's master control logbooks and confirmed the youth have allotted time each day for recreation. Observations and documentation found youth were participating in teamwork, healthy competition, and physical fitness. Three interviewed youth reported they are provided at least one hour of large muscle activity daily and the program provides activities promoting or creating teamwork, healthy competition, mental stimulation, and physical fitness. Three staff were interviewed and indicated the type of recreation and leisure activities are provided to youth are basketball, flag football, and kickball.

Standard 2: Assessment and Performance Plan

2.01 Initial Contacts to Parent/Guardian and Court Notification	Failed 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 policy and procedures addressing initial contact to parents/guardians and the court notification upon each youth's admission. The program had only one applicable record for initial contact to parent/guardian and court notification. The reviewed case management record found the parent/guardian was not notified by telephone of the youth's admission within twenty-four hours of arrival to the program. The youth was admitted on October 17, 2019 and the first documented telephone contact was made on November 8, 2019. In addition, there was no documentation to support the youth was provided a telephone call to the parent/guardian at the time of admission. The reviewed record documented an admission letter and an input questionnaire sent to the parent/guardian; however, it was not mailed until November 11, 2019. The reviewed youth case management record documented a notification letter to the committing court was mailed within twenty-four hours of the youth's admission to the program and a copy was sent to the assigned juvenile probation officer. The reviewed record did not document the youth was assigned to a post-residential counselor at the time of admission nor did the record indicate the youth was under the supervision of the Department of Children and Families.

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 addressing youth orientation. The program had two youth who were applicable for a youth orientation. One youth was a new admission to the program and one youth was a readmission. A review of two case management records supported each youth was provided an orientation within twenty-four hours of admission or readmission. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet and information on the program's daily schedule, expectations, youth responsibilities, services available to the youth in the program, how to access medical and mental health services, performance planning inclusive of length of stay, the Florida Abuse Hotline and the Department's Central Communications Center (CCC) numbers, contraband, dress code, hygiene procedures, community access, grievance procedures, emergency procedures, services provided, and assigned living units. The orientation packet provided to each youth included a map of the facility and designated areas which are not accessible to youth. The reviewed records validated both youth received a copy of the youth handbook which outlined the program rules governing conduct and positive/negative consequences for behavior. Three interviewed youth reported orientation included program rules, procedures, schedules, and all other pertinent information and each received an orientation on the day 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. Two case management records were reviewed, and one was applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. The reviewed record contained the required signed consent of the youth who was eighteen years old at the time of admission and/or readmission to the program.

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

The program has a policy and procures addressing the classification process. The policy outlines the effective delivery of treatment services based on the determination of each youth's individual needs and risk factors. The program's policy also addresses when reassessments are warranted based upon changes in the youth's supervision status, new or updated alerts, relevant information available to the treatment team, and behavioral concerns. A review of two case management records found one youth had a completed admission classification completed for the purposes of assigning youth to a living/sleeping area and staff advisor at the time of admission and/or readmission. One youth was admitted on October 17, 2019 and the initial classification was not completed until December 24, 2019; therefore, the youth was assigned to a living area, sleeping room, and staff advisor without pertinent information gathered from the classification process.

During an interview, the program's facility administrator (FA) reported all classification factors are taken into consideration when deciding where to place the youth. The program has an internal alert system. All program alerts are maintained and updated, as needed, on an alert board which is accessible to all staff, as reported by the FA. Two admission classification forms were reviewed, and neither was applicable for alerts entered into the Department's Juvenile Justice Information System (JJIS).

The program's policy and procedures address reassessment of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects, other actives which involve the use of tools, and a youth's participation in any off-campus activities. Two reviewed case management records indicated each was applicable for reassessment prior to participation in activities, work projects, consideration for an increase in privileges, or freedom of movement. Each reviewed record documented the completion of a reassessment which included review of

the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. Documentation confirmed reassessment results were discussed at treatment team meetings. It is the program's practice to complete a classification reassessment each month for each youth and reviewed documentation supported this practice.

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 admission for suspected gang involvement. Youth who are identified as a gang member or gang associate have an alert placed in the Department's Juvenile Justice Information System (JJIS). Additionally, the program notifies the local law enforcement's gang liaison by e-mail of each youth admitted to the program when they are identified as a gang associate or gang member. The law enforcement gang liaison notifies the local law enforcement in each youth's home county if the youth is identified as a gang member or gang associate post-admission. The gang information is shared with the educational staff at the program, the youth's juvenile probation officer (JPO), and the post-residential services counselor, if applicable. The program has identified each case manager as the gang liaisons. The program did not have any applicable youth during the annual compliance review period.

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 to include information on youth documented as gang members or associated with a gang. If a youth is identified as a gang member or gang associate upon admission or post-admission, the youth's Individual Performance Plan will include a gang prevention and intervention strategy. The program utilizes the Gangs: 50+ Stories of Fractured Lives curriculum. The curriculum includes individual lessons and a final essay. The program maintains sign-in sheets to document youth participation in gang prevention and intervention activities, as well as certificates of completion for each youth. The program maintains a policy and procedures which addresses gang prevention and intervention activities and procedures to ensure the youth have the opportunity, if they desire, to disaffiliate from a street gang. Two case management records were reviewed and nether was applicable for participation in gang prevention and/or interventions strategies. The program did not have any applicable youth during the annual compliance review period.

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

A review of two case management records found each contained a Residential Assessment for Youth (RAY) completed within thirty days of each youth's admission or readmission to the program. Each RAY was completed in the Department's Juvenile Justice Information System (JJIS) and was used to identify criminogenic risk and protective factors and prioritized the youth's criminogenic needs. A copy of the RAY overview report was maintained in each youth's case management record. Two reviewed case management records found each was applicable for a RAY Reassessment. Documentation supported each RAY Reassessment was completed within ninety-days of the initial RAY. Each RAY Reassessment was maintained in the youth's case management record. There were no other updates or reassessments deemed necessary by the intervention and treatment team.

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

One applicable case management record was reviewed and contained a Youth Needs Assessment Summary (YNAS) completed within thirty days of the youth's admission to the program. One youth was readmitted into the program and a new YNAS was not required. Reviewed documentation supported the YNAS was documented in the Department's Juvenile Justice Information System (JJIS) and a copy was maintained in the youth's case management record.

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Failed 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 addressing performance plan development. The treatment team, including the youth, meet and develop the Individualized Performance Plan

(IPP), based on the findings of the initial assessment of each youth within thirty days of the youth's admission. The program had one applicable youth for development if an IPP within thirty-days of admission and reviewed documentation reflected the IPP was developed two days late. Additionally, there was no documentation to support any members of the treatment team participated in or were present during the development of the IPP. The reviewed IPP was developed after the initial assessment. Interviews conducted with three youth reflected each participated in the development and received a copy of their IPPs.

The IPP is a document developed by the treatment team, including the youth, which stipulates goals the youth must achieve prior to release from the program. The goals are measurable, individualized, and based upon the prioritized needs reflecting the risk and protective factors identified during the initial assessment process, to include delinquency interventions, targeted court-ordered sanctions, and identifies transition activities. One applicable youth IPP was reviewed and did not included individualized goals based on prioritization needs. Each goal was generic and did not include specific interventions which were measurable or included appropriate projected target dates for completion. Each goal contained a projected completion date within thirty-days of admission into the program, and the plan did not include mental health or wellness goals.

A review of the youth's disposition court order did not include additional court-ordered sanctions besides court fees. The reviewed record indicated the youth was enrolled in educational programing; however, the programming was not included on the IPP. The reviewed IPP documented the youth's top three criminogenic needs. The initial IPP was modified on December 19, 2019, two months after the youth's admission into the program, which included the participation of all treatment team members, as well as specific and individualized goals and interventions with appropriate and realistic target dates.

Three closed records were reviewed for documentation of transition activities and each applicable IPP documented transition activities. Three interviewed youth reflected each youth was familiar with their IPP goals and were able to explain the treatment process. Each interviewed youth confirmed they received a copy of the initial IPP. Observations of a treatment team meeting could not be conducted, as there were no treatment team meetings scheduled during the annual compliance review week.

Within ten working days of completion of the IPP, the program sends a transmittal letter and a copy of the IPP to the committing court, each youth's juvenile probation officer (JPO), and each parent/guardian. One applicable youth case management record was reviewed and indicated a transmittal letter and a copy of the IPP was sent within ten working days to the committing judge, JPO, and parent/guardian. The IPP was not signed by the youth, treatment team leader, or all significate parties responsible for the goal completion. The program mailed the IPP to the parent/guardian to sign and return to the program. Reviewed documentation indicated the signature page was not returned to the program.

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 addressing performance plan revisions. Two youth case management records were reviewed, and each was applicable for a revision to the Individual Performance Plan (IPP). Documentation supported each IPP was revised based on

the Residential Assessment for Youth (RAY) Reassessment results, newly acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and/or completing a goal. Documentation found each IPP was updated with recommendations from the treatment team. In addition, three closed youth case management records were reviewed, and documentation supported each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

2.11 Performance Summaries and Transmittals	**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 addressing performance plan summaries and transmittals. Two case management records were reviewed, and each was applicable for a performance summary. Documentation validated the performance summaries were completed every ninety-days following the signing of the initial Individualized Performance Plan (IPP). Both youth records supported the IPP was updated every ninety days. Each performance summary included the youth's overall progress on the IPP, academic status, behavior, level of readiness to change, interactions with peer and staff, the status of each goal, and significant positive or negative events. Both reviewed performance summaries were signed by each youth and included comments. Each original performance summary was filed in the youth's case management record. Three interviewed youth reported they received a copy of their performance summaries. Each of the two reviewed case management records contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and parent/guardian.

Three closed youth case management records were reviewed for completion of a release summary. Documentation supported a release summary was completed and forwarded to the assigned JPO, along with the Pre-Release Notification (PRN) at least forty-five prior to each youth's planned release. Each of the three applicable closed case management records also contained a signed PRN. There were no youth applicable for the Sexually Violent Predator Program (SVPP) and the victim notification.

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

The program has a policy and procedures which addresses encouraging parent/guardian involvement in case management services, where each parent/guardian should be contacted by telephone by the case manager upon each youth's admission to the program, and a welcome letter should be mailed within forty-eight hours of admission. The welcome letter includes a calendar of all treatment team meetings and parents/guardians are encouraged to participate in

person or by telephone. Parents/guardians were involved in the assessment process, the development of the youth's performance plan, and progress reviews. The program hosts family days and weekly visitation; however; in compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, visitation and family day activities were suspended from March 2020 until September 2020. Three interviewed youth reported their parent/guardian is involved in the case management process and treatment team meetings. In addition, one youth stated their parent/guardian participates regularly in family therapy. Each youth reported all participation is conducted over the telephone. During an interview, the program's facility administrator stated each youth's parent/guardian is contacted by the assigned case manager upon admission and is consistently updated on the youth's progress or lack thereof during the entire stay in the program. In addition, parents/guardians are invited to all special events including family days.

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

The program has a policy and procedures addressing treatment team and its members. At a minimum, treatment team includes the youth, a representative from the program's administration, living unit representative, education staff, and others responsible for providing or overseeing the provision of intervention and treatment services. Two youth case management records were reviewed, and one contained an initial Individual Performance Plan (IPP) signed by all required members of treatment team inclusive of each youth's case manager, a representative from administration, a living unit representative, educational staff, mental health staff, the assigned juvenile probation officer (JPO), and the youth's parent/guardian. One of the two reviewed IPPs was updated approximately two months after the youth's admission into the program, at which time all required signatures were obtained. Observations of a treatment team meeting could not be conducted, as there were no treatment team meetings scheduled during the annual compliance review week.

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.	

Each youth's Individualized Performance Plan (IPP) shall reference or incorporate the youth's treatment or care plan. Two youth case management records were reviewed. Each had separate academic, mental health and/or substance abuse, and wellness plans which were incorporated into the current IPP. The goals included the responsibility of the program staff in assisting the youth to successfully complete the goal(s). The Department of Children and Families (DCF) and the Agency for Persons with Disabilities (APD) behavior support plan was not applicable for any of the two youth records reviewed.

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

The program has a policy and procedures addressing formal and informal treatment team meetings. Two case management records were reviewed, and documentation supported formal treatment team meetings were conducted at least once every thirty days for one of the two youth. One youth was missing a formal treatment team meeting during January 2020. Two case management records were reviewed for informal treatment team reviews, and documentation supported informal treatment team meetings were conducted at least once within thirty-days for each of the two youth.

The program utilized a Performance Plan Review form which included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions. Reviewed documentation confirmed treatment team meeting attendees included the youth, case management staff who act as the treatment team leader, clinical staff, education, and a program administration representative. Each youth's juvenile probation officer, parent(s)/guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and Residential Assessment for Youth (RAY) Reassessment results. All staff provided relevant input on the youth and agreed on how to proceed to formal treatment team. Observations of a treatment team meeting could not be conducted, as there were no treatment team meetings scheduled during the annual compliance review week. The program stated if there were any positive or pending COVID-19 results, treatment team meetings would be conducted over the telephone, and reviewed documentation supported this practice. Three interviewed youth stated, during treatment team reviews, staff review their performance to include progress on performance goals, positive and negative behavior, and treatment progress. Additionally, each youth stated they are given the opportunity during treatment team meetings to demonstrate any skills they have learned in the program.

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

The program has a written policy and procedures in place addressing career education. The program offers Type 2 career education services. Career education services are provided by the Okeechobee County School District. The program's career education addresses communication, interpersonal, and decision-making skills. The program offers Type 2 educational programming which teaches personal accountability skills and behaviors appropriate for youth in all age groups and ability levels leading to work habits which will help maintain employment and living standards. In addition, youth are given an orientation to the broad scope of career choices based upon personal abilities, aptitudes, interests, and exploring and gaining knowledge of occupation options and the level of effort required to achieve them. Youth may obtain a high school diploma or General Equivalency Diploma (GED) credentials. The program provides opportunities for youth to earn certifications in vocational skills while at the program. Youth complete résumé writing to summarize individual education and past work

experiences, and completion of job applications and college applications for youth looking to further their education. Three closed youth case management records were reviewed. Each closed record included a sample application, a résumé, and referral to a Career Source Center. Each record contained documentation supporting notification to the youth's parent/guardian and juvenile probation officer (JPO) of the youth's vocational plan. The facility administrator (FA) reported youth in the program attend a vocational learning class during the school day. The GED preparation is offered during school and assessments are taken by the youth to prepare for the GED test once released from the program. An interview with the lead teacher found youth in the program were enrolled in vocational employment skills and vocational certification classes.

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 lead teacher revealed educational services are provided 250 days a year, with 300 minutes of instruction five days a week. During the annual compliance review week, observations confirmed the youth received the required minimum 300 minutes of daily instruction. Youth enrolled in educational programming will receive course credit for the completion of the education and training experience. Youth receive standard instruction in mathematics, reading, language arts, science, and social studies, at a level appropriate with their grade and in a manner indicated by the youth's individual education plan (IEP). Youth are given the opportunity to take the General Equivalency Diploma (GED), and if youth meet the requirements, can graduate with a standard high school diploma during their stay in the program. Documentation showed youth received 300 minutes of daily instruction, as scheduled. Reviewed activity schedules and logbook documentation supported there is minimal interference of educational instruction.

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

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

individuals who are responsible for the reintegration and coordination of the provision of support services.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	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.*	

Three closed case management records were reviewed for a transition planning conferences and Community Re-Entry Team (CRT) meetings. Reviewed documentation validated each transition conference was conducted at least sixty days prior to the youth's release date. All pertinent parties were invited to attend the transition conference through advanced notice and encouraged to provide written input if unable to attend. Reviewed documentation in two of the three transition conferences supported the youth, case manager (who also acted as the treatment team leader), the facility administrator (FA) or designee, educational staff, mental health staff, and medical staff participated in person, and the parent/guardian and the assigned juvenile probation officer (JPO) participated by telephone or documented attempted telephone contact with the parent/guardian. One transition conference was missing the input and participation of the FA or designee. The transition activities and target dates were reviewed, and all required signatures were obtained. A copy of the transition plan and conference was electronically sent to the JPO for all three youth and each closed record contained an electronically signed copy of the form. A copy of the transition plan and conference documentation were mailed to each parent/guardian; however, none were returned with a signature. Each transition conference included a discussion of all transition activities including persons responsible for completing the activities and targeted completion dates. Each of the three reviewed closed records contained documentation supporting a CRT meeting was conducted and documented the youth and case manager's participation in the CRT meeting.

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

The program assembles an exit portfolio for each youth to assist the youth upon release back into the community. A review of three closed case management records found the exit portfolios were discussed and signed by each youth during the transition conferences. Each youth's exit portfolio included a copy of the transition plan, calendar with dates, times, and locations of follow-up appointments in the community, social security card, birth certificate, vocational certificates, school transcripts, résumé, and a sample job application. Two closed records

contained a State of Florida identification card. One youth did not have a State of Florida identification card; however, an appointment letter with the appropriate entity was included in the exit portfolio. Reviewed documentation confirmed educational staff forwarded information to the receiving school board and program staff sent a copy to the juvenile probation officer (JPO) for all three youth. Documentation indicated each youth was given a copy of the exit portfolio upon release. Youth were provided with completed forms and clear instructions on how to obtain relevant information, when applicable. All responsible staff were identified during the transition conference to assist the youth in obtaining the required information to successfully complete their goals.

2.21 Exit Conference	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.	

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

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

The program has a policy and procedures addressing the safety planning process for youth. The program maintains a safety plan for each youth which is located in each sub-control and accessible to all staff. Three interviewed staff were identified the location of all safety plans and reported the plans are reviewed daily. Two case management records were reviewed, and one was applicable for completion within fourteen days of the youth's admission into the program during the annual compliance review period. One youth was readmitted into the program, and a new safety plan was not required. Reviewed documentation supported the applicable initial safety plan was completed within fourteen days of the youth's admission. Documentation in the reviewed record indicated the safety plan was jointly prepared by the youth, parent/guardian, and clinical staff. Three interviewed youth confirmed they contributed to their safety plans. Two reviewed youth records contained safety plans which were applicable to be updated at least once every thirty-days. One of the two reviewed case management records documented safety plan updates were made every thirty-days. One youth was missing a review from the time frame of February 3, 2020 until March 27, 2020. Three interviewed staff stated safety plans are reviewed daily and whenever youth are having a bad day.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) and as the clinical director. The DMHCA is supervised by the campus-wide director of treatment services. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from 9:00 a.m. to 5:00 p.m. The program does not maintain a sign-in log for the DMHCA since they are a full-time employee. The DMHCA position became vacant on August 21, 2020 and reviewed Notification of Essential Key/Critical Position Vacancy to the Department indicated the position will be permanently filled by August 24, 2020. The campus-wide director of treatment services served as the interim DMHCA until the position was filled on September 27, 2020. The program's contract outlines the position requirements of the DMHCA to be accountable for ensuring appropriate coordination, implementation and oversight of mental health and substance abuse services in the program. The DMHCA supervises one part-time LMHC and four non-licensed master's-level therapists; however, at the time of the annual compliance review, there was one therapist vacancy. In addition, the DMHCA supervises the recreational therapist and the contracted certified behavior analyst. The DMHCA is responsible for providing weekly face-to-face clinical supervision to the program's non-licensed therapists.

A review of the DMHCA position description indicated the DMHCA provides oversight of the mental health and substance abuse clinical staff and shall provide at least one hour of weekly on-site, face-to-face supervision to each non-licensed therapist. The DMHCA serves as the mental health and substance abuse authority and is responsible for ensuring compliance with the substance abuse treatment overlay services (SAOS), behavior modification, cognitive behavioral therapy, individual and group services, assessments, and diagnostic services. The DMHCA is responsible for ensuring youth receive evidenced-based group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required primary Standardized Program Evaluation Protocol (SPEP) services, and supplemental specialty services addressing each youth's unique clinical needs. Additional responsibilities also include oversight of Assessments of Suicide Risk, crisis interventions, diagnostic assessments, interviews and examinations, and administration and interpretation of psychological and psychiatric testing. The DMHCA position requires the availability for consultation twenty-four hours a day, seven days a week. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and also participates in weekly meetings with the psychiatrist to discuss each youth receiving services. A review of the DMHCA's position description validates the services provided and serving as the program's mental health and substance abuse authority.

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

The program is contracted to have one full-time designated mental health clinician authority (DMHCA), who also serves as the clinical director. In addition, the contract requires a licensed therapist to serve as the campus-wide director of treatment services for five campus-wide programs. The DMHCA is a licensed mental health counselor (LMHC) and the director of treatment services is a LMHC. The DMHCA and director of treatment services each have a clear and active license in the State of Florida and expires March 31, 2021. The campus-wide director of treatment services is responsible for mental health oversight of five programs co-located on the same campus. The director of treatment services is responsible for monitoring group fidelity as it relates to standardized protocols, coordinate training agreements with doctoral and master's degree programs, validate supervision of doctoral students, interns, and staff, and provide on-the-job training for all new clinical staff. The director of treatment services monitors the fidelity of psychiatric services campus-wide. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021. The program has a part-time LMHC scheduled to work Monday through Friday from 10:00 a.m. to 2:00 p.m.

According to staff interviews, the part-time LMHC provides all services remotely and does not provide on-site services. An interview with the Department Office of Health Services during the annual compliance review week determined this practice was not authorized by the Department and does not meet the requirements outlined in the approved COVID-19 pandemic alternative service delivery plan. The LMHC was providing services prior to the Department's approval of the alternative service delivery plan. The program maintains a comprehensive plan for mental health and substance abuse services. The procedures documented a review by the DMHCA on January 10, 2020. The psychiatrist and DMHCA are on-call for emergencies and consultation twenty-four hours a day, seven days a week. The program maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services and be on-site weekly. A review of the license reflected the psychologist's license was free and clear in the State of Florida with an expiration date of May 31, 2022.

According to staff interviews and reviewed documentation, the psychologist is required to complete assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the director of treatment services. The psychologist is required to meet weekly with the DMHCA to discuss youth tested and the results, participate in weekly group supervision to provide input into case reviews and/or provide training, provide guidance on treatment planning needs for youth who have been tested to have borderline or low IQ, and be available for consultation on youth who may be experiencing a crisis-related situation. Program administration indicated the psychologist has not been on-site or provided services since the signing of the independent contractor agreement on September 30, 2018.

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

The program is required to have four master's-level non-licensed therapists; however, at the time of the annual compliance review, the program had one vacant position. The program had three vacant non-licensed positions during the annual compliance review period. One position became vacant June 19, 2020, another on July 17, 2020, and the third position on July 23, 2020. The program was utilizing two master's-level therapists from Okeechobee Intensive Halfway House (OIHH) where the therapists carried caseloads at both programs until OIHH no longer had any youth in the program. The two therapists became full-time at the program on August 11, 2020. Reviewed documentation supported the group facilitator position became vacant on August 9, 2020. According to the assistant facility administrator, the position will not be filled, as the contract only requires one group facilitator and position will be located at the Okeechobee Youth Treatment Center (OYTC) program. At the time of the annual compliance review, the position remains vacant at OYTC. The program's mental health file clerk position became vacant on June 18, 2020 and remains vacant as of the annual compliance review.

At the time of the annual compliance review, the program had four youth in the population. Two therapists were assigned to one youth each and one therapist was assigned to two youth. A review of caseload assignments reflected each therapist had a caseload less than sixteen youth, as contractually required. The program also has a contracted board-certified behavior analyst (CBA). Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The program utilizes a part-time CBA to provide services to youth in the program and is on-site on Monday's and Wednesday's each week. Services provided include conducting functional behavioral assessments and developing behavioral plans. The youth are referred through program staff and the schoolteachers. At the time of the annual compliance review, the CBA was not providing services as no youth were applicable for referral of services.

The program's therapists provide mental health and substance abuse treatment under the direct supervision of designated mental health clinician authority (DMHCA). The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2021. The program's DMHCA is responsible for providing clinical supervision to the non-licensed clinical staff. Reviewed Clinical Supervision Logs found the DMHCA did not conduct the required weekly face-to-face supervision with each non-licensed therapist. In the last six months, there were seven weeks of supervision missing. Reviewed supervision found on the weeks there was a face-to-face clinical supervision conducted, it was not always documented on a form which included all information, as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The reviewed documentation found the completed Clinical Supervision Logs included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. The program provided training documentation to validate the applicable non-licensed

therapists received the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Reviewed mental health records and documented practice supported the applicable ASRs were completed by a licensed mental health counselor.

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

The program has a policy and procedures to ensure each youth's mental health and substance abuse needs are identified through a comprehensive screening process. The program ensures mental health and substance abuse services are available to all youth who are determined to meet clinical criteria and certified to receive such services. Mental health and substance abuse treatment is provided on-site through the provision of mental health overlay services (MHOS). Upon the youth's arrival to the program, an initial mental health and substance abuse screening process is initiated by the multidisciplinary treatment team staff to ensure the identification of mental health and substance abuse issues requiring immediate attention and/or further assessment and evaluation. The screening process is designed to gather information on the youth prior to the youth entering the general population. As a key component of the initial intake process, following the completion of the Facility Entry Physical Health Screening form conducted by nursing staff, the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) is administered by a trained staff member in the Department's Juvenile Justice Information System (JJIS).

A review of two mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for both youth. A review of JJIS found each was completed electronically in full, as required. Following the MAYSI-2 screening, the assigned non-licensed therapist reviews all available information to include the youth's commitment packet information, pre-dispositional reports, previous psychological and/or psychiatric evaluations for information regarding suicide risk, mental health or substance abuse issues to include inpatient and/or outpatient mental health and substance abuse treatment. The review includes the youth's history of drug and alcohol use, emotional instability, significant trauma, mental illness in the family, and any suicide risk factors. The review is documented on the program's Records Review form. Both MAYSI-2 screenings resulted in the youth requiring a referral for further evaluation; however, the program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results. Therefore, no additional referrals were generated during the intake process. There were no instances where a staff member believed the youth needed further evaluation contrary to the MAYSI-2 results or where a need for a crisis intervention or emergency service as a result of the screening.

Each youth received a new Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results. An interview with the program's facility administrator (FA) revealed when a youth arrives to the program, the youth are immediately given a MAYSI-2 within one hour. This screens any risks the youth might have for suicide and drug use. If there is a hit for suicide, the youth is immediately placed on suicide alert and the youth is immediately screened utilizing the Department's ASR to see if the youth need to remain on suicide alert or suicide precautions, or if the youth can be downgraded to standard observation in the program.

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

The program maintains a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the process by which all youth, regardless of identified needs, are referred for the completion of a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. The non-licensed therapist is responsible for completion of the evaluation, make recommendations, and to provide a provisional diagnosis. The program's licensed clinical staff is then responsible for reviewing each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and document a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review.

A review of two mental health and substance abuse records supported each youth received a new evaluation completed within thirty days of admission by a non-licensed therapist. Reviewed practice supported the licensed mental health counselor (LMHC) reviewed and signed the evaluation within ten calendar days, as required, for one evaluation and reviewed and signed the remaining evaluation thirteen days late. Reviewed practice supported the program assesses each youth utilizing Department's Assessment of Suicide Risk (ASR), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Adolescent Psychopathology Scale™ – Short Form (APS-SF), the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), and Trauma Symptom Checklist for Children (TSCC).

Each reviewed Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, recommendations, and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use. The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment. A review of the program's Chapter 397 license showed it was active and expires April 7, 2021. Reviewed documentation validated both youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each reviewed youth record contained a signed Youth Consent for Substance Abuse Treatment form and a signed Youth Consent for Release of Substance Abuse Treatment Records form.

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

The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to youth at the program who are determined to meet clinical criteria to receive services. Each youth's mental health and substance abuse treatment is prescribed by an individualized mental health and substance abuse treatment plan. A review of two youth mental health and substance abuse records documented each youth was assigned to a multidisciplinary treatment team upon arrival to the program. Each youth is assigned to a primary therapist who develops the youth's individualized treatment plan with the multidisciplinary treatment team, which is based on identified needs, and treatment is provided by staff trained to perform the services provided.

According to staff interviews, the program conducts an initial classification meeting on the day of admission with members from all services to make up the multidisciplinary treatment team. The youth is assigned to a treatment team at this meeting and the Initial Mental Health and Substance Abuse Treatment Plan. Both reviewed mental health and substance abuse records supported each youth was assigned to a treatment team; however, one of the two classification meetings did not take place on the day of admission. The youth was admitted on October 17, 2019 and the classification meeting was documented in December 2019. The initial treatment plans were developed on the day of admission; however, one was completed without the involvement of the multidisciplinary treatment team. A review of case notes for both youth for the past six months supported mental health and substance abuse groups were provided daily, as scheduled. A review of services for each youth for a six-month period documented participation in group therapy, individual therapy, and family therapy sessions.

The program is licensed under Florida Statute, Chapter 397, and certified through the Florida Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2021. The program's licensed and non-licensed master's-level therapists facilitate mental health and substance abuse groups. Three interviewed youth indicated they participated in monthly individual and family therapy. Three program staff were interviewed regarding mental health and substance abuse groups at the program. Each interviewed staff reported the clinical staff facilitate groups. An interview with the facility administrator and the director of treatment services confirmed the program offers mental health overlay services.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse services. All treatment services are provided through the provision of mental health overlay services (MHOS). Treatment services conducted at the program are provided by or under the direct supervision of the licensed mental health counselor (LMHC) who serves the program's designated mental health clinician authority (DMHCA). Youth determined to have a mental health and/or substance abuse Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, shall have an Initial Mental Health and Substance Abuse (MHSA) Treatment Plan and an Individualized MHSA Treatment Plan. Upon release from the program, a discharge summary is completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services. Two MHSA records were reviewed for an initial treatment plan. Each reviewed youth record contained an initial MHSA plan documented on the Department's Initial MHSA Treatment Plan form documenting development on the day of admission. Each reviewed initial plan included signatures of the master's-level non-licensed therapist, licensed therapist, and the youth. One reviewed plan was missing a signature by the living unit representative. One youth was applicable for admission with prescribed psychotropic medications and this was addressed on the initial plan.

Each of reviewed youth MHSA records contained a completed Individualized MHSA Treatment Plan developed within thirty days of each youth's admission. Each completed individualized plan was documented on the program's form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy. Both reviewed plans were signed by the non-licensed therapist creating the plan and each plan was reviewed and signed by the licensed therapist within ten days of completion. Both reviewed plans documented signatures of treatment team members who participated in the development of the plan; however, the education staff did not document participation in the development of one plan. One applicable plan included provision for psychiatric services. Each plan documented prescribed services to include individual therapy once each month, group therapy one time daily, and family therapy once each month. Reviewed weekly progress notes validated each youth received the prescribed services, as outlined on the individualized plan. Both reviewed youth MHSA records documented the multi-disciplinary treatment team conducted a treatment plan review at least every thirty days with the exception of one record, which was missing reviews for the month of November and December 2019. One reviewed record indicated the individualized treatment plan reviews conducted review on August 18, 2020 did not have a documented review from the licensed mental health counselor until September 3, 2020.

Three closed records were reviewed for the completion of a MHSA discharge summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference, as required. The program's practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

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

A review of the program's contract, clinical program description, and an interview with the facility administrator indicated the program provides on-site mental health and substance abuse (MHSA) services through the provision of mental health overlay services (MHOS). Youth with co-occurring substance abuse disorders receive substance abuse services. Treatment services is guided by an individualized mental health and substance abuse treatment plan addressing the youth's needs in accordance with 63N-1, Florida Administrative Code. At the time of the annual compliance review, the program had a youth census of four. Treatment is provided by the licensed mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA) or provided by one of the four non-licensed therapists working under the direct supervision of the DMHCA. At the time of the annual compliance review, the program had one non-licensed therapist vacancy.

Each youth is assessed upon admission utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). The program provides each youth with group therapy services seven days a week. The program's contract outlines MHOS provided includes Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Skillstreaming the Adolescent, Thinking, Feeling, Behaving and the Passport Program. In addition, MHOS includes The Teen Relationship, Living in Balance, Seeking Safety, and Toward No Drugs. The contract outlines gender-specific groups to include Young Men's Work and 24:7 Fathering Handbook. There was no documentation indicating Seeking Safety groups were conducted in the last twelve months. The program confirmed the group was not conducted and could not provide a reason; however, the program planned to commence the group starting October 4, 2020.

The program's contract requires the utilization of a certified behavior analyst (CBA). The program utilizes a contracted part-time board-certified CBA. Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The youth are referred through program staff and the schoolteachers. Services provided include conducting functional behavioral assessments and developing behavioral plans. The CBA maintains monthly data sheets on

each youth to document the progress of each youth and provides weekly incentives and monthly incentives. Reviewed documentation supported the contracted psychiatrist provides bi-weekly on-site services. At the time of the annual compliance, review the CBA was not providing services as no youth were applicable for referral of services. The program was unable to provide supporting documentation to validate the CBA was utilized during the annual compliance review period.

The program's contract requires the program to have a licensed psychologist available to provide services, as needed. A review of the license reflected the psychologist's license was free and clear in the State of Florida with an expiration date of May 31, 2022. Reviewed documentation supported the psychologist completes assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the director of treatment services. The campus-wide director of treatment services reported the program ensures each youth receives services outlined in the contract by using trackers and reviewing group sign-in sheets. An interview with the facility administrator validated the program provides MHOS treatment to youth in the program.

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

The program maintains a written policy and procedures for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program's procedures outline the role of a contracted psychiatrist for the management and oversight of psychiatric care. The program's psychiatrist supervises the treatment team and provides psychopharmacological therapy to youth receiving psychotropic medications. In addition to a psychiatric evaluation, medical and psychiatric follow-up visits are conducted on an individualized basis. The program maintains an independent contractor agreement with a State of Florida, licensed psychiatrist, board-certified in psychiatry, as well as child and adolescent psychiatry, to provide services to the youth at the program. A review of the license showed the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program does not utilize an advanced registered nurse practitioner (ARNP).

A review of the program's contract and reviewed sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly, as required. The psychiatrist is on-call for emergencies and consultation twenty-four hours a day, seven days a week. Additional reviewed documentation supported the psychiatrist participates in the weekly clinical treatment team meetings with the program's designated mental health clinician authority (DMHCA) and the mental health therapists. Treatment team meeting minutes included a review of each referred youth, assigned cottage, date of admission, reason for treatment team, and notes outlining discussion and meeting outcomes. The program's policy and practice are to conduct a new psychiatric evaluation on all newly admitted youth within fourteen days of admission. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave; however, no back-up coverage was provided since the last annual compliance review. A

review of the back-up psychiatrist's license showed it was a clear and active MD licensure in the State of Florida with an expiration date of January 31, 2021.

A review of two mental health and substance abuse records found neither youth was admitted on prescribed psychotropic medications. However, program practice is to complete a psychiatric initial diagnostic interview completed within seven days of admission on all youth. Both reviewed records documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN completed within the required time frame. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported participation in treatment team meetings when on-site. The psychiatrist reported working closely with the treatment team regarding the progress and treatment recommendations for each youth and also with the medical staff with regard to potential medical issues and side effects. The psychiatrist reported meeting with the clinical treatment team members and the DMHCA to review youth in the program. The psychiatrist indicated contacting the parents/guardians for minors especially when any psychotropic medication is being considered and obtain appropriate consent.

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 suicide prevention plan. The suicide prevention plan was last updated and approved by the campus-wide director of treatment services on July 14, 2020. The plan outlines the assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. An informal interview with the director of treatment services indicated staff receive suicide prevention training during pre-service and in-service trainings, as well as through mock emergency mental health drills.

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

The program maintains a written comprehensive plan for mental health and substance abuse (MHSA) services and a plan detailing suicide prevention procedures. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department reviews the circumstances surrounding the event, procedures relevant to the incident, relevant training received by involved staff, pertinent

medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

The program maintains three complete suicide response kits located in master control, sub-control, and the medical clinic. Interviews with three staff and pictured observations during the annual compliance review confirmed the kits contain a knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct the Department's Assessment of Suicide Risk (ASR) on each during the admission screening process. A review of two youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. Both reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. According to an interview with the campus-wide director of treatment services, the program had one youth who was placed on Precautionary Observation (PO) within the last twelve months. The one applicable youth placed on PO was determined to be at risk due to staff observations. A review of the applicable ASR found the form was completed by the non-licensed and was reviewed and approved by the licensed clinical social worker (LCSW) the same day. The youth was referred and assessed and was determined to be at risk and was placed and maintained on a constant supervision status. The program documented the referral on the Department's Mental Health and Substance Abuse Referral Summary form. Reviewed documentation supported the authorization of PO status, the completion of Suicide Precautions Observation Logs, and support services provided by the program's mental health staff. Reviewed practice supported the completion of a Follow-Up ASR the day after the ASR was completed. Upon completion of the Follow-Up ASR, the youth was transitioned to close supervision and remained on this level for twenty-four hours prior to being assessed by completion of a mental status examination and transitioned to standard supervision. The transition to a lower supervision level documented a discussion between the LCSW and the facility administrator. In addition, there was telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. A review of the Department's Juvenile Justice Information System (JJIS) documented an alert was initiated and removed, as required, for the applicable youth.

A review of the program's shift reports and logbooks documented clear updates regarding youth on PO status. Reviewed program policy and procedures and interview with the director of treatment services indicated the program does not utilize secure observation. The program utilizes New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Raulerson Hospital in Okeechobee, Florida for Marchman Act. Three interviewed staff each indicated when a youth expresses suicidal thoughts, staff notify the mental health staff, search the youth and their room, place the youth on constant sight and sound, and document supervision.

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

The program maintains a written suicide prevention plan outlining staff supervision and documentation requirements during precautionary observation (PO) status. A review of two youth mental health and substance abuse records found neither were applicable for placement on PO. According to an interview with the campus-wide director of clinical services, the program

had one youth who was placed on Precautionary Observation (PO) on three separate occasions within the last twelve months. The youth was placed on PO each time due to staff observations. The applicable youth mental health and substance abuse record and Suicide Precaution Observation (SPO) Logs were reviewed. Program practice is to complete the Department's SPO Log form. The reviewed SPO Logs and Close Supervision Visual Checks (CSCV) Log were documented in real time and were conducted by the direct-care staff. The SPO Logs documented visual checks at least every thirty minutes and the CSCV Logs documented visual checks every five minutes. There were no documented behavioral warning signs while the youth was placed on PO. Each reviewed SPO Logs documented the shift supervisor's signature and the clinical mental health staff signature. The youth was no longer in the program; therefore, the youth could not be interviewed.

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

The program maintains a written policy and procedures outlining staff training in suicide prevention. The policy outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, in addition to participation in suicide and emergency drills. A review of three pre-service and three in-service training records indicated each staff completed the required six hours of annual suicide prevention and implementation of suicide precautions training. During the annual compliance review period, the program ran two twelve-hour shifts (6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m.).

A review of the program's suicide drills confirmed the program completed drills on both shifts during the past twelve months; however, not monthly as indicated by the program. The A-shift was missing a drill in July 2020 and B-shift was missing a review in July and August 2020 and December 2019. A review of the program's staff roster indicated thirty-seven staff were required to have participated in mock suicide drill; however, documentation clearly reflected only twenty-two staff participated in suicide drills at least semi-annually. Fifteen staff did not participate in at least one drill which included the use of cardiopulmonary resuscitation (CPR) annually. However, a review of the emergency medical drills supported the A-shift conducted a monthly drill which included the use of CPR five times and B-shift conducted monthly drills which included the use of CPR seven times. Three interviewed staff indicated drills are conducted monthly. Three of the completed mock drills on each shift included the use of life saving measures. Each reviewed emergency drill documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved; however, some of the drills only included a signature page and not the drill conducted.

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

The program maintains a written crisis intervention plan. The plan detailed crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process. The program maintains a written policy and procedures to establish a method of crisis intervention services to be provided to all youth. The program maintains a written crisis intervention plan. The plan was reviewed, approved, signed, and dated by the campus-wide director of treatment services on July 14, 2020. The program's crisis intervention plan included a process for notification and alert system, means of referral, communication, supervision, documentation, and review ensuring the safety and security of youth and staff.

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

The program maintains a written crisis intervention plan, which includes provisions for the completion of crisis assessments. A review of two youth mental health and substance abuse records found neither youth required the completion of a Crisis Assessment. An interview with the campus-wide director of clinical services indicated the program had only one applicable youth requiring a Crisis Assessment in the last twelve months. A review of the applicable Crisis Assessments found the program utilized the Department's Crisis Assessment form. Each Crisis Assessment documented completion immediately following the determination a youth may be in crisis. A Mental Health and Substance Abuse Referral Summary was completed by the clinical staff as well as a mental status examination. The Crisis Assessments was completed in full by a licensed mental health counselor (LMHC). The reviewed record also documented the completion of a mental status examination prior to transitioning the youth to standard supervision. The program had no alleged Prison Rape Elimination Act (PREA) events during the annual compliance review period.

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

The program maintains a written emergency mental health and substance use services plan, which was last revised and approved by the campus-wide director of treatment services on July 14, 2020. The plan included procedures for immediate staff response, notifications, communication, supervision, authorization for transport to emergency mental health or substance abuse services, transport for emergency Baker Act, transport for emergency Marchman Act, documentation, training, and review. An interview with the director of treatment services indicated there were no youth applicable for emergency mental health and/or substance abuse services since the last annual compliance review. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act to New Horizon's of the Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilizes the emergency services through Raulerson Medical Center in Okeechobee, Florida for substance abuse Marchman Act. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in case of an emergency. Three interviewed staff indicated all program staff have the ability to call 9-1-1 in the event of an emergency.

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 Baker Act or Marchman Act procedures during the annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The program maintains a written policy and procedures ensuring a health authority shall be responsible for the healthcare services provided. The program maintains an independent contractor agreement with a State of Florida physician to serve as the designated health authority (DHA) signed on September 4, 2019. The DHA holds an active, unrestricted license under Chapter 458, Florida State Statute, with a license expiration date of March 31, 2022 and is an osteopathic physician with specialty training in family practice. The program does not utilize an advance practice registered nurse or physician's assistant. The DHA is scheduled to be on-site for approximately two hours weekly. Reviewed physician logs for the past six months supported the DHA was on-site weekly, as required. In the event the DHA cannot be on-site, duties have been delegated to a medical doctor who holds a clear and active license in the State of Florida which expires on January 31, 2021 to act on behalf of the DHA. The DHA is responsible for communication with program staff regarding youth medical needs, and is available for consultation twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. The scope of services includes medical screenings, assessments, evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical medications.

Supporting documentation reflected the DHA consults and works with the treatment team members in developing and modifying treatment plans and performance plans, as needed. an interview with the DHA confirmed their role at the program includes performing Comprehensive Physical Assessments, sick call, periodic evaluations, and reviewing healthcare policies and procedures and nursing protocols. The program maintains independent contractor agreements with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist license expires February 28, 2022. The optometrist license expires February 28, 2021.

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

The program maintains facility operating procedures for all health-related procedures and protocols utilized. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation validated the DHA signed all healthcare policies and procedures on June 16, 2020, and the facility administrator documented a review on June 17, 2020. The program maintains three full-time licensed registered nurses (RN) and one part-time RN. One RN serves as the program's health services administrator (HSA). The program maintains a training requirement whereby newly employed healthcare staff shall receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, to include Florida Administrative Code 63-M, provided by the HSA. Reviewed training curricula and plan reflected a new nursing staff would receive the required pre-service and orientation training to include on-the-job training. The program hired one new nursing staff since the last annual compliance review and reviewed documentation supported, the staff completed the required training. The program maintains a nursing protocol manual developed and approved by the DHA on September 16, 2019.

Reviewed nursing staff training records validated training on the treatment protocols and healthcare policies and procedures on various dates throughout the annual compliance review period. Treatment protocols were reviewed by the DHA on June 16, 2020 and remained effective without change to include admission standing orders, non-licensed medical and emergency protocol guide, body mass index protocol, and approved first-aid kit content and designee.

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

The program maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent regarding healthcare provided to their children. The Authority for Evaluation and Treatment (AET) form is signed by the parent(s) who have legal custody or by the legal guardian and the AET serves as informed consent for non-invasive medical procedures which can be treated by healthcare staff or for minor ailments requiring over-the-counter (OTC) medications. The signed AET is valid until the parent/guardian revokes or modifies it, or the youth leaves the custody of the Department. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information, as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. There were no reviewed records applicable for a youth in the care of the Department of Children and Families.

A review of two youth healthcare records found all were applicable for a signed AET. Each of the two reviewed youth healthcare records contained a copy of the signed AET and the word, “Copy” was clearly stamped on each. One youth was eighteen years old after admission to the program and the youth healthcare record contained the required signed consent. Each reviewed AET and/or Release of Information form was filed in each youth’s healthcare record in the appropriate section. There were no original AETs reviewed. An interview with nursing staff indicated the licensed registered nurses review all admissions in the Department’s Juvenile Justice Information System (JJIS) and validates the AET. If needed, the assigned juvenile probation officer would be contacted through the case manager to obtain a new AET.

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

The program maintains a policy and procedures requiring notification to the parent/guardian of any significant changes in a youth’s condition and obtaining consent when new medications and treatments are prescribed. A review of two youth healthcare records revealed one youth was applicable and documented parental notification for over-the-counter (OTC) medications beyond those covered by the Authority for Evaluation and Treatment (AET) form. One youth turned eighteen years old after admission. When notification is required, the healthcare staff will contact the parent/guardian by telephone and written notification is mailed out to the parent/guardian. Both reviewed healthcare records were applicable for requiring parent/guardian consent for OTC medications beyond those covered by the AET and each was documented in the respective section within the records. None of the two reviewed records were applicable for parental consent for vaccinations, discontinuation of medications prescribed prior to the youth’s program admission, hospitalizations, or invasive surgeries. None of the reviewed

records were for youth in the care of the Florida Department of Children and Families (DCF). The program also maintains a written policy and procedures for obtaining consent specific to any discontinuation, significant changes to, or newly prescribed psychotropic medication. None of the two reviewed records were applicable for a youth prescribed psychotropic medication.

It is the program's practice for all youth admitted to the program to receive a comprehensive psychiatric evaluation within fourteen days of admission and to complete page three of the Clinical Psychiatric Progress Note (CPPN) regardless of prescribed medications. Each of the two reviewed records contained a completed psychiatric evaluation and documented page three of the CPPN sent to the parent/guardian with a request for the return of the written consent. The program maintains a policy and procedures requiring the program to obtain information regarding a youth's immunization history and for youth to receive proper immunizations. Both reviewed healthcare records documented the immunization histories for each youth were verified within thirty days of admission. Each record documented receipt of the youth's vaccination history on the day of admission and none required any immunizations; therefore, none were applicable for refusing consent for immunization for religious or medical reasons.

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

The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation upon admission and ensure a healthcare admission rescreening shall be completed each time the physical custody of the youth changes and the youth are subsequently returned or readmitted. A review of two youth healthcare records supported each youth received an initial admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse (RN). An interview with nursing staff indicated a nursing assessment is conducted immediately following the initial search, shortly after the youth's arrival. The licensed practical nurse notifies the designated health authority (DHA) by telephone, by text, or verbally, if on-site, with the youth's history and identified chronic condition and documents the notification on the DHA Notification form and in the nursing admission chronological notes. The DHA Notification form is filed in the youth's healthcare record in the practitioner's chronological note section. Referrals are documented in the physician's log. None of the two reviewed healthcare records were applicable for a change in custody; however, the HSA reported the program is required to rescreen each youth and complete a new FEPHS form anytime a youth is returned to the program after any physical custody change.

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

The program maintains a written policy and procedures establishing a system whereby all youth shall be oriented to the healthcare system upon admission or the next available opportunity. The health education shall be provided by the healthcare staff, in writing, and during an individual session with the youth to ensure youth with identified disabilities can understand the information provided. A review of two youth healthcare records supported each youth received a healthcare orientation on the day of admission as documented on the Department's Health Education Record form. The orientation included information on how to access medical and mental health

services. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet including a copy of the youth handbook. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. In addition to the admission health orientation, youth received health education throughout their stay, as documented in the healthcare record. Two reviewed healthcare records validated this practice.

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

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

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

The program maintains a written policy and procedures ensuring nursing staff shall complete the Department's Health-Related History (HRH) form prior to the Comprehensive Physical Assessment (CPA). A review of two youth healthcare records supported a new HRH was completed for each youth within seven days of the youth's admission. Reviewed practice validated the HRH was completed on the same day of each admission. The nursing staff provided an electronic or written signature on the HRH. The DHA documented a review of the HRH on the completed CPA. An interview with nursing staff confirmed the practice and indicated the HRH is completed whenever any new significant medical event or change occurs and then annually, thereafter.

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

The program maintains a written policy and procedures ensuring each youth receives a physical health evaluation after admission and prior to any participation in sports, exercise, or any other

strenuous activity. The program maintains a written policy and procedures ensuring each youth receives a routine healthcare screening and evaluation for latent or active tuberculosis. A review of two youth healthcare records reflected the program utilizes the Department's standardized Comprehensive Physical Assessment (CPA) form. All CPAs were completed by the designated health authority (DHA). All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. One youth record reflected an "X" was marked on the CPA without any further elaboration on the abnormality by the DHA. An informal interview with the registered nurse (RN) revealed the DHA made this in error and will be on-site to correct and initial the error. Both reviewed CPAs did not complete sections numbers twenty-five or twenty-six (pelvic and rectum examination) and each documented "deferred by clinician due to age" on the CPA. Reviewed documentation confirmed the Department's Problem List was updated for each youth throughout the youth's stay, when applicable.

A review of two youth healthcare records reflected each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis. As part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I tuberculosis screening. All tier I tuberculosis screenings were conducted on the day of admission for each youth. Reviewed documentation found the results of the TST were also documented on the Department's Infectious and Communicable Disease (ICD) form, and on the program's Tuberculosis Skin Test/Purified Protein Derivative (PPD) form. Nursing interviews indicated nursing staff review the Department's Juvenile Justice Information System to ensure there is a documented TST and to ensure the TST is current and documented, as required. The nursing staff also utilizes a tracking log to monitor TST/PPD due dates. There were no youth in the program with symptoms suggestive of active TB. Program procedures outline if the screening indicates the youth has symptoms suggestive of active TB, the youth are not placed in the general population until medically assessed by the DHA.

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

The program maintains a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STI). The designated health authority (DHA) shall then decide based on the screening tool and medical evaluation to order testing for sexually transmitted diseases or infections. A review of two youth healthcare records reflected each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Sexually Transmitted Infectious Screening form. Each youth was referred to the DHA for further evaluation and testing was ordered and was performed for each youth. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form for both youth. 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. Nursing staff interviews confirmed the program's practice.

The program maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. The program maintains a separate written policy and procedures to ensure youth receive a confidential HIV test when

testing is recommended on a clinician's assessment, based on risk assessment, or when the youth requests testing. A review of two youth healthcare records supported each youth was offered the opportunity to receive counseling and testing for HIV. The program maintains a separate written policy and procedures to ensure youth receive a confidential HIV test when testing is recommended on a clinician's assessment, based on risk assessment, or when the youth requests testing. A reviewed of two youth healthcare records reflected one youth consented for testing. The program utilizes the designated health authority (DHA) to provide pre and post-counseling. Each of the reviewed youth healthcare records validated the youth received pre-counseling, testing, and post-counseling, and the youth's Health Education Record form was updated. The results were placed in a sealed envelope marked "confidential" with the youth's name and test date documented on the outside of the envelope. Nursing staff interviews indicated the confidential results are given to the youth upon discharge. Nursing staff maintain a HIV Testing Tracking Log to document the youth's name, Department identification number, date refused testing (if applicable), date of testing, pre-testing date, post-testing date, and provider name. Two interviewed youth indicated they can request HIV testing.

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

The program maintains a written policy and procedures ensuring all youth shall be able to submit sick call requests and have complaints treated appropriately through the sick call system. The program identifies sick call as the official method for a youth to request healthcare services for an illness or injury. Sick call care, including dental complaints, shall be available to all youth. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). The sick call process is intended to provide care in response to complaints of illness or injury of non-emergency nature, but which requires some form of assessment and/or decision-making by a licensed nurse and/or licensed physician. Each youth is oriented to the program's sick call process upon admission.

The program offers youth the opportunity to submit written sick call requests seven days a week. Sick calls are scheduled twice daily Monday through Friday from 12:00 p.m. until 12:40 p.m. and from 6:00 p.m. until 7:00 p.m. On Saturdays and Sundays, sick call is to be conducted from 8:50 a.m. until 9:50 p.m. and from 5:30 until 6:30 p.m. All scheduled sick calls are conducted by the registered nurse (RN). Sick call forms and a wall-mounted deposit box for the forms are accessible to all youth in the hallway.

An interview with the health services administrator indicated the program checks the sick call box every two hours. Completed Sick Call Request forms are filed in chronological order in the nursing progress note section of the youth healthcare record. In addition, all sick calls are documented on the Department's Sick Call Index and on the Sick Call Referral Log. A review of two youth healthcare records found one youth completed a Sick Call Request form at least one time. In each instance, the RN documented the treatment and/or services provided to the youth during the sick call event on the sick call request form. There were no instances of a youth presenting with a similar sick call complaint three or more times within a two-week period. An interview with the program nurse indicated all sick call referrals are documented on the sick call

log and in the chronological notes. The program nurse reported youth have the availability for sick call services outside of scheduled sick call hours, when needed. The program nurse additionally reported sick calls are conducted by RNs in the clinic to ensure youth privacy. A sick call was unable to be observed during the annual compliance review, as no sick call requests were submitted. Three interviewed staff indicated the RN conducts sick call.

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

The program maintains a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. Staff must be able to respond to unexpected illnesses, accidents, or conditions which require immediate attention or an immediate professional assessment to determine their severity. A review of two youth healthcare records found both youth required episodic and/or first-aid care while in the program. All treatment services were provided by nursing staff and the nursing progress notes clearly documented treatment services rendered in standard narrative charting and/or problem-oriented subjective, objective, assessment, and plan (SOAP) elements. Nursing staff also maintained an Episodic/First-Aid/Emergency Care Log documenting all incidents of care by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA). Nursing interviews validated the program's practice. Youth who are sent off-site for emergency care are tracked in the nursing progress notes and documented on the Episodic Log.

The program maintains a written policy and procedures ensuring the program-based automated external defibrillator (AED) is properly managed and administered to persons eight years of age and older who experience sudden cardiac arrest. The program maintains two AED which are located in the master control which is adjacent to the secure program and within the program's sub-master control office. The AED procedures were observed as audio, written instructions, and each AED was demonstrated by the health services administrator (HSA) during the annual compliance review. Reviewed documentation confirmed the program's AEDs were checked monthly by nursing staff according to the program's policy. Reviewed AED batteries expire in October 2022 and July 2022. Reviewed AED pads expire in April 2021 and December 2020. Reviewed training records supported all non-healthcare staff who have direct contact with youth maintained current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. Additionally, all nursing staff maintained current certifications in CPR and AED. The program maintains five first-aid kits with three kits located in master control, two of which were designated for the program's transportation vans, one in the program's sub-master control office which was specifically identified for use in the maximum risk program, and one in the program's medical clinic. Inspected first-aid kits were sealed with plastic snap-tabs and were fully stocked with the list of items approved by the DHA and contained no expired items. The first-aid kits and suicide response kits are inventoried weekly and perpetually by medical staff and observed documentation validated the practice. The program maintains one epinephrine auto injector which is maintained in the program's medical clinic in a locked medical cart. Reviewed training records supported all supervisory staff completed training in the administration of the epinephrine auto injector. The program conducts announced and unannounced emergency medical drills monthly on each shift. A review of drills conducted for the last twelve months supported drills were conducted monthly on each shift and included CPR and AED demonstration at least quarterly. There was no documentation to indicate drills were conducted in August 2020 and September 2020 on the C-shift.

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

The program maintains a written policy and procedures ensuring for timely referrals and coordination of medical services to an off-site healthcare provider. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care Form. The designated health authority (DHA) reviews, signs, and dates the off-site care instructions. A review of two youth healthcare records found none of the youth went off-site and were not applicable; therefore, one additional applicable youth healthcare record was reviewed. The program reported having no other additional record applicable for off-site care during the annual compliance review period. The reviewed record was for a youth under eighteen years of age and documentation indicated the parent/guardian was notified of the provision of off-site care. The Summary of Off-Site Care Form was completed for the youth and was filed in the appropriate section of the healthcare record with the discharge paperwork. The DHA reviewed and completed the Summary of Off-Site Care forms and discharge paperwork, as evidenced by signature and date. The reviewed healthcare record required follow-up care and services were received, as prescribed. An interview with the program's health services administrator (HSA) reported the program notifies the DHA as soon as each youth returns from an off-site visit and all documentation is placed in the youth's chart for the DHA to review upon return to the facility. An interview with HSA revealed follow-up testing, referrals, and appointments are tracked by healthcare staff on the laboratory log, the transportation calendar, the appointment calendar, as well as the health service provider tracker.

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

The program maintains a written policy and procedures ensuring youth who have been identified with a chronic illness receives regularly scheduled evaluations and necessary follow-up treatment. The purpose of the periodic evaluation is to ensure the youth requiring ongoing treatment or who have experienced changes in condition or treatment regimen are adequately monitored. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of two youth healthcare records indicated one youth was admitted with an identified chronic condition, as documented on the Facility Entry Physical Health Screening (FEPHS) form. The one youth identified with medical chronic condition was classified with a medical grade of two and the other reviewed youth record indicated the youth was identified with a medical grade of one. The program maintains a youth roster and tracking log of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records reflected each youth received periodic evaluations, as required.

An interview with the designated health authority (DHA) indicated chronic conditions are monitored at least every sixty days and some conditions require more often. An interview with nursing staff indicated youth identified with a chronic condition are placed on the medical tracking log to ensure the DHA follows-up with each applicable youth. The DHA indicated the nursing staff and DHA meet regularly to discuss important treatment plans for youth. In addition,

the DHA indicated formal quarterly meetings are conducted with the facility administrator, nursing staff, clinical director, consultant pharmacist, and DHA to discuss the youth in the program. The program did not have any youth taking anti-tuberculosis medication or who were pregnant. Reviewed documentation supported the Department's Problem List was updated, as required.

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

The program maintains a written policy and procedures ensuring medical staff shall verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or orders/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and documented. Nursing staff complete the Facility Entry Physical Health Screening (FEPHS) to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered.

An interview with nursing staff indicated only a licensed practical nurse completes the admission and any applicable medications are verified with the youth's medical records and the youth's parent/guardian. A review of two youth healthcare records indicated there were no reviewed youth admitted into the program on prescribed medication and one youth was prescribed medication subsequent to admission. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation reflected all medications have a current, valid order, and are administered pursuant to a current practitioner's order. The program does not utilize restrictive housing; therefore, all medications are administered with consistent practice. The two reviewed youth healthcare records reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. Oral prescription medications are administered, according to instructions. All staff administering medications shall have knowledge or are informed of the common side effects and precautions of prescribed medications. Two reviewed youth healthcare records found each youth had a Medication Administration Record (MAR) outlining over-the-counter (OTC) medications approved through the Authority for Evaluation and Treatment (AET) form. The medication was administered in accordance with the approved protocols and physician's order. Both applicable youth were prescribed medications and reviewed documentation supported the program utilizes a pre-printed 1st Choice MAR to document administration of medication. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, and a current picture of the youth. Observations confirmed all medications were maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. Shift-to-shift inventories of controlled medications are conducted by two licensed registered nurses (RNs). The inventory is completed by the RN and a shift supervisor when there is only one RN on-site. One youth healthcare record reviewed MARs supported the youth received the medication(s) as prescribed. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry.

Nursing staff maintain locked cabinets in the medical clinic with OTC medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff, who are also shift supervisors, are permitted to assist youth in OTC medications when nursing staff are not on- site. Opened OTC medication is stored in the locked medication cart. Closed and unopened OTC medication is stored in a locked cabinet in the medical clinic. A review of the Department's Central Communications Center reports validated there were no incidents of missed medications. Nursing staff documented side effect monitoring on the MAR daily each time medication was administered. There were no youth applicable for a refusal of medication.

During the annual compliance review, there were no youth on the sick call list or episodic list; therefore, observations of medication administration could not be observed. The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented, as required, by the Board of Pharmacy and Department requirements. Program procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. There were no applicable youth taking any controlled substances; however, observations confirmed the program does have a secure locked boxed within the secured locked medication cart for controlled substances. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the temperature is monitored daily.

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

The program maintains a written policy and procedures ensuring all medications shall be identified and secured in a locked area designated for storage of medications. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Oral medications are not stored with injectable or topical medications. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications. The program maintains a written policy and procedures ensuring all chemical products, medicines, and medical and dental instruments assigned to the medical department are securely stored, regularly inventoried, disposed of and properly maintained in accordance with federal and state laws. Reviewed documentation and nursing interviews confirmed all over-the-counter (OTC) medications are inventoried at least weekly. Program practice is for OTC medications to be inventoried using a perpetual daily inventory and verified weekly. Perpetual inventories with running balances are maintained on all controlled substance with a shift-to-shift inventory conducted by two licensed registered nurses (RN). Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The program's medications are procured through the contracted pharmacy in blister packs documenting the number of pills in each prescription order. The program's pharmacy license issued through the Department of Health, Division of Quality Assurance expires on February 28, 2021 and the consultant pharmacist license expires on December 31, 2020.

The program's process for the disposal of medication is for all medication to be disposed in the physical presence of the consultant pharmacist utilizing the Drug Buster® medication disposal system. Reviewed documentation and nursing interviews validated all OTC medications were inventoried perpetually and weekly. The program maintains a written policy and procedures for

youth self-administration of oral, topical, or inhaled prescribed medications assisted by non-licensed trained supervisory staff. Non-licensed supervisory staff are to assist with self-administration of medication only when licensed healthcare staff are not on-site. A review of training logs indicated all program supervisors received training for youth self-administration of medications by the program's licensed health services administrator (HSA). All youth medications are administered by nursing staff when on-site. Each youth's individual controlled medication inventory record is updated after each administration and shift-to-shift inventories are conducted by two registered nurses. The program had one youth with a prescribed controlled medication during the annual compliance review. The inventory for the one controlled medication was accurate. The nurse reported the consultant pharmacist is on-site monthly for inspection which reviewed documentation validated. The HSA reported the consultant pharmacist assists in checking all nursing units, medication carts, OTC medications, sharps containers, medication count sheets, refrigerators, and emergency kits.

Reviewed documentation confirmed the consultant pharmacist conducts a quarterly interdisciplinary risk reduction quality improvement process with the facility administrator and licensed healthcare staff. Observations conducted during the annual compliance review week supported three youth prescribed medication inventories, including one controlled mediation, were accurate. Three OTC medications were reviewed, and inventories were confirmed to be accurate. Three sharps were reviewed, and inventories were also accurate. A review of the program's counts from the previous six months indicated there were no discrepancies identified with the counts. The program has a written biomedical waste plan signed by the designated health authority (DHA) and maintains a current agreement with Stericycle, Inc. for monthly biomedical waste treatment and removal. Stericycle, Inc. has a State of Florida, Department of Health operating permit which expires on September 30, 2020.

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

The program maintains a written policy and procedures ensuring there is an approved plan for exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Centers for Disease Control and Prevention (CDC), Occupational Safety and Health Administration (OSHA) federal regulations, and State of Florida guidelines. The plan was reviewed and approved by the facility administrator (FA) on August 17, 2018 and designated health authority (DHA) on August 30, 2018. The 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-terrorist agents, chemical exposures, 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 maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program had no instances in which the local health department, Centers for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified of an infectious disease. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the facility administrator has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility / occupational exposure.

The program's Exposure Control Plan/Infection Control Plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The plan includes risk assessment and methods of compliance. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. There were no documented instances of staff having experienced a facility or occupational exposure since the last annual compliance review. The plan is accessible to all staff and is maintained in the medical clinic and in the administrative offices.

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

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

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.	

The program maintains a written policy and procedures ensuring all licensed staff are credentialed and current. The program has licensed nurses to include on-site nursing coverage provided by registered nurses. Review documentation supported all RN(s) licenses were clear and active for each nurse according to Florida Department of Health Medical Quality Assurance. All RNs had a valid and current cardiopulmonary resuscitation (CPR) certification.

Standard 5: Safety and Security

5.01 Youth Supervision	Failed 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 staff promote safety and security by maintaining active supervision of youth including interacting positively with youth, engaging youth in a full schedule of meaningful activities, monitoring youth behavior and changes in behavior, and applying the program's positive performance system. Youth and staff observations were conducted for four days during the annual compliance review week. The observations included youth movement from the dorm to the outdoor recreation area, from the dormitory to school, leisure time, and from the school to the dormitory. During each observation, staff were well positioned and actively supervising the youth. Each of the interviewed staff described the steps to take when there is a discrepancy in youth counts. Observations of youth-to-staff ratios determined ratios were in compliance with the program's contract during the annual compliance review week. The program's head counts were documented in the facility logbook which is maintained by the program staff in master control. Youth counts were consistently conducted during each shift and the master control staff calls for a count from each youth care worker. The master control staff documented all youth and staff movement throughout the day in the facility logbook. Observations found staff interactions with the youth were positive and followed the program's behavior management system.

The program has a daily schedule posted in the dormitory. During a review of six days of the program's video footage, it was observed there was a lack of youth supervision during nighttime which showed improper sight and sound supervision. Observed video footage showed the program staff sitting in a chair appeared to be resting and provided improper sight and sound supervision for the following dates: September 29, 2020 for one hour, September 27, 2020 for six hours, September 23, 2020 for one hour and fifteen minutes, September 19, 2020 for two hours and fifteen minutes, September 13, 2020 for one hour and twenty-eight minutes, and August 28, 2020 for one hour. Three interviewed staff stated when a count cannot be reconciled, all movement will stop at the program, conduct an emergency count and contact the supervisor. The supervisor will then physically count all youth at the program.

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

The program maintains a written policy and procedures for the training and implementation of the program's behavioral management system (BMS). The program utilizes a clearly written,

multi-level BMS designed to enhance the youth treatment, to increase healthy pro-social behavior using positive reinforcement at a four to one ratio and to decrease negative behaviors through consequences. The program and the school have a joint agreement on the implementation of BMS during school hours. The BMS is clearly written in the program's youth handbook. A review of two youth case management records indicated each youth received an orientation to the program which included training on the program's BMS, and an explanation of youth expectations, responsibilities, and consequences. An observation was made of the BMS tracking sheets and incentives which were posted in the dormitory. Observations made during youth movements and in the school setting indicated staff adhered to the BMS when interacting with youth and adhered to a ratio of four-to-one ratio of positive to negative consequences when redirecting the youth, as indicated in the program's policy.

An interview with the facility administrator (FA) indicated the program uses the BMS Tracker/Level System. There are five levels associated with the BMS which include Orientation, Trainee, Maintenance, Independent, and Honors. Youth are promoted to the next level during treatment team meetings. Behavior report (BR) referrals are issued to youth by staff for negative behaviors and special treatment teams address the negative behaviors. Youth receive daily incentives, weekly incentives, monthly incentives for positive behavior. Three staff were interviewed and each correctly explained the program's BMS, knew what type of rewards the program provided as a part of the BMS, and stated nothing can be taken away from youth as a consequence. Three youth were interviewed and were able to describe the process for receiving rewards and consequences.

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 maintains a written policy and procedures regarding the implementation of the behavioral management system (BMS) and to ensure staff are provided feedback on their implementation of the BMS system. A review of the BMS indicated it is not used to increase a youth's length of stay, deny basic rights, or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program's policy requires immediate processing of negative behavior with the youth. The program has a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity during this process to explain their behavior. A special treatment team meeting is held when youth whose behavior requires immediate intervention. The program does not utilize room restriction for major infractions. A review of three staff position descriptions indicated BMS implementation is addressed as a part of the staff daily functions. A review of three in-service records indicated all reviewed staff completed training on the BMS. A review of training documentation verified the educational staff were trained in the implementation of the BMS on April 20, 2018 by the program's clinical director.

Three youth were interviewed, and each youth explained the difference between the levels, how to move from one level to the next, and about the rewards used in the program's BMS. Each youth stated, youth are not allowed to punish other youth, staff are consistent in the use of rewards and, the BMS was rated as "good." Three staff were interviewed, and each staff stated youth are able to explain their behaviors before a behavior report (BR) is written or talk with the supervisor after the BR is written and reviewed with the youth. In addition, all three staff stated they receive feedback on the implementation of the BMS on a daily basis from a supervisor. An interview with the facility administrator (FA) indicated the program uses special treatment team meetings to monitor consequences for negative behaviors. Additional goals are assigned by the clinical and case managers after reviewing the sanctions on the BMS tracker. In order to ensure BMS consistency, new staff receive ninety-day evaluations and in-service staff receive annual evaluations which includes the implementation of the BMS. In addition, the FA and/or unit managers conduct fidelity checks to ensure staff are adhering to the BMS system and that it is fairly administered. The BMS calendar is in place to make sure residents are gaining their incentives properly.

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

The program has a written policy and procedures regarding ten-minute checks. All staff shall observe youth at least every ten minutes while the youth are in sleeping quarters, either during sleep time or at other times, such as during an illness. 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 utilizes a ten-minute check log to document the checks while the youth are in sleeping quarters. A formal interview was conducted with the facility administrator (FA) and confirmed the program is equipped with ninety-eight digital cameras to aid in ensuring security and facility control. All ninety-eight cameras were operational during the annual compliance review. The video system can store video recordings for up to forty-five days according to the FA. A review of ten-minute check logs from nine selected days and several times were reviewed and compared with corresponding video recordings. Six of the nine reviewed videos verified ten-minute checks were not completed and documented correctly. Checks reviewed on September 27, 2020 showed staff sitting down in a chair and awake; however, the staff did not conduct checks for six hours. On September 29, 2020, reviewed video showed only one check was completed by supervisor during the one-hour time frame. On September 23, 2020, the supervisor conducted two checks within an hour and fifteen-minute time frame. On September 19, 2020, the supervisor conducted two checks within a two hour and fifteen-minute time frame. On September 13, 2020, there were no ten-minute checks conducted for a one hour and twenty-eight-minute time frame. On August 28, 2020, the supervisor conducted two checks within a one-hour time frame. In addition, observed video footage discovered ten-minute checks did not occur as documented on the ten-minute check logs. The incident was reported and accepted to the Department's Central Communications Center (CCC). The program provided documentation in which one staff member was terminated in reference to ten-minute checks discrepancies.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day.

The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.

The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.

The program maintains a written policy and procedures to ensure youth are accounted through a system of physically counting youth at various times throughout each day. The program conducts formal head counts each hour and informal head counts are requested by master control. The program's policy indicates counts are conducted during power outages, escapes, riots or any other disruptions which may occur. A review of selected dates and times in the facility logbooks for the previous six months validated head counts and movements were conducted at the beginning of each shift, after outdoor activities, during emergency situation such as riots and during drills, actual or simulated. In addition, the program logbooks included documentation of new admissions, releases, transfers, and youth temporarily away from the program. Documentation verified there were youth temporarily away from the program due to placement in a Department detention center and/or the county jail. The daily census was documented in the facility logbook at the start of each shift. All formal and informal counts documented in the logbook included the time of the count and number of youth at each location. Observations made during the annual compliance review week indicated it is the program's practice to conduct hourly formal counts. In addition, observations included counts conducted in the classrooms, dormitories, and outdoor activities. Three interviewed staff stated if there is a discrepancy in the count, all movement stops, and a supervisor conducts a physical count.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

The program maintains a written policy and procedures for the daily account of routine and emergency situations involving youth to be documented using logbooks. Master control maintains a permanently bound logbook with pre-printed, sequentially numbered pages. Master control staff document emergency situations, incidents, population counts, perimeter checks, transports, removal of youth from population, admission, releases, calls to the Department's Central Communications Center (CCC), calls to the Florida Abuse Hotline, special instructions for the supervision and monitoring of youth, and unannounced facility tours by supervisors. Each entry is to be made in ink with no erasures or white-out. The campus-wide facility

administrator stated in an interview the program does not maintain living unit logbooks. A review of logbooks from the previous six months verified staff documented emergency situations, population counts, security checks, transports, and admissions and releases. Reviewed logbooks indicated errors were struck through with a single line and were initialed by the staff correcting the error. Supervisors conducted staff briefings prior to the beginning of each shift, which were documented on the daily shift report. Incoming staff were briefed from the previous shift and signed the shift report to acknowledge the information had been shared. A review of program shift reports indicated information was shared with incoming staff prior to the beginning of the shift.

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 maintains a written policy and procedures for the assignment, inventory, tracking, storage, and accountability of all keys used in the facility. The program utilizes a Daily Key Log to track keys. The log indicates the name of staff and what type of key was assigned according to their position. Program keys are maintained in the master control office within a locked key box which has limited access. Keys are bound on tamper-resistant color-coded rings which include a brass colored tag with a tracking number and the initials of staff positions. Medical staff keys are maintained in a separate locked key box to ensure only appropriate staff are issued medical keys. Upon arrival at the facility, staff gain access to the program by way of master control. Staff are to submit personal keys in exchange for a program key. Staff sign the key log, acknowledging receipt of the keys. Personal keys are to be placed in the key box next to the corresponding staff's name. Observations of key assignment and reconciling of keys verified this practice. Damaged keys are turned over to maintenance staff to have the key replaced.

The program has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff sign an acknowledgment form indicating receipt of the key identification number and the number of keys issued. Master control staff complete a daily inventory of program keys. A review of key inventory documentation for the previous six months confirmed this practice. An interview with the master control operator indicated if keys are reported lost, all program movement is stopped, and a search is conducted. If the keys are not found within two hours, a call to the Department's Central Communications Center (CCC) is made. A review of CCC incident reports since the last annual compliance review verified there were no incidents in which program keys were lost and not recovered. Three interviewed staff explained the program's key control process including how keys are assigned, reconciled, as well as the processes for missing or lost keys, and damaged keys.

5.08 Contraband Procedure	Satisfactory Compliance

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

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

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

The program maintains a written policy and procedures to address illegal contraband and prohibited items. Youth are informed of unauthorized items and prohibited contraband, as well as the consequences of possessing contraband through the program's youth handbook, to which each youth is orientated. Each parent/guardian is provided a parent handbook which explains the items considered to be unauthorized and prohibited contraband at the program. Visitors are notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, youth handbook, parent handbook, and written rules for visitation confirmed the list of unauthorized and contraband items was included. Unannounced random youth room searches are to be conducted, as well as searches of common areas before and after use by youth. Any contraband or unauthorized items found are documented on a contraband report to include the disposition of the items found.

A review of daily search reports for the previous six months validated this practice. All incoming and outgoing correspondence is searched to control the introduction of contraband into the program and to detect information which could present a threat to the security safety of the program. The program's perimeter security is checked on each shift. A review of the program logbooks for the previous six months indicated perimeter searches were conducted and documented in the logbook. A review of the Department's Central Communications Center (CCC) reports for the past six months indicated there was one incident of illegal contraband confiscated by the program. The program secured the item in the chief of security's office and will be discarded. Three interviewed staff stated youth searches are conducted anytime a youth is moved from one area to the next. An interview with the facility administrator (FA) indicated if contraband is found, the items will be sent home, stored with the youth's property until youth is released, and/or returned to owner or disposed. Illegal contraband is stored in the FA's office until handed over to law enforcement.

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

The program maintains a written policy and procedures to ensure searches and full body visual searches are conducted according to Florida Administrative Code. Youth are searched at the time of admission, after any off-campus activity, and visitation. Searches are conducted by a staff of the same gender as the youth searched. Parents/guardians are notified of searches during visitation by way of the parent/guardian intake letter which is sent at the time of the youth's admission. Youth are searched after school, transports, groups, outdoor recreation, meals, and at each movement. 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 prior to returning to the general population. Observations of searches conducted during the week of the annual compliance review indicated searches were conducted by a staff of the same gender conducted in a manor not to degrade the youth, and based on the Protective Action Response (PAR) training manual. A review of video footage of youth using class B tools in the dormitory verified the youth were not searched after cleaning the dormitory and putting the tools back into the tool closet. Three interviewed youth indicated searches are conducted when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail. Three interviewed staff stated youth searches are conducted after every youth movement.

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

The program maintains a written policy and procedures to ensure vehicles used for youth transportation are properly maintained. The program had one operable van to transport youth during the annual compliance review period. Inspection of the vehicle confirmed it had an installed safety screen and doors which could not be opened from inside the passenger area. The observed vehicle was equipped with a fully-charged fire extinguisher, a seatbelt cutter, window punch, and operable seatbelts for each passenger. The vehicle's first aid kit was stored in master control to be checked out when using the vehicle. Annual vehicle inspections are conducted by the program's in-house mechanic, who is automotive service excellence (ASE) certified until June 30, 2022 to conduct auto maintenance, breaks, and light repairs. Reviewed documentation indicated the vehicle received an annual safety inspection on August 21, 2020. The program's practice is to secure all program vehicles and personal vehicles when not occupied. Observations of the program vehicle and fifteen personal vehicles parked in the staff parking lot outside of the secure fenced perimeter validated each was locked and secure.

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

The program maintains a written policy and procedures for the safe and secure transportation of youth. Staff are not permitted to leave a youth unattended in a vehicle and youth are not permitted to drive the program or staff vehicles. Observations of a transport was not possible during the week of the annual compliance review. An informal interview with a transportation staff verified transporters are provided with a company cellular telephone to communicate during youth transport, and there is always one staff of the same gender of the youth being transported. The program requires a ratio of one staff to a maximum of five youth during transport; however, the driver is not included in the ratio. The program's policy requires maintenance of a list of staff holding an eligible driver's license which is to be updated monthly and signed by the facility administrator (FA). Reviewed documentation verified the practice. Three interviewed staff stated the program provides a company cellular telephone for communication. Each staff verified the vehicle is equipped with a fire extinguisher and a first aid kit and the vehicle is checked for contraband prior to transporting youth. All three interviewed staff confirmed they are not allowed to use personal vehicles to transport youth. Two of the three interviewed staff stated in case of an emergency, they would call 9-1-1 and master control. One reviewed staff did not conduct transports.

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

The program maintains a written policy and procedures to ensure safety and security of the program is maintained. The policy identifies who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. The program's policy calls for the weekly safety and security audits to be conducted by the physical plant manager (PPM) or designee and documented on the Department's Facility Security Audit and Safety Inspection form. In addition, the PPM conducts monthly electrical, central air conditioner, and campus inspections. Identified deficiencies were documented on the reports including the status and due date of any needed corrective action and were added to the program's tracker. A review of weekly safety and security audits for the previous six months verified the audits were completed, as required. The interviewed facility administrator (FA) stated a security audit and safety inspection walkthrough is conducted weekly by the FA or designee, and maintenance staff to identify and address and security concerns and/or maintenance issues. A weekly walkthrough is conducted with the chief of security. Once identified, work orders are completed to ensure maintenance follows up to correct identified issues in a timely manner. The audit tracker is also forwarded to the Department weekly.

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 maintains a written policy and procedures addressing the proper control and management of tools used within the facility. The policy encompasses the storage and inventory of tools, as well as class type. All tools which are classified as Class A list tools by the program

are labeled and inventoried daily. Class A tools are maintained in the carpenter's shop and the mechanic shop which are located outside of the program's secured fenced perimeter and inaccessible to youth. Tools are stored on shadow boards, in locked cabinets, with a list of the contained tools posted on the outside of each cabinet. Additional tools are maintained in the maintenance truck's bed-mounted tool chests, organized with wooden tool cut-outs for each stored tool. An informal interview with maintenance staff indicated there were no occurrences of any lost or missing tools since the last annual compliance review. A review of the inventory lists for both carpentry and mechanical tools validated there were no missing tools. Observations of the carpentry and mechanical tools areas confirmed the areas were organized and clean. Class B tools, which includes brooms, scrub brush, dustpan, and mops, were stored in the dormitory in a designated locked room with an inventory list available in the class B tool room. The list identifies the type and number of each tool maintained in the closet. A review of the inventories confirmed each listed tool was accounted for. Three interviewed staff stated youth are allowed to use scrub brushes, mops, dustpan, and brooms.

5.14 Youth Tool Handling and Supervision	Failed 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 to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to themselves, other youth, and staff. Class B tools, which includes brooms, scrub brush, dustpan, and mops, are stored in the dormitory in a designated locked room with an inventory list available in the class B tool room. Youth are not allowed to handle any tools unless a risk assessment has been completed determining the youth is not at risk. A review of three youth case management records verified risk assessments were completed and identified whether the youth was eligible to handle tools. Observations of a secured storage room confirmed it contained a broom, mop, mop bucket, toilet plunger, and dustpan. A video observation of a work detail revealed staff unlocked the tool room and brought out the mop bucket with the cleaner poured in by staff. Youth entered the class B storage room and removed the brooms and mops while two staff were sitting down which showed improper supervision during work detail. The youth cleaned the area behind the staff who were observed sitting down. The staff was not positioned in a way to properly observe youth cleaning. After the work detail was completed, youth returned the class B tools back to the storage room. Observations of the video footage showed the youth were not searched by the program staff after the work detail was completed. A review of three staff in-service training records indicated each staff completed training in the appropriate use of tools. Three interviewed youth stated they are allowed to use brooms, mops, and dust pans.

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 specific to outside contractors entering the program areas with tools and equipment. The program is to restrict tools to those necessary, check tools upon the worker's arrival and departure, restrict youth access to the work area, ensure immediate reporting of any tool the worker cannot locate, and follow up if any tool is missing. When a contractor arrives on campus, the workers are to sign-in on the log, are provided a visitor's contraband list outlining unauthorized items, and review and sign the contractor guidelines. A list of tools the contractor requires to complete the project is

inventoried. If any unauthorized items are needed by the contractor while in the program, approval must be obtained by the facility administrator (FA) or designee. An interview with the physical plant manager indicated youth are not allowed in the vicinity of the work area while work is completed. A maintenance staff is assigned to the work area to ensure the work is completed, all tools are accounted for, and to ensure no items which may be identified as contraband are present. A review of documentation for the previous six months supported the forms were signed by the outside contractors and witnessed by the maintenance staff. A review of nine vendor project invoices and the program's contractor binder revealed the program maintained a contractor sign-in sheet, a Prison Rape Elimination Act (PREA) acknowledgement, and a Vendor/Outside Contractor Tool Inventory List for each outside worker. In addition, documentation was entered in the program's logbook detailing, the time, date, contractor/vendor name, and which staff escorted the contractor.

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 March 4, 2020. The COOP requires the program to conduct and document unannounced fire drills once a month on each shift. Drills are to be conducted on a random basis under varied conditions and include all staff, youth, and visitors located on the premises of the facility. Program staff document drills on Facility Drill forms which include the beginning and ending times of the drill, the nature of the drill, the participants, a brief scenario description, and the recommendations. Reviewed documentation validated fire drills were conducted on all shifts each month, for the previous six months. The program additionally conducted monthly emergency drills on each shift ensuring fire, severe weather, escapes, gang/riots, hostage situations, and chemical spills were covered on a rotating basis. Drill documentation included the type of drill, date and time, participants, a brief scenario description, deficiencies identified during the drill, and applicable corrective actions.

An interview with the facility administrator (FA) confirmed fire drills are completed once on each shift every month. COOP drills such as bomb threat, hurricane, hostage situations, are completed monthly across campus and rotated to capture all types of situations. All COOP binders are accessible to staff in master control and in the program administration areas. There are three emergency medical drills done once a month, on each shift. Three interviewed youth confirmed they had been instructed on what to do in the case of a fire and participated in fire drills. An interview with three staff revealed they participated on various drills within the last six months including drill scenarios involving weather, major disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorism, escape, medical emergencies, and fire.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance

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

A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.

The program maintains a written Emergency Disaster Preparedness and Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a varied range of potential emergency situations. A review of the COOP validated the plan was submitted and approved by the Department on March 4, 2020. Further review of the COOP indicated alternative housing plans were included should the program be required to vacate due to an emergency or disaster. The program maintains the required critical identifying information for each youth in administrative hard-copy records which are accessible and mobile in the event of an emergency in master control. The program has a generator, water, and food supply among other supplies required for continuous operation and services during an emergency or disaster situation. An interview with the facility administrator (FA) and an informal interview with the campus-wide assistant superintendent indicated copies of the program's COOP are maintained in master control, the FA's office, the program's administration office, and the medical office.

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

The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.

The program maintains a written policy and procedures to address the control of hazardous materials. These items are stored in locked metal cabinets within a secure building outside the secure fenced perimeter of the program and are inaccessible to the youth in the program. A binder of Safety Data Sheets (SDS) is located with the chemical items and includes a photograph of each item. The program's physical plant manager maintains a list of materials, an authorized staff list for access to chemicals posted on the outside of the door, and a permanent log to display the signing in/out of chemicals. The program records the daily use of chemicals on a daily chemical usage log including the initials of the authorized staff using each chemical. All of the chemicals are inventoried once a week by the program's physical plant worker. The storage area was neat and well-organized. Chemicals such as bleach are located in a locked locker in medical. Non-toxic chemicals such as all-purpose cleaner and detergent is located in the locked storage room which is inaccessible to youth. A reviewed of documentation for the previous six months reflected the chemical inventory logs identified each item by brand name, amount used and the initials of the staff updating the log.

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

The program maintains a written policy and procedures prohibiting youth from handling poisonous, flammable, and toxic items and materials. The program's policy stipulates the facility administrator (FA), program director, unit manager, physical plant manager, and shift supervisors may draw and utilize chemicals. Youth care workers, nursing staff, case management staff, clinical staff, and administrative staff are authorized to use chemicals but may not draw chemicals from the inventory. Authorized staff maintain control over all flammable, poisonous, toxic items off-site and must be secured when not in immediate hands of staff. When needed, authorized staff will obtain a supply of chemicals used to clean the dormitory from the supply room. A chemical sign-out log is maintained within the supply room. Youth are not allowed to possess flammable, poisonous, toxic, or caustic items. When necessary, staff are to spray the chemical and youth will wipe it up. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waste. Three interviewed youth confirmed they do not use any chemicals or cleaning products. A video observation verified staff poured cleaning product in the mop bucket for youth to clean the dormitory.

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

The program maintains a written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials are kept in the locked storage shed located off campus and are disposed of according to the Safety Data Sheet (SDS). The program has a list of staff who are authorized to dispose of unused flammable, poisonous, and toxic materials. An interview with the physical plant manager indicated the program disposes of unused chemicals during the county's Amnesty Day which is a day set bi-annually by Okeechobee County Waste Management for the disposal of toxic materials and signed documentation from the county is received identifying what materials are disposed. According to the physical plant manager, the program had no chemicals disposed of since the last annual compliance review. Used kitchen grease and waste is stored in a large container outside the kitchen area and is disposed of quarterly by a contracted provider. An informal interview with the physical plant manager confirmed the program has not had any chemical spills occur since the last annual compliance review. A form interview with the facility

administrator (FA) verified the program participates in Amnesty Day twice a year where all hazardous chemicals can be disposed. These chemicals cannot be dumped on the ground, in sewers, or waterways and must be kept in the maintenance area until disposed. In addition, a log of all disposed chemicals must be kept.

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

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

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

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

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

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

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

5.22 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program maintains a written policy and procedures to allow youth to have visitation and communication with family members to maintain and re-establish family and community relationships. Youth are informed of visitation upon admission during the orientation process. The program’s youth handbook, which is provided to each youth upon admission to the program, outlines visitation, telephone calls, and mail correspondence. The program encourages visitation from the parents/guardians by sending a welcome letter and parent handbook upon the youth’s admission, notifying the days and time of visitation, who is allowed

to visit, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in each youth's case management records and updated as needed. Youth are permitted weekly telephone calls. Youth are permitted to visit with the parent/guardian, grandparents, siblings, and step-parents unless prohibited by a court order. The program's policy also details procedures for visitation including when a person is denied visitation or correspondence with a youth.

A review of three youth case management records verified each record contained an approved correspondence, visitation, and telephone log. Visitations are held on Saturdays from 1:00 p.m. to 4:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate in the regularly scheduled visitation day. Due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control and Prevention (CDC), on-site visitation at the program was suspended at the Department's direction effective March 13, 2020. Youth are provided writing materials, and a self-addressed stamped envelope to send letters to approved family members. Youth have unimpeded access with the courts, attorneys, assigned juvenile probation officer (JPO), and/or Department of Children and Families case worker. An informal interview with the campus-wide assistant superintendent verified youth can use video conferencing to call their family members. Three youth were interviewed, and each indicated they are given the opportunity to communicate with family members by mail, telephone, and/or visitation.

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

The program maintains a written policy and procedures for the use of controlled observations. The program has two controlled observation rooms which meet the size and construction requirements required by Florida Administrative Code. An inspection of the controlled observation room verified the door was metal with a shatter-resistant window. All the light fixtures were covered with shatter-resistant materials, the vents were not easily accessible, there were no electrical outlets in the room and the electric switches were located outside the room. The interviewed facility administrator (FA) stated there have been no youth placed in controlled observation since the last annual review.

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

The program maintains a written policy and procedures for the use of controlled observation. The interviewed facility administrator (FA) stated there have been no youth placed in controlled observation since the last annual compliance review.

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

The program maintains a written policy and procedures for the use of controlled observation safety checks and for releasing youth from controlled observation. The policy requires safety checks to be completed every fifteen minutes on all youth placed in controlled observation. The interviewed facility administrator (FA) stated there have been no youth placed in controlled observation since the last annual compliance review.